

2017 Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary
UnitedHealthcare Community Plan of Iowa – 2017



Welcome

Welcome to the Community Plan provider manual. This complete and up-to-date reference PDF (manual/guide) allows you and your staff to find important information such as processing a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Operational policy changes and other electronic tools are ready on our website at UnitedHealthcareOnline.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.
- [West Capitated Administrative Guide](#), or go to uhcwest.com > Provider, click Library at the top of the screen. The Provider Administrative Guides link is on the left.
- 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.

This manual will be amended as policies change.

Table of Contents

• Chapter 1: Welcome to UnitedHealthcare Community Plan of Iowa	1
• Chapter 2: Member ID Cards	4
• Chapter 3: Medical Management	5
• Chapter 4: Grievances, Appeals and State Fair Hearings	9
• Chapter 5: Quality Management	12
• Chapter 6: Hospital Services	14
• Chapter 7: Durable Medical Equipment (DME)	15
• Chapter 8: Hospice End of Life	18
• Chapter 9: Home Health Services	23
• Chapter 10: Health Homes	25
• Chapter 11: Long Term Care/HCBS	26
• Chapter 12: Claims	35
• Chapter 13: Physician and Facility Standards and Policies	39
• Chapter 14: Provider Communications	48
• Chapter 15: Covered Benefits	49
• Chapter 16: Glossary	75

Chapter 1: Welcome

This manual is designed as a comprehensive reference of information that you and your staff need to interact with us in the quickest and most efficient manner possible. Much of this material, as well as operational policies and additional information, is available at UHCCommunityPlan.com.

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

If you have any questions about the information or material in this manual or about any of our policies or procedures, please contact Provider Services at 888-650-3462. In addition, the UnitedHealthcare Community Plan office is located at:

UnitedHealthcare Community Plan
1089 Jordan Creek Parkway
West Des Moines, IA 50266

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

Important Information Regarding the Use of This Manual

In the event of a conflict or inconsistency between your participation agreement and this manual, the manual controls unless the agreement dictates otherwise.

We reserve the right to supplement this manual to help ensure that its terms and conditions remain in compliance with relevant federal and state statutes and regulations. This manual will be amended as operational policies change.

Communications to Care Providers

From time to time, there may be important information about policies and protocols that must be communicated to all participating care providers. These communications may be done through *Network Bulletins* or through the *Practice Matters* provider newsletter. If the information communicated through these methods is a change to any protocol set forth in this manual, you will see the updated information in this manual upon the next provider manual revision notification.

Network Bulletin – The Network Bulletin is a monthly publication posted to UnitedHealthcareOnline.com. The Bulletin contains information and updates as well as administrative changes for all care providers, not just Medicaid. Articles located in the Bulletin that are specific to Iowa Medicaid care providers will also be communicated through the provider newsletter called *Practice Matters*.

Practice Matters – *Practice Matters* is the provider newsletter published quarterly specific to Iowa Medicaid products within UnitedHealthcare Community Plan of Iowa. This newsletter includes any policy changes and communicates any clinical topics or reminders. Articles regarding policy or administrative updates will be included in this publication, but may also be found in the Network Bulletin as specified above. The *Practice Matters* newsletters are posted at UHCCommunityPlan.com For Health Care Professionals > Iowa > Provider Newsletters.

About UnitedHealthcare Community Plan of Iowa

UnitedHealthcare Community Plan of Iowa seeks to help the people we serve live healthier lives. We understand that compassion and respect are essential components of a successful health care company. UnitedHealthcare Community Plan employs a diverse workforce, rooted in the communities we serve, with varied backgrounds and extensive practical experience that gives us a better understanding of our members and their needs.

Our Approach to Health Care

Our personalized programs encourage the efficient utilization of quality services. These programs, some of them developed with the aid of researchers and clinicians from academic medical centers, are designed to help members best manage their chronic medical conditions.

Our clinical model helps people live healthier lives through integrated health care and services that support the people we serve, to live a meaningful life in a community of their choice, providing accessible, affordable options focused on improving health literacy, connecting them to a medical/behavioral health home, and maintaining or improving their health, well-being, and highest possible functional status.

Through our integrated model, medical, behavioral and long-term care services and supports are fully integrated for all members to help ensure seamless care transitions and coordination of health care. Clinical programs — Care

Coordination, Utilization Management, Disease Management, and Specialty — are connected through the Interdisciplinary Care Team and a common member record.

Wellness

We recognize the importance of the routine medical exams and screenings for our members. We monitor opportunities to close this gap in care through a universal tracking database which helps us identify members who have not had their HEDIS recommended exam or screenings as indicated. Members who are compliant with recommend exams and screenings are eligible to have their annual insurance premiums waived through the Healthy Behaviors Program. Our Baby Blocks Program encourages member compliance for prenatal, postnatal and the first 15 months of life. Gaps in care reporting is available for your utilization through our online coordination tool, Community Care.

Cultural Competency

Cultural competency is at the heart of serving all of our members, including those who are poor, homeless, or belong to a minority population, with their special health needs and their unique circumstances. Cultural sensitivity plays a vital part in realizing our goal of supporting member recovery and resiliency in ways that are meaningful and appropriate for individuals in their communities and relevant to their unique cultural experiences. UnitedHealthcare Community Plan is committed to helping ensure that we, as well as our care providers, treat members with respect and dignity, regardless of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, health status, income status, or physical or mental disability.

Our philosophy for ensuring cultural competency emphasizes a “whole member” approach that honors members’ beliefs, cultural diversity and fosters staff and care provider attitudes and personal communication styles with respect to the member’s environment, cultural background and beliefs.

We are also committed to disability competency in which individuals and systems provide services effectively to people with various physical and behavioral disabilities. We believe care delivery includes respecting the worth of each individual and preservation of personal dignity and helping ensure member are free to choose where they live and who provides their services.

These considerations include:

- Compliance with American Disabilities Act (ADA) indicated through policies and procedures
- Mobility and accessibility, including wheelchair ramps and entrance access

- Accessible medical equipment and services adapted to member needs and disability (i.e. adjustable examination table)
- Community resources and assistance, including transportation

For additional information on disability competency for Home- and Community-Based (HCBS) waiver members, please see Chapter 10 Long-Term Services and Supports/Home- and Community-Based Services.

In the event that you find that you are unable to assist a member’s access needs, including counseling or referral services, call us at 888-650-3462 so that we can refer the member to a network care provider who is able to make the necessary accommodations for member care.

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 UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Administrative Guide.

National Provider Identifier

NPI is the standard unique identifier (a 10-character number with no imbedded intelligence) for healthcare providers under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which covered entities must accept and use in standard transactions.

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

The NPPES assists care providers with their application, processes the application and returns the NPI to the care provider.

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

Only care providers who are direct providers of healthcare

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

How to get an NPI



Healthcare providers can apply for NPIs in one of three ways:

- For the most efficient application processing and the fastest receipt of NPIs, use the web-based application process. Simply log onto the National Plan & Provider Enumeration System – Home Page and apply online at nppes.cms.hhs.gov/NPPES.
- Healthcare providers can agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so.
- Healthcare providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. The form will be available only upon request through the NPI Enumerator. Healthcare providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of these ways:
 - Phone: 800-465-3203 or TTY: 800-692-2326
 - Mail: NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059
 - Email: customerservice@npienumerator.com

Chapter 2: Member Cards

The following represents the member ID cards. Please note that the member's benefit plan is differentiated in the lower, right-hand corner of each ID card:

Medicaid ID Card

Health Plan/Plan de salud (80840) 911-87726-04


Member ID/ID del Miembro: 1234567X **Group/grupo: IAQHP**

Member/Miembro:
SUBSCRIBER M BROWN **Payer ID/ID del Pagador: 87726**

PCP Name/Nombre del PCP:
DR. PROVIDER BROWN

PCP Phone/Teléfono del PCP:
(999)999-9999

DOB:
00/00/0000




Rx Bin: 610494
Rx Grp: ACUIA
Rx PCN: 4444

Iowa Medicaid

DHS14 Administered by UnitedHealthcare Plan of the River Valley, Inc

Printed: 04/23/12



En caso de emergencia, acuda a la sala de emergencia más cercana o llame al 911. In an emergency, go to the nearest emergency room or call 911. Unauthorized use of non-plan providers may result in benefits denial. www.MyUHC.com/CommunityPlan

For Members/Para Miembros: 800-464-9484 TDD 711



For Providers: www.unitedhealthcareonline.com 888-650-3462

Claims Address: P.O. Box 5220, Kingston, NY 12402-5220

For Pharmacist: 877-495-2272

Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903

Iowa hawk-i ID Card

Health Plan/Plan de salud (80840) 911-87726-04


Member ID/ID del Miembro: 1234567X **Group/grupo: IAQHP**

Member/Miembro:
SUBSCRIBER M BROWN **Payer ID/ID del Pagador: 87726**

PCP Name/Nombre del PCP:
DR. PROVIDER BROWN

PCP Phone/Teléfono del PCP:
(999)999-9999

DOB:
00/00/0000



Rx Bin: 610494
Rx Grp: ACUIA
Rx PCN: 4444

Iowa hawk-i

DHS14 Administered by UnitedHealthcare Plan of the River Valley, Inc

Printed: 04/23/12



En caso de emergencia, acuda a la sala de emergencia más cercana o llame al 911. In an emergency, go to the nearest emergency room or call 911. Unauthorized use of non-plan providers may result in benefits denial. www.MyUHC.com/CommunityPlan

For Members/Para Miembros: 800-464-9484 TDD 711

For Providers: www.unitedhealthcareonline.com 888-650-3462

Claims Address: P.O. Box 5220, Kingston, NY 12402-5220

For Pharmacist: 877-495-2272

Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903

Chapter 3: Medical Management

3.1 Admissions

Prior authorization is not required for emergency services, including transportation. Emergency care should be rendered immediately upon member presentation. Please provide notification to us of an admission by 5 p.m. the following business day through any of the following avenues:

- Use Link through [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com)
- Phone: 888-650-3462
- Fax: 888-899-1680 (Fax forms are located at [UHCCommunityPlan.com](https://www.uhccommunityplan.com) > For Health Care Professionals > Iowa > Provider Forms > [Prior Authorization Faxed Request Form](#)).
- We review emergency admissions within one working day of notification.

Authorization Notification Requirements

UnitedHealthcare Community Plan emergency room admission authorizations/notification must contain the following information:

- Member name and health plan member ID number
- Facility name and tax identification number (TIN) or national provider identification (NPI)
- Admitting/attending physician name and TIN/NPI
- Description for admitting diagnosis or ICD-10, or its successor, diagnosis code
- Admission date (Admission to inpatient starts at the time the order is written by a physician that a member's condition has been determined to meet an acute inpatient level of stay.)

UnitedHealthcare Community Plan **prior** authorizations must contain the above criteria with the following information:

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

For Behavioral Health and Substance Use Disorder authorizations, please see the current Network Manual and the Manual Addendum available on [providerexpress.com](https://www.providerexpress.com).

Care providers who are non-participating with UnitedHealthcare Community Plan of Iowa are required to follow the same guidelines related to prior authorization as participating care providers. Prior authorization is required for all non-participating provider services, with the exception of family planning services, emergency services, and approved prior authorized services. We provide coverage for emergency services without regard to the emergency care provider's contractual relationship with UnitedHealthcare Community Plan of Iowa.

Emergency Medical Condition Defined

An emergency is defined as a physical or behavioral condition with acute and severe symptoms, including severe pain. A layperson could reasonably expect the absence of immediate medical attention to result in:

- a. placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy
- b. serious impairment to bodily functions
- c. serious dysfunction of any bodily organ or part. This includes cases where immediate medical attention would not have resulted in such impairment or dysfunction
- d. UnitedHealthcare Community Plan representative instructs the member to seek emergency services.

Urgent Care

Urgent care is the treatment of a health condition, including behavioral, which is not an emergency. However, the condition is severe or painful enough to cause a prudent layperson, possessing the average know ledge of medicine, to believe that the person's condition requires medical treatment or evaluation within 24 hours to prevent serious deterioration.

Please have a plan in place for those members for whom you can reasonably anticipate may require urgent care at some point due to their medical condition; perhaps a same or next day appointment availability with you or directions for them.

Potentially Preventable Emergency Room Visits

A majority of our members live with chronic and complex medical conditions. We believe that the person-centered care model is a cornerstone to their medical management. We urge you to practice wellness by closing gaps in care per HEDIS and best practice guidelines. Please help teach our members to:

- Actively participate in health maintenance activities and care planning

- Recognize worsening symptoms and their triggers
- Have an emergency plan in place and know when to:
 - Come to your office for a same- or next-day visit with you
 - Visit an urgent care center
 - Go to the emergency room

3.2 Delivery Admissions

Prior authorization for delivery is not required as is delivery notification. Please call 888-650-3462 or fax the following information for the newborn to 866-943-6474:

- Date of birth
- Birth weight
- Gender
- Delivery type
- Gestational age

3.3 Newborn Admissions

Prior to or upon a mother's discharge, if the baby stays in the hospital after the mother is discharged, Healthy First Steps will conduct concurrent review of the newborn's extended stay. The hospital should make available the following information:

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

3.4 Care Coordination

We screen all our members with an initial health risk screening as they are:

- Newly enrolled to our health plan, within 90 days of enrollment
- Re-enrolling to our health plan who have not been enrolled in the prior 12 months
- Reasonably believed to be pregnant

The initial health risk screening may be conducted in person; by phone; electronically through a secure website or by mail. During the initial health risk screening process, members are offered assistance in arranging an initial visit with their primary care provider (PCP) for a baseline medical assessment and other preventive services.

High-Risk Case Management for Members not in an HCBS Waiver Program

For some members, the results of the initial health risk screening may indicate the potential need for a more in-depth assessment of their needs to best serve them. A care coordinator in our case management program designed for members with high risk conditions will complete a comprehensive assessment by telephone or during a visit to a member's home. The assessment includes: condition of health, history, medications, level of environmental functioning, current care provider and service treatment, and member knowledge of their health condition(s) and level of personal health care management. Members who are determined eligible to receive continued services through this program are referred to our care coordination program for enrollment. If they choose to take part of this program, they will then have a person-centered care plan developed with their care team and receive on-going coordination of their care.

Person-Centered Care Model

We use a person-centered care model to manage those members not in an HCBS waiver program. The model includes planning and implementation, which is led by the member where possible. Members are encouraged to choose the participants and those who provide their care. We are dedicated to helping ensure our members receive the quality care they need to allow them to live the healthiest possible lifestyle in the community of their choice to the best of their ability. The role of our Complex Community Care Team consisting of the behavioral health advocate, registered nurse, PCP, community health worker and member or representative is to facilitate member care through a team approach based on member need and choice. Through our care coordination, we strive to:

- Empower members
- Deliver flexible person-centered care
- Help ensure member understanding of their health care conditions and prescribed treatment
- Increase member compliance with recommended treatment protocols
- Coordinate care across the health care delivery system
- Improve quality outcomes

We have developed disease management programs to meet the needs of our members with chronic illnesses and to support efforts for member self-management. These programs include diabetes and maternity. We use Community Care, an online planning tool that is accessible by the coordination team, including the member or member representative. Participants are invited to the member record on this platform by email. For more information, visit [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com) > Tools & Resources > Training and Education > Medicare > Community Care.

Care plans are updated at least annually or sooner if indicated by a change in member condition or circumstances. A member may request a re-assessment and a re-visit to their care plan at any time. Once the plan is in place, our care coordinators continue to monitor service delivery and member treatment participation and circumstances. For more information, please visit UHCCommunityPlan.com > For Health Care Professionals > Iowa > Billing and Reference Guides > Our Care Coordination.

If you see a change in member condition or circumstances in your interactions with a member, please report this right away to their care coordinator directly or call Provider Services at 888-650-3462.

3.5 Lock-In Program

The pharmacy Lock-In Program helps ensure that members selected for enrollment in the program will use services appropriately and in accordance with department rules and policies. The program limits Lock-In members to fill their prescriptions at one pharmacy. Members with potentially inappropriate patterns of medication utilization are identified, using pharmacy and medical claims data.

When a member is identified for Lock-In Program review, the clinical pharmacy team reviews the pharmacy and medical claims history to determine if the member has used prescription medications with the potential for high abuse, at a frequency that is not medically necessary/abusive/excessive. It is then determined if the member should be considered for the Lock-In Program.

When a member is enrolled in the Lock-In Program, they are sent a written notification of the intent to restrict their medication utilization to one pharmacy. The member is allowed 30 days from the mailing of the notification letter to change the pharmacy that is assigned to them. If a response is not received from the member within 30 days, the member is assigned to the pharmacy indicated in the notification letter. After this time, the member may request a network pharmacy change for a good cause reason as long as it is agreeable to both the member and the health plan. To request a Lock-In pharmacy change, the member should call Member Services at 800-464-9484.

The Lock-In will remain in effect until member shows a pattern of utilizing services appropriately. At a minimum, member's utilization will be reviewed every two years. If the member transfers to another MCO, the member's Lock-In may continue.

A one-time 72-hour emergency supply for medications is available at a pharmacy other than the member's Lock-In pharmacy on a one-time basis per member, per drug if the Lock-In pharmacy is unable to obtain inventory of the required medication.

The member or their representative may request an appeal of this restriction decision within 30 days, by calling Member Services at 800-464-9484 or by sending a written appeal to:

Grievance and Appeals
PO Box 31364
Salt Lake City, UT 84131-0364
Fax: 801-994-1082

To refer a member to the pharmacy Lock-In program, call Provider Services at 888-650-3462. Please include an explanation for your referral, member name, member ID number, and member demographics.

3.6 Family Planning

Family planning services are covered when provided by physicians or practitioners to members who voluntarily choose to delay or prevent pregnancy. Covered services include the provision of accurate information and counseling to allow members to make informed decisions about specific available family planning methods. Members have a choice to receive services from a UnitedHealthcare Community Plan of Iowa care provider or go directly to a local health department or family planning clinic. Members do not need a referral for these services.

3.7 Maternity Care

Please notify us promptly of a member's pregnancy status to help ensure appropriate follow-up and coordination by our UnitedHealthcare Healthy First Steps team by submitting an American College of Gynecology or other initial prenatal visit form to Healthy First Steps by fax 877-353-6913 or call 888-650-3462.

3.8 Healthy First Steps

Designed to improve birth outcomes and reduce Neonatal Intensive Care Unit (NICU) admissions, the Healthy First Steps program uses early identification to:

- Help overcome common social and psychological barriers to prenatal care
- Increase member understanding of the importance of early prenatal care
- Increase the mother's self-efficacy by identifying and building the mother's support system
- Help ensure appropriate postpartum and newborn care
- Develop the physician/member partnership and relationship before and after delivery

Concurrent Review

We do concurrent reviews on hospitalizations for the duration of the stay based on contractual arrangements with the hospital. UnitedHealthcare uses evidence-based, nationally accepted, clinical criteria guidelines for determinations of appropriateness of care.

Inpatient Concurrent Review: Clinical Information

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

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

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

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

Discharge Planning and Continuing Care

We are involved in a member's hospital discharge planning. We work with the member, member representatives, physicians, hospital discharge planners, rehabilitation facilities, and home care agencies. We evaluate the appropriate use of benefits, oversee the transition of members between various settings, and refer to community-based services as needed.



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

Fraud and Abuse

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

Definitions of Fraud and Abuse

Fraud: An intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit to them or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse: Care provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the program or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to the program.

Examples of fraud and abuse include:

- Misrepresenting services provided, such as billing for services or supplies not rendered or misrepresentation of services/supplies.
- Falsifying claims/encounters, such as incorrect coding, double billing or false data submitted in a claim.

Reporting Fraud and Abuse

You do not have to prove, but if you suspect Medicaid or welfare fraud, waste or abuse, you have a responsibility and a right to report it. Reports of suspected fraud or abuse can be made by calling:

- 888-650-3462 or
- Contacting the State of Iowa for Medicaid and Welfare Fraud and Abuse at 800-831-1394.

For suspected Medicaid Fraud or Abuse, call the Fraud and Abuse Hotline at 866-242-7727.

Chapter 4: Grievances, Appeals and State Fair Hearings

If a member has a complaint about a service or care received from UnitedHealthcare Community Plan or a network doctor, they may call Member Services or talk to the doctor. If the issue cannot be resolved informally, the member has the right to file a formal grievance or appeal. Below are the member grievance, appeal and State Fair Hearing processes as described in the Member Handbook. If the member has questions about grievances, appeals or State Fair Hearings, they can call us at 800-464-9484, TTY: 711. The appeal form can be found online at UHCCommunityPlan.com > For Health Care Professionals > Iowa. We can help if the member needs help filling out the form. As a care provider, if you are appealing on behalf of a member, please call Provider Services at 888-650-3462.

Member Grievances

A grievance is a verbal or written expression of dissatisfaction about any matter other than an Action, as defined in the Appeal section. The member, their representative or a care provider acting on behalf of the member may file a grievance, with written consent from the member. The grievance must be filed within 60 calendar days from the date the dissatisfying event occurred. The member has the right to file a grievance if they disagree with a decision made by UnitedHealthcare. Examples include, but are not limited to:

- Unhappy with the quality of care.
- The doctor the member wants to see if not a UnitedHealthcare Community Plan doctor.
- Not able to receive culturally competent care.
- The member got a bill from a care provider for a service that should be covered by UnitedHealthcare Community Plan.
- Rights and dignity.
- Recommended changes in policies or services.
- Any other access to care issues.

Member Grievance Process

The member, or their representative, can file a grievance by calling UnitedHealthcare Member Services at **800-464-9484**. Care providers acting on behalf of a member who have written consent may also file a grievance by calling Provider Services at 888-650-3462. The member, member representative or a care provider acting on behalf of the member, with written consent from the member, may also file a grievance by sending a letter to UnitedHealthcare Community Plan at:

Grievance and Appeals

PO Box 31364

Salt Lake City, UT 84131-0364

Fax: 801-994-1082

If someone else is going to file a grievance for a member, we need the member's written permission. We will send a letter within three working days confirming we received the grievance. We will review the grievance and send our decision in writing within 30 calendar days of receipt of the grievance or as quickly as the member's health condition requires. UnitedHealthcare Community Plan may extend up to 14 calendar days. If the time frame is extended, for any extension not requested by the member, we will give the member written notice of the reason for the delay and inform the member of the right to file a grievance if the member disagrees with the decision. There is no right to appeal a grievance decision.

Member Appeals

An appeal is a request for a review of an action. An action, as defined in 42 C.F.R. § 438.400(b) is the:

- (i) denial or limited authorization of a requested service, including the type or level of service;
- (ii) reduction, suspension or termination of a previously authorized service;
- (iii) denial, in whole or in part, of payment for a service;
- (iv) failure to provide services in a timely manner;
- (v) failure of UnitedHealthcare Community Plan to act within the required timeframes set forth in 42 C.F.R. § 438.408(b); or
- (vi) for a resident of a rural area with only one
 - (1) Medicaid managed care contractor, the denial of a member's request to exercise their right, under 42 C.F.R. § 438.52(b)
 - (2)(ii), to obtain services outside the network (if applicable).

Member Appeals Process

The member, member's authorized representative or estate representative of a deceased member, including a care provider who has the member's written consent, can file an appeal by calling or writing to UnitedHealthcare Community Plan. As a care provider, if you are appealing on behalf of a member, please call Provider Services at **888-650-3462**, Fax to **801-994-1082**, or write to:

Grievance and Appeals

PO Box 31364

Salt Lake City, UT 84131-0364

The member must file the appeal within 30 days from the date on the notice of Action. If they need help writing or filing an appeal, call us. The appeal form is on UHCCommunityPlan.com > For Health Care Professionals > Iowa.

If someone else, such as the member's care provider or family member is going to file on their behalf, we need the member's written permission.

If a member files an appeal, we will send a letter within three business days telling them that we got the appeal.

We will review your appeal and send you a decision within 30 calendar days of getting the appeal. This time may be extended up to 14 calendar days if you ask for this, or if we need more information and the delay is in your interest. If we do need more time, we will send you a letter telling you.

You will get a Notice of Appeal Decision letter with our decision and the reason for the decision. We will tell you what to do if you do not agree with the decision.

Continuation of Care

The member's benefits may continue while an appeal or state fair hearing is pending if all of the following apply:

- The appeal or state fair hearing request is filed;
- Within 10 calendar days from the date we mailed the notice of action, or
- Before the effective date of this notice.
- The appeal or state fair hearing request is related to reduced or suspended services, or to services previously authorized for you.
- The services were ordered by an authorized care provider.
- The authorized period for the services has not ended.
- You asked that the service continue.

The member's benefits will continue until one of the following occurs:

- The member withdraws the appeal request.
- The member does not request a state fair hearing within 10 days from the date we mailed the notice of action.
- The authorization for services expires or service authorization limits are met.
- A hearing decision is issued in the state fair hearing that is adverse to the member.

Any benefits the member receives while their appeal is decided may have to be paid back if UnitedHealthcare's actions are correct.

Expedited Appeals

The member, member's authorized representative, or care provider can ask for an expedited appeal if the care provider has said that a delay would seriously jeopardize the life, health or ability to attain, maintain or regain maximum function. Verbal expedited appeal requests do not require a written, signed confirmation. If you choose to do an expedited appeal, you have limited time to present documentation in person or in writing regarding your request. As a care provider, if you submit an expedited appeal on behalf of a member, please call Provider Services at 888-650-3462, fax to 801-994-1082, or write to:

Grievance and Appeals
PO Box 31364
Salt Lake City, UT 84131-0364

UnitedHealthcare Community Plan will review the request and make a decision within three calendar days. We will call you and/or the member within two calendar days if the appeal is denied for expedited review and is being reviewed through the standard appeal process instead. These times may be extended up to 14 calendar days if you and/or the member ask for this or if we need more information and the delay is in the member's interest. If we need more time, we will send you and/or the member a letter.

You will get a Notice of Appeal Decision letter with our decision and the reason for the decision. We will tell you what to do if you do not agree with the decision.

For full details about the grievance and appeals process, please call Member Services. You can also file the grievance or appeal in person at:

UnitedHealthcare Community Plan
1089 Jordan Creek Parkway, Suite 320
West Des Moines, IA 50266

State Fair Hearings

If you don't agree with UnitedHealthcare Community Plan's Pre-Service appeal decision, the member, member's representative or care provider acting on the member's behalf and has the member's written consent can ask for a State Fair Hearing. Before requesting a State Fair Hearing, you must exhaust the appeal process through UnitedHealthcare.

You have 120 calendar days to file a State Fair Hearing request from the date on the notice of UnitedHealthcare's appeal decision. At the time you file for the State Fair Hearing, you may also request that the member's benefits continue while the State Fair Hearing is pending. Any benefits the member gets while the State Fair Hearing is being decided may have to be paid back if UnitedHealthcare Community Plan's actions are correct.

At the time you file for the State Fair Hearing, you may also request that your benefits continue while the State Fair Hearing is pending.

You may keep your benefits until the State Fair Hearing process is complete if all the following apply:

- The State Fair Hearing Request is filed:
- Within 10 calendar days from the date of the appeal decision notice, or
- Before the effective date of the appeal decision notice.
- The State Fair Hearing request is related to reduced or suspended services or to services that were previously authorized for you.
- The services were ordered by an authorized care provider.
- The authorization period for the services has not ended.
- You ask that the services continue.

The member's benefits will continue until one of the following occurs:

- You withdraw the State Fair Hearing request.
- The authorization for services expires or service authorization limits are met.
- A hearing decision is issued in the State Fair Hearing that is adverse to the member.

Any benefits the member gets while the State Fair Hearing is being decided may have to be paid back if UnitedHealthcare Community Plan's actions are correct.

Filing for a State Fair Hearing and requesting benefits continuation is easy. You can make both requests in person, by telephone or in writing. To file in writing, take one of the following actions:

- Complete the Appeal and Request for Hearing form electronically at <http://dhs.iowa.gov/node/966>, or
- Write a letter telling DHS why you think a decision is wrong and whether you would like benefits to continue during the State Fair Hearing, or
- Fill out the Appeal and Request for Hearing form. You can get this form at your local DHS office.

You can mail, fax or take your request to:

Department of Human Services
Appeals Section, 5th Floor
1305 E Walnut Street
Des Moines, Iowa 50319-0114
Fax: 515-564-4044

If you need help filing a State Fair Hearing request or want to file by telephone, please ask your local DHS office or contact the DHS Appeals Section at 515-281-3094.

If you are given a State Fair Hearing, you will receive a written notice that tells you the date and time of that hearing. You have the right to present evidence and legal arguments for the hearing. Please follow the instructions on the backside of the notice to ensure your information will be considered during the hearing. Parties to the State Fair Hearing will include the member, member's authorized representative or the representative of a deceased member's estate, as well as UnitedHealthcare.

The member isn't required to have a lawyer at the hearing. The member is allowed to attend the appeal hearing without legal representation. If the member does have a lawyer, write the lawyer's name on the Appeal and Request for Hearing form or call the Appeals Section at 515-281-3094. You will need to tell the Appeals Section the name and address of the lawyer. The lawyer will receive a copy of everything that you get, including the Notice of Hearing, the Proposed Decision and the Final Decision. For more information about the right to appeal, go to the Iowa Administrative Code Section 441 Chapter 7 at dhs.iowa.gov/appeals.

Member Choice

If at any time a member has a complaint, please encourage them to call us. We can help. If the member still wants to change their MCO, they may do so at any time during the first 90 days after their initial enrollment in a MCO. The member may also change their MCO during the open enrollment period. To change their MCO, members should contact Iowa Medicaid Member Services at 800-338-8366, or locally in the Des Moines area at 515-256-4606 Monday through Friday, 8 a.m. to 5 p.m. (CT). **hawk-i** members should call the **hawk-i** program at 800-257-8563 from 8 a.m. 6 p.m. (CT). Members may also email Iowa Medicaid Member Services at IMEMemberServices@dhs.state.ia.us.

Chapter 5: Quality Management

Clinical Practice Guidelines

We review and update our adopted clinical practice guidelines annually to help ensure we meet the needs of our members.

Approved guidelines include, but are not limited to:

- Asthma
- Cardiovascular disease
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Major depression
- Prenatal care
- Post-partum care

These guidelines are intended to assist you in clinical decision making by describing a range of generally acceptable approaches to the diagnosis, management, and prevention of specific diseases or conditions. The guidelines attempt to define practices that meet the needs of most patients in most circumstances. The ultimate judgment about care of a particular member rests with you as the health care provider in light of all the circumstances presented by a particular member. A full listing of the guidelines is located at UHCCCommunityPlan.com > For Health Care Providers > Iowa > [Clinical Practice Guidelines](#).

Health Effectiveness Data and Information Set (HEDIS®)

HEDIS is a uniform tool used by United States' health plans to measure performance on important dimensions of care and service. In our accountability to these standards, we look to you as the health care provider. Gaps in care are opportunities to satisfy wellness criteria. For example, a member gap in care could be a postpartum visit that has not yet occurred. Data is collected through claims and pharmacy utilization. Please note that these measures may change from year to year. For more information visit The National Committee for Quality Assurance (NCQA) which publishes HEDIS at NCQA.org > [HEDIS Quality Measurement](#).

HEDIS Measures (not all-inclusive)

- Adolescent well-care visits
- Adults' access to preventive/ambulatory health services
- Antidepressant medication management
- Appropriate treatment for children with upper respiratory infection
- Asthma Medication Ratio (AMR)
- Childhood immunizations (we commit to the combo four series)
- Children's and adolescents' access to PCP Comprehensive diabetes care
- Diabetes monitoring for people with diabetes and schizophrenia
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications
- Follow-up after hospitalization for mental illness
- Follow-up care for children prescribed ADHD medication
- Frequency of ongoing prenatal care
- Medication management for people with asthma
- Prenatal and postpartum care
- Use of appropriate medications for people with asthma
- Well-child visits in the first 15 months of life
- Well-child visits in the third, fourth, fifth and sixth years of life

Maintaining Medical Record Documentation Standards

UnitedHealthcare Community Plan requires member medical records to be maintained in a manner that is current, detailed and organized, and permits effective and confidential patient care and quality review. Annually, a sample of high-volume care providers are selected for medical record review. Three charts per care provider are reviewed to determine compliance with medical record documentation standards. In the event that you receive a score below 85% on your chart audit, an additional five charts will be reviewed to help ensure a representative sample of charts was examined. If the further review results in a score below 85%, then you will be re-audited in six months. In the event that the re-audit does not receive a passing score, actions may include education and counseling, further audits, and recommendation for termination of contract for non-compliance with Medical Record Documentation Standards. Documentation guidelines can be found in the Physician and Facility Standards and Policies chapter in the Medical Record Review section.

Clinical data needs to be provided to UnitedHealthcare Community Plan consistent with state and federal law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the American Recovery and Reinvestment Act of 2009 (ARRA) and the Clinical Laboratory Improvement Act (CLIA). You need to ensure that the data submitted is accurate and complete, meaning all clinical data will represent the information received from the ordering physician and all results from the rendering care provider. The UnitedHealthcare Quality Improvement Program is allowed to use practitioner and provider performance data to conduct quality activities.

We verify that security measures, protocols, and practices are compliant with HIPAA regulation and our e data usage, governance, and security policies, and will be used for the lawful receipt of clinical data from care providers. Any clinical data received will be used only as allowed under applicable state and federal law. We use this data to perform treatment, payment or health care operations — as defined in HIPAA — for its members.

Our operations may include the following:

- Compliance with state and federal data collection and reporting requirements, including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS), NCQA accreditation, Centers for Medicare & Medicaid Services' (CMS) Star Ratings, and CMS Hierarchical Condition Category Risk Adjustment System
- Care coordination and other care management and quality improvement programs including physician performance, pharmaceutical safety, customer health risks using predictive modeling and the subsequent development of disease management programs used by UnitedHealthcare Community Plan and other member and care provider health awareness programs
- Quality assessment and benchmarking data sets
- Coordination with HCBS Provider Quality Assurance Activities
- Any other lawful health care operations

HIPAA minimum necessary data requirements are defined in specific documents related to the method of clinical data acquisition, including HL7 companion guide(s) and process documentation related to proprietary file exchange, fax submissions, paper data submission and/or manual data collection by UnitedHealthcare authorized personnel. The companion guides are available at uhc.com/hipaa-and-edl/companion-docs, numbers 11 and 12.

Protect Confidentiality of Member Data

Medical records reflect all aspects of patient care, including ancillary services. Members have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates that need that information to fulfill contractual service obligations and to facilitate improvements to member health care.

We require our associates and business associates to protect privacy and abide by privacy laws. If a member requests specific medical record information, we refer the member to you as the primary holder of the medical records. Applicable regulatory requirements need to be observed, including but not limited to those related to confidentiality of Medical information. Our care providers agree to comply in all relevant respects with

the applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and associated regulations, including applicable state laws and regulations.

5.1 Member Rights

UnitedHealthcare will follow any federal and state laws regarding member rights. Members have:

- The right to receive information in an easily understood format and manner about the organization, its services, its practitioners and care providers, and member rights and responsibilities.
- The right to be treated with respect and recognition of their dignity and right to privacy, including a right to fully participate in the community and to work, live and learn to the fullest extent possible.
- The right to receive information on available treatment options and alternatives, including treatment in the least restrictive setting, presented in a manner appropriate to the member's condition and ability to understand.
- The right to participate with practitioners in making decisions about their health care, including the right to refuse services.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- The right to request and receive a copy of their medical records, and request that they be amended or corrected.
- The right to be furnished healthcare services in accordance with requirements for access and quality of services.
- The right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- The right to voice complaints or appeals about the organization or the care it provides.
- The right to make recommendations regarding the organization's member rights and responsibilities policy.
- The right to exercise their rights, and that the exercise of those rights doesn't adversely affect the way members are treated.
- The responsibility to supply information (to the extent possible) that the organization and its practitioners and care providers need in order to provide care.
- The responsibility to follow care plans and instructions that they have agreed to with their practitioners.
- The responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Chapter 6: Hospital Services

HIPAA Compliance

You are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. You are required to furnish the Department of Health and Human Services all information required by the department during its review and investigation. You are required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Iowa Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

A care provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. You must not obstruct any audit, review or investigation, including the relevant questioning of employees of the provider. You will not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

6.1 Hospital Billing Instructions

Introduction to the UB-04 Claim Form

Hospital providers must use the UB-04 red claim form when requesting payment for medical services and supplies provided under. Any UB-04 claim not submitted on the red claim form will be returned to the provider. An example of the UB-04 claim form is on both the public and secure websites.

Instructions for completing this claim form are included in the following pages. UnitedHealthcare will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

Completing the UB-04 form: refer to CMS for most current guidelines

To submit claims electronically, have your office software vendor make connection to our clearinghouse OptumInsight, OptumInsight.com. Be sure to use our electronic payer (ID 87726) to submit claims to us. For more information, contact

your vendor or our Electronic Data Interchange (EDI) unit at 800-210-8315. You may also submit claims online at UHCommunityPlan.com.

If you do not have access to internet services, you can mail the completed claim to:

UnitedHealthcare Community Plan
P.O. Box 5220
Kingston, NY 12402-5220

Chapter 7: Durable Medical Equipment

Durable Medical Equipment (DME) is defined as equipment which is all of the following:

1. Able to withstand repeated use
2. Primarily and customarily used to serve a medical purpose
3. Appropriate for use in the member's home
4. Generally not useful to a person in the absence of illness or injury

DME may be provided to members who:

- Require DME for life support
- Would require higher cost care without DME
- Require DME for employment purposes

A medical supply may be provided when all of the following apply:

1. It is necessary and reasonable for the treatment of the patient's illness/injury.
2. It will be used in the member's home.
3. It is prescribed appropriately.
4. It is indicated as a covered item.

Definition of "Necessary and Reasonable"

Although an item is classified as DME or medical supply, it may not be covered in every instance. Coverage is based on the fact that the item is necessary and reasonable for treatment of an illness/injury or to improve the functioning of a malformed body part.

It is your responsibility prior to service delivery to verify member eligibility and to secure any necessary prior authorizations for services.

Definition of "Member's Home"

- Their own dwelling
- An apartment
- A relative/caretaker's home

Dispensing/Prescribing Requirements

The date of receipt of the prescription (ordering date) is considered the date of service and you may bill UnitedHealthcare Community Plan before the actual dispensing of the item(s), since the intent to render service has been confirmed by the acceptance of the prescription.

DME supplies provided on an ongoing routine basis that have limitations may be billed using the dates the services will be used. This allows you delivery or mailing time. You are expected to follow all limitations for the individual supply. You cannot bill future dates. For you to receive payment when billing a date range, the claim will have to be filed on or after the last date on the claim.

UnitedHealthcare Community Plan will only accept prescriptions for DME/Medical Supply items from:

1. Doctors of Medicine (M.D.)
2. Doctors of Osteopathy (D.O.)
3. Doctors of Podiatric Medicine (D.P.M.)
4. Doctors of Chiropractic (D.C.) – may prescribe cervical collars and "soft type" spinal supports only
5. Advanced Registered Nurse Practitioners (ARNP) only if:
 - They are treating the beneficiary for the condition for which the item is needed.
 - They currently are assigned their own individual provider number.
 - They are permitted to do all of the above in the state in which the services are rendered.
6. Physician assistants (PAs) may prescribe only if:
 - They are permitted to perform services in accordance with state law.
 - They are treating the beneficiary for the condition for which the item is needed.
 - They are practicing under the supervision of a M.D. or D.O.
 - They currently are assigned their own individual provider number.

To verify services provided in the course of a post-payment review, you will retain the prescription signed by the physician.

Many low cost items may only be purchased; rental is non-covered.

Delivery, Repair, Maintenance and Installation

The delivery of a DME item is covered only when the equipment is initially purchased or rented and the supplier customarily makes a separate charge for delivery.

Proof of delivery is required to verify that the beneficiary received the DME supplies or prosthesis. DME and Prosthetic and Orthotic

suppliers are required to maintain proof of delivery in their files. Proof of delivery documentation must be made available to upon request.

We will recoup payment for services in a post-pay review if you do not have adequate proof of delivery in your records. If a pattern appears of not providing documentation to support claimed services, we may refer the situation for investigation by the Fraud Unit, which may ultimately lead to a termination of your provider agreement with our network.

Direct Delivery

You and your employees, or anyone else having a financial interest in the delivery of the item, are prohibited from signing and accepting an item on behalf of a member. The relationship of the person receiving the delivery for the member must be noted on the delivery slip obtained by the person delivering the item. The signature of the recipient must be legible. If the signature of the designee is not legible, the person making the delivery must note the name of the person receiving the delivery on the delivery slip.

An example of proof of delivery is having for your records a signed delivery slip that includes all of the following:

1. Member name
2. Delivery address
3. Quantity delivered
4. Detailed description of the item being delivered
5. Brand name
6. Serial number, if applicable
7. Signature of the member or other person receiving the delivery
8. Relationship of the person receiving the delivery to the member
9. Date of signature on the delivery slip (must be the date that the item was received by the member or someone else on their behalf)

Delivery by Shipping Service (such as UPS, Federal Express)

The same procedure as outlined above for a direct delivery to a member by your company, also applies to delivery by a third party such as the United Parcel Service or Federal Express. The relationship of the person receiving the deliver to the member should be noted on the delivery slip, if possible, but is not required for this type of shipping. When using this type of delivery service, proof of delivery would include the service's tracking slip and your own shipping invoice. If possible, your records should also include

the delivery service's package ID number for that package sent to the member. The shipping service's tracking slip should reference each individual package, the delivery address, the corresponding package ID number given by the shipping service, and the date delivered, if possible.

You may also use a return postage-paid delivery invoice from the member or another person receiving the delivery as a form of proof of delivery. The descriptive information concerning the item (member's name, quantity, detailed description, brand name, and serial number) as well as the required signatures from either the member or the member's designee should be included on this invoice as well.

Repairs of DME equipment require prior authorization. You may bill for the labor component under or plus the appropriate part code.

Maintenance of rental equipment (testing, cleaning, regulating and checking equipment) is considered the responsibility of the supplier and is not covered a covered benefit. Extensive maintenance on purchased equipment requiring an authorized technician may be billed by the supplier as a repair.

Installation of rented or purchased equipment is covered in most situations. Construction as part of installation is not covered. Installation of DME also requires an invoice. If charges are going to exceed \$25, a prior authorization is required.

Medical Supply Benefits and Limitations

No payment is made for medical supplies or DME for members receiving inpatient or outpatient care in a hospital.

No payment is made for medical supplies or DME for members for whom the facility is receiving skilled nursing care payment, except for orthotic and prosthetic services, orthopedic shoes, and therapeutic shoes for diabetics.

No payment is made for DME or supplies for members in an ICF/ID or a facility receiving nursing facility payments except for the following:

- Assistive Technology
- Catheter (indwelling Foley)
- Colostomy and ileostomy appliances
- Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape
- Diabetic supplies
- Disposable catheterization trays or sets (sterile)

- Disposable bladder irrigation trays or sets (sterile)
- Disposable saline enemas
- Hearing aid batteries
- Orthotic and prosthetic services, including augmentative communication devices
- Orthopedic shoes
- Repair of member-owned equipment
- Oxygen services (nursing facility only; no payment is made for oxygen in an ICF/ID as they are included in the per diem and are not payable separately)
- Therapeutic shoes for diabetics
- Wheelchairs for members in an ICF/ID
- Wheelchairs for members in a Nursing Facility are covered when the wheelchair is a customized wheelchair.

For members in nursing facilities who have member-owned equipment, replacement of components, parts, or systems for the equipment is allowed as long as:

- Cost does not exceed two-thirds the cost of a new item
- Replacement is not due to change in size or condition of the member

If it is medically necessary to dispense more than the amount allowed for a particular item, document the reason for additional units on a Certificate of Medical Necessity form and attach to your claim.

Chapter 8: Hospice End of Life

Hospice is a comprehensive set of services, identified and coordinated by a hospice interdisciplinary team (IDT) to provide physical, psychosocial, spiritual, and emotional needs of a terminally ill member and family members. The hospice care priority meets the needs and goals of the hospice member and family.

The hospice must organize, manage, and administer resources to provide the hospice care and services to members, caregivers, and families necessary for the palliation and management of the terminal illness and related conditions.

Advance Directives

We expect our network providers to comply with federal legislation (OBRA 1990, Sections 4206 and 4751) concerning advance directives.

Provide written information to every adult member receiving medical care. The information pertaining to the right to:

- Make decisions concerning their own medical care
- Accept or refuse medical or surgical treatment
- Make advanced directives
- Have those advanced directives honored

Incapacitated Members

A member may be admitted to a facility in a comatose or otherwise incapacitated state, and be unable to receive information or articulate whether they have an advance directive. If this is the case, families of, surrogates for, or other concerned persons of the incapacitated individual must be given the information about advance directives. If the incapacitated member is restored to capacity, the facility must provide the information about advance directives directly to them even though the family, surrogate or other concerned person received the information initially. If a member is incapacitated, otherwise unable to receive information or articulate whether they have an advance directive, this must note this in the medical record.

Mandatory Compliance with the Terms of the Advanced Directive

When a member, relative, surrogate, or other concerned/related person presents a copy of the member's advance directive to the facility, the facility must comply with the terms of the advance directive to the extent allowed under state law. This includes recognizing powers of attorney.

Hospice Physician Certification

Hospice must obtain a physician's certification that the member is terminally ill. A terminally ill member is an individual who has a

life expectancy of six months or less if the illness runs its normal course. The certification must be signed by the:

- Hospital medical director
- Hospice interdisciplinary group physician
- Member's attending physician (if the member has an attending physician)
- The attending physician is a physician who is a doctor of medicine or osteopathy and is identified by the member at the time the member elects to receive hospice care, as having the most significant role in the determination and delivery of the member's medical care.

Hospice Plan of Care

A hospice plan of care (POC) must be completed for each hospice member to meet the member and family's assessed needs under direction of the hospice IDT and in collaboration with other non-duplicative Medicaid services, if applicable.

The hospice POC must be reviewed, revised and documented, at a minimum, every 15 days, or less if the member's condition changes.

Face-to-Face Encounter

A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice member whose total hospice support is anticipated to exceed 180 calendar days or the two initial hospice benefit periods or 90 days each. The face-to-face encounter must occur prior to, but no more than 30 calendar days, to the 180th day or the beginning day of the third benefit period recertification, and every benefit period recertification thereafter.

Election Statement

A revocable statement signed by a member or their legal representative that is filed with a particular hospice and consists of:

- Identification of the hospice selected to provide care to the member
- Acknowledgement that the member has been given a full explanation of hospice and the palliative rather than curative nature of hospice care
- Member acknowledgement that our services payments, other than those stated above and related to the terminal illness or conditions, are waived by choosing hospice care. The member may still receive HCBS waiver services if the service(s) are not duplicated under the hospice benefit and continue to be medically necessary due to the side effects and limitations that may occur with terminal illness.

Note: Hospice providers are responsible for the coordination of all services and communication with our community-based case manager. Evidence of coordination with other Care Coordinator must be reflected in the hospice plan of care.

Palliative Care

Hospice provides palliative care, not active or curative care. Palliative care means member and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate member autonomy, access to information, and choice.

Note: The palliative, non-active, and non-curative requirement for hospice care does not include terminally ill children, up to age 21. Children may concurrently receive the hospice benefit and curative or active care.

8.1 Hospice election periods

Hospice coverage must be certified by a physician. Coverage includes:

- An initial 90-day period
- A subsequent 90-day period
- An unlimited number of subsequent 60-day periods based on continued eligibility for the hospice program

The following forms must be completed by the hospice provider, according to the purpose for each, and the originals retained in the member's case file:

- Election of Medicaid Hospice Benefit
- Case Activity Report (CAR)
- Revocation of Medicaid Hospice Benefit

All forms must be completed, dated, and signed on the day that the action is effective.

8.2 Discharge from Hospice

A member will be discharged from hospice if the:

- Member moves out of the hospice provider's service area
- Member transfers or changes to another hospice provider
- Hospice physician determines the member is no longer terminally ill
- Member's (or other persons in the member's home) behavior is disruptive, abusive, or uncooperative and member care is seriously impaired. This is based on written and approved policy developed by the hospice provider.

8.3 Hospice Covered Services

The hospice program includes the following services. Any of the services can be combined by duration or frequency to meet the daily needs of the member and family.

- **Nursing care.** Skilled nursing care must be provided by or under the supervision of a registered nurse.

Hospice must provide nursing care directly unless you submit a waiver and it is approved by the Centers for Medicare and Medicaid Services (CMS).

Nursing care must help ensure the member's nursing needs are met based on the member's initial assessment, comprehensive assessment, and updated assessments.

- **Medical social services.** Social workers, under the direction of the physician, must provide medical social services.

Social work services must be based on the member's psychosocial assessment and the member's and family's needs and acceptance of these services.

- **Physician services.** Physicians' services are performed by a physician or a nurse practitioner with the exception of the Hospice medical director or the physician member of the Hospice interdisciplinary team. The Hospice medical director or the interdisciplinary team (IDT) physician must be a doctor of medicine or osteopathy.

The Hospice medical director, physician employees, and contracted physicians of the Hospice, in conjunction with the member's attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.

All physician employees and physicians under contract are under the supervision of the Hospice medical director.

All Hospice physicians coordinate care with the attending physician if the member chooses an attending physician outside of the Hospice network. If the attending physician is unavailable, the Hospice medical director, Hospice physician or contracted physician will coordinate care.

- **Spiritual counseling.** Spiritual counseling must provide the following:
 - An assessment of the member's and family's spiritual needs.
 - Meet member's needs and family's acceptance of this service in a manner consistent with member and family beliefs and desires.
 - Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the member's spiritual needs.
 - Advise the member and family of this service.

- **Dietary counseling.** Dietary counseling is provided by a qualified professional who is able to address and assure the identified dietary need of a Hospice member is met.
- **Bereavement counseling.** Bereavement counseling is a required service, but is not reimbursable.

Qualified professionals with experience or education in grief or loss counseling must provide services.

Bereavement services are available to the family and other individuals in the bereavement plan of care up to one year following the death of the member. Bereavement counseling may also be provided to residents of:

- A skilled nursing facility (SNF)
- A nursing facility (NF)
- **Hospice aide.** Hospice aides provide personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the member, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the member. Hospice aide services must be provided under the general supervision of a registered nurse.
- **Physical therapy, occupational therapy, and speech-language pathology.** Physical therapy, occupational therapy, and speech-language pathology services are provided for purposes of symptom control or to help enable the member to maintain activities of daily living and basic functional skills.
- **Volunteer services.** Volunteers must provide day-to-day administrative or direct member care services in an amount that, at a minimum, equals five percent of the total member care hours of all paid Hospice employees and contract staff.

The Hospice must maintain volunteer records for member care and administrative services, including the type of services and time worked.

- **Short-term inpatient care.** Hospice must notify UnitedHealthcare of any hospital admission. Short-term inpatient care is provided in a participating hospital. Services provided in an inpatient setting must conform to the written Hospice plan of care. General inpatient care may be required for procedures necessary for pain control, acute or chronic symptom management, which cannot be provided in other settings.

Inpatient care may also be furnished to provide respite for the member's family or other persons caring for the member at home. Respite care is the only type of inpatient care provided in a nursing facility when the member is otherwise receiving Hospice services in a home setting.

- **Medical supplies and medical equipment.** Medical supplies include drugs and biologicals. Only drugs used primarily for the member's terminal illness pain relief and symptom control are covered.

Medical equipment includes durable medical equipment and other self-help and personal comfort items for member's terminal illness palliation or management. Equipment is provided by the Hospice for use in the member's home while the member is under Hospice care. Medical supplies include the written Hospice care plan..

- **Other services.** Any other service medically necessary for the member's palliation, management, and related conditions will be covered under the Hospice program.
- **Non-covered services**
 - Medicaid-covered services, including direct physician care unrelated to the terminal illness or related conditions; These are billed separately by the respective care provider.
 - Service costs not covered by the health maintenance organization (HMO) when the member is enrolled in an HMO and elects Hospice.
 - AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

8.4 Hospice Coverage in Nursing Facilities

For hospice in a nursing facility, the nursing facility and hospice provider must enter into a written agreement which states:

- Hospice provider takes full responsibility for the professional management of the member's hospice care.
- Nursing facility agrees to provide room and board, along with basic nursing facility services.

Basic nursing facility services include:

- The performance of personal care services, including assistance in activities of daily living;
- Socializing activities;
- Administration of medication;
- Maintaining the cleanliness of the member's room; and
- Supervising and assisting in the use of DME and prescribed therapies.

No payment is made for inpatient respite care (revenue code 655) for a member who resides in a nursing facility.

The Hospice provider is reimbursed for daily routine home care (revenue code 651) for a hospice member who resides in a nursing facility.

The hospice provider is reimbursed for 95% of the nursing facility's daily room and board. Hospice is responsible for payment to the nursing facility for room and board. The nursing facility must not bill during the hospice-election time frame. Entering nursing facility dates of service (DOS) which overlap with hospice DOS on any portion of a claim will result in the entire claim denied. Enter the name of the nursing facility and the nursing facility Medicaid ID or NPI number in box 80 of the UB-04 claims form. Any claim for hospice in a nursing facility without this information will deny.

8.5 Hospice in an Assisted Living Program

For payment of hospice services, an Assisted Living Environment (hospice/AL) is considered a community, not a facility, living environment.

8.6 Care Provider Requirements

- The hospice must comply with the UnitedHealthcare provider agreement and meet the Medicare conditions for participation of hospices.
- All hospice providers must be enrolled with the state of Iowa as an Iowa Medicaid care provider prior to contracting with UnitedHealthcare. This is to help ensure payment of appropriate rate as determined by the state.
- All services provided by the hospice must be performed by appropriately qualified personnel. However, it is the nature of the service, rather than the qualifications of the person who provides it, that determines the coverage category of the service. Hospice services must be reasonable and necessary for the palliation or management of the terminal illness, as well as related conditions, to be allowed.

8.7 Hospice Limitation Audits

- Limitation audits are in place to help ensure accurate payment of hospice services will not allow reimbursement to exceed one unit per day for the following per diem hospice level of care codes: T2042 T2044 T2045 T2046
- Reimbursement of hospice level of care code combinations that are billable on the same date of service will remain unchanged.
- Reimbursement for level of care code T2043 is billable when a minimum of eight hours of continuous care is provided in a 24-hour period. Reimbursement will not exceed 24 hours of care per day.

8.8 Transportation Services for Hospice Beneficiaries

Transportation to hospice-related services is the responsibility of the hospice provider. Medical services unrelated to hospice treatment or diagnosis may be covered if medical criteria are met.

8.9 Hospice Care for Children in Medicaid

Members receiving services reimbursed by Medicaid and *hawk-i* can continue medically necessary curative services, even after the election of the hospice benefit by or on behalf of children receiving services. Section 2302 of the Affordable Care Act, entitled "Concurrent Care for Children," allows curative treatment upon the election of the hospice benefit by or on behalf of children enrolled in Medicaid or *hawk-i*.

The Affordable Care Act does not change the criteria for receiving hospice services. However, prior to enactment of the new law, curative treatment of the terminal illness ended upon election of the hospice benefit. This new provision requires states to make hospice services available to children eligible for Medicaid and *hawk-i* programs without terminating any other service that the child is entitled to under Medicaid for treatment of the terminal condition.

Medical Services and Concurrent Care for Children Receiving Hospice Services

Children receiving hospice services can continue to receive other reasonable and necessary medical services, including curative treatment for the terminal hospice condition.

- Prior authorization is only required if the services rendered are on the UnitedHealthcare prior authorization list.
- Hospice providers will be responsible for coordinating all services related to the hospice diagnosis and assisting non-hospice care providers to obtain authorization when required on UnitedHealthcare's prior authorization list.
- Hospice providers will be responsible for all durable medical equipment, supplies, and services related to the hospice diagnosis.
- Non-hospice care providers must first communicate and coordinate with hospice providers regarding needed services or procedures prior to rendering concurrent care for children.
- Non-hospice care providers must bill hospice first to receive a payment or denial for the service provided.
- If payment is denied by hospice, non-hospice care providers can submit the claim to UnitedHealthcare for payment.

Hospice patients (0 through 20 years of age) can receive the services identified below as long as the services are not duplicative of services provided by the hospice facility.

- Case management services when provided and billed by an ARNP enrolled in
- Technology Assisted (TA) waiver program attendant care services

Note: Hospice providers will continue to be responsible for all DME and supplies

8.10 Basis of Payment

Non-Reimbursable Diagnosis for Hospice

The hospice provider is to report diagnosis coding on the hospice claim required by ICD-10 coding guidelines. The principal diagnosis reported on the claim is the diagnosis most contributory to the terminal prognosis. A list of non-reimbursable ICD-10 diagnosis codes is available in the Iowa Medicaid Hospice Provider Manual available at [dhs.iowa.gov > Home > Policy Manual > Medicaid Provider](https://dhs.iowa.gov/Home/PolicyManual/MedicaidProvider).

Revenue Codes

- Revenue Code 651 Routine Home Care
- Revenue Code 652 Continuous Home Care
- Revenue Code 655 Inpatient Respite Care
- Revenue Code 656 General Inpatient Care
- Revenue Code 657 Direct Physician Care
- Revenue Code 658 Hospice Nursing Facility Room and Board

Payment for Physician Services

- **Physicians Employed by or Under Contract with the Hospice:** The basic payment rate for hospice reimbursement reflects the costs of covered services related to the treatment of the member's terminal illness including the administrative and general supervisory activities performed by the medical director, physicians, if employed by the hospice, or consulting physician.
- **Attending Physician Services:** When the designated attending physician is not a hospice employee or volunteer, the reimbursement of an independent physician is made in accordance with the usual Medicaid reimbursement. The physician bills UnitedHealthcare directly. The only services billed by the attending physician will be the physician's personal professional services. Costs for services such as lab or x-rays will be included on the attending physician's bill.

- **Direct Physician Care:** Direct physician member care provided by a hospice employee or any contracted physician other than the attending physician is billed by the hospice agency. Reimbursement will be in accordance with the care provider's contract. When billing on the UB-04 for physician services, use the CPT-4 code.
- **Voluntary Physician Care:** Physician services furnished on a volunteer basis are excluded from reimbursement.

Chapter 9: Home Health Services

9.1 Home Health Services

The Home Health Services program includes:

- Skilled nursing care
- Home health aide services
- Occupational therapy
- Physical therapy
- Speech-language pathology
- Medical Social Services

Medicaid members do not require skilled care before they are eligible to receive Home Health Aide Services. Members do not need to be homebound for Home Health Services eligibility. However, services are covered only when provided in the member's home. Payment will be made for restorative and maintenance services. These member services are for stabilized conditions requiring nurse observation and defined by the physician as a possible deterioration of health status.

Non-Covered Home Health Services

The following services are not covered as part of home health services:

- Homemaker services
- Services provided in the home health agency office
- Transportation and escort services
- Well-child medical care and supervision
- Medical supplies and medical equipment rental. Medical supplies and medications used in conjunction with Home Health Services are covered as part of that visit. Home Health Agencies should obtain and bill for dressings, durable medical equipment (DME), and other supplies through a medical equipment dealer or pharmacy. Special consideration may be given to unusual circumstances.

Basis of Payment

Bill claims on a UB-04 form or the electronic equivalent. Reimbursement for home health services is contractually determined. Home health services have established revenue codes. A unit of service is one visit. Claims submitted without a revenue code and an applicable diagnosis code will be denied.

- Revenue Code 551 Skilled Nursing Care
- Revenue Code 421 Physical Therapy
- Revenue Code 441 Speech Therapy
- Revenue Code 431 Occupational Therapy
- Revenue Code 571 Home Health Aide
- Revenue Code 561 Medical Social Worker

Submitting Medicare Non-Covered Home Health Services Claims

Medicare non-covered home health services do not require an Explanation of Medicare Benefits (EOMB) or other documentation from Medicare. Care providers may report Medicare non-covered home health services with the following information:

- For electronic submissions, put "Not Homebound" in the 2300 loop – billing or claim note.
- For paper submissions, put "Not Homebound" in box 80 – remarks.

9.2 Private-Duty Nursing and Personal Care Services

The Private-Duty Nursing and Personal Care (PDN/PC) Services for children is part of the Early Periodic Screening Diagnosis and Treatment (EPSDT) program that provides in-home PDN/PC services by Home Health Agencies. Children age 20 and younger are eligible to receive this program. This benefit is not available to *hawk-i* members. Members are eligible for up to 16 hours per day of PDN/PC services, based on medical need.

Non-Covered PDN/PC Services

The following services are not covered as part of the PDN/PC program:

- Homemaker services
- Services provided in the home health agency office
- Homework assistance
- Medical transportation
- Nurse supervision services
- Respite care
- Two Medicaid services provided simultaneously
- Well-child medical care and supervision

- Medical supplies and medical equipment rental. Medical supplies and medications used in conjunction with home health services are covered as part of that visit. Home health agencies should obtain and bill for dressings, DME, and other supplies through a medical equipment dealer or pharmacy. Special consideration may be given to unusual circumstances.
- Services provided in nursing facilities, skilled nursing facilities, intermediated care facilities for the intellectually disabled (ICF/ID) or hospitals.

Basis of Payment

Claims are billed on a UB-04 form. Reimbursement for PDN/PC Services is contractually determined. HCPCS codes have been established for billing of PDN/PC Services.

Service Category	Revenue Code	HCPCS Code	Unit of Service
Personal Cares (Home Health Aid)	572	S9122	1 unit = 1 hour
Private Duty Nursing (Skilled Nursing)	559	T1000	1 unit = 15 minutes

Prior Authorizations

Prior authorization is required for PDN/PC Services as defined in the Prior Authorization Requirements for Iowa available at UHCCommunityPlan.com > [For Health Care Professionals](#) > [Iowa](#).

If PDN/PC Services need to be initiated outside of normal business hours, please request prior authorization within 24 hours or by 5 p.m. Central Time the next business day. Prior authorizations for medically necessary PDN/PC Services can be backdated up to two calendar days from the date of receipt. Upon completion of the initial assessment, care providers should request prior authorization for the medically necessary services based upon the assessment. You must submit a written treatment plan with the PDN/PC Services request. Written treatment plan review may be required for continued Skilled Care needs and progress toward goals.

Include the following information with the request for prior authorization:

- Services requested
- Number of visits and weekly frequency
- Diagnosis codes
- Revenue codes or HCPCS codes
- Start date of care
- Plan of Care. The Plan of Care will support the medical necessity and intensity of services provided. More information on a Plan of Care is available at dhs.iowa.gov > [Policy Manual](#) > [Medicaid Provider](#) > [Home Health Services](#). This must be signed by an MD or DO.

9.3 Physician Certification and Face-to-Face Encounter

The physician certification and accompanying face-to-face encounter follow Medicare guidelines, notwithstanding the homebound criteria, and must be completed no less than every 60 days.

9.4 Post-Hospital Discharge Home Health Services

We are involved in the member's hospital discharge planning. It is important you follow the Admission Notification guidelines outlined in section 3.1 Admissions to help ensure you meet member's discharge needs. For urgent requests, please call 888-650-3462 and indicate the request is for post-hospital care.

Chapter 10: Health Homes

We implement a health home model which builds upon the PCP-led medical home model. These health homes are designed to help our qualifying Medicaid members who primarily qualify due to chronic, complex life conditions that require extensive care management to allow them to continue to functioning in the community of their choice. We contract with motivated medical practices willing to implement this person-centered approach with the support of our care coordination. Through this continuum, multi-faceted approach we work to maintain or improve each member's community living by:

- Improving or preventing further progression of medical, social and behavioral health issues associated with member's complex conditions
- Encouraging quality of life while respecting member dignity, culture, and personal choice
- Nurturing member and care provider relationships
- Improving prevention and access to services
- Coordinating transparent care planning through online tools accessible by the care team, including the member
- Using education and planning to reduce otherwise avoidable emergency room visits and admissions
- Accommodating any necessary transitions between service care providers and levels of care

Our health homes are designed for children and adult members who have two or more of the following chronic conditions or have one chronic condition and are at risk of developing a second:

- Mental health condition
- Substance abuse disorder
- Asthma
- Diabetes
- Hypertension
- Overweight
 - BMI over 25
 - BMI over 85 percentile for pediatric population

The goal of the Integrated Health Homes program is to develop a team of healthcare professionals to integrated medical, social, and behavioral healthcare needs for individuals with serious mental illness (SMI) or serious emotional disturbance (SED). Children and adult members may qualify for the Integrated Health Homes program if they have a SMI or SED. SMI is defined as:

- Psychotic disorders
- Schizophrenia
- Schizoaffective disorder
- Major depression
- Bipolar depression
- Delusional disorder
- Obsessive-compulsive disorder

SED is a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current Diagnostic and Statistical Manual of mental disorders published by the American Psychiatric Association or its most recent International Classification of Diseases equivalent that result in functional impairment. SED may co-occur with substance use disorders, learning disorders, or intellectual disorders that may be a focus of clinical attention.

In some geographic areas, we implement an Accountable Care Community approach to improve community health. We work toward optimizing resources while reducing service redundancy by utilizing collaborative partnerships involving medical, social, business and community representation. This approach also incorporates the PCP-led Medical Home model which empowers members to actively manage their personal health. Integrated Health Home care coordinators are responsible for service plan development and monitoring HCBS Habilitation and CMH Waiver members.

As a network care provider, you may be invited to become involved in this team approach through referrals to care for one or more of our members. To see more information about our health homes and accountable care communities visit UHCCCommunityPlan.com > For Healthcare Professionals > Iowa > Billing and Reference Guides > Our Care Coordination. For additional information about Iowa Medicaid health homes, please go to dhs.iowa.gov/ime/providers/enrollment/healthhome.

Chapter 11: Long-Term Services and Supports/ Home and Community Based Services (HCBS)

The HCBS Program is a Medicaid long-term delivery system which fully integrates traditional physical health, behavioral health and nursing facility-based services, with Home and Community Based Services (HCBS). This integration helps ensure a full continuum of services for Medicaid members through a Managed Care Organization (MCO). The state of Iowa now fully integrates these services into the MCO and no longer directly administrates these valuable services for the HCBS programs outlined in the section below.

The HCBS programs are designed to meet the needs of members who would otherwise require care in a medical institution. The variety of services are designed to provide the most integrated means for maintaining the overall physical and mental condition of those members with the desire to live outside of an institution. All HCBS services require prior authorization through the plan of care (POC) process. The collective goals of the HCBS Program include:

- Integrated, whole-person care.
- Preserving or creating a path to independence.
- Alternative access models and an emphasis on home and community based services.

These goals can be accomplished through the systematic process of assessment, planning, coordinating, implementing, and evaluating a member's care by care coordination. Fully-integrated care coordination helps ensure that the member's acute/chronic physical healthcare, behavioral healthcare, and HCBS program services are provided in a seamless, cohesive, and collaborative manner reducing waste, duplication, and redundancy in services. Care coordination not only provides the member with a concierge to facilitate scheduling and service access; it also provides the recipient with an advocate that assists the member in gaining needed knowledge of services and alternatives to make the most informed decision related to healthcare and custodial services.

Disability Sensitivity

Each health plan and its care providers must comply with the Americans with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its members. Health plans and their care providers can demonstrate compliance with the ADA by conducting an independent survey/site review of facilities for both physical and programmatic accessibility.

The health plan must reasonably accommodate individuals and will help ensure that the programs and services are as accessible to an individual with disabilities as they are to an individual without disabilities. This will be accomplished by written policies

and procedures to help ensure compliance while ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all covered services.

11.1 Overview of HCBS Programs

UnitedHealthcare fully integrates the HCBS for the AIDS, Brain Injury, Children's Mental Health, Elderly, Health and Disability, Intellectual Disability, and Physical Disability Waivers.

Eligibility for all of the HCBS programs is determined by the state or state designees. For information on the following, please refer to the Iowa HCBS Manual available at: dhs.iowa.gov/sites/default/files/HCBS.pdf.

AIDS/HIV Waiver

The AIDS/HIV waiver offers services for those who have been diagnosed with AIDS or HIV. These are the services members may receive if there is a need for this waiver:

- Adult day care
- Consumer directed attendant care (CDAC)
- Counseling services
- Home-delivered meals
- Home health aide
- Homemaker
- Nursing
- Respite

Brain Injury Waiver

The Brain Injury waiver offers services for those who have been diagnosed with a brain injury due to an accident or illness and are at least must be one month of age. There is no upper age limit for this waiver. These are the services members may receive if there is a need for this waiver:

- Adult day care
- Behavioral programming
- CDAC
- Family counseling & training
- Home & vehicle modification
- Interim medical monitoring & treatment
- Personal emergency response
- Prevocational services
- Respite
- Specialized medical equipment

- Supported community living
- Supported employment
- Transportation

Children's Mental Health Waiver

The Children's Mental Health waiver offers services for children who have been diagnosed with serious emotional disturbance. These are the services members may receive if there is a need for this waiver:

- Environmental modifications & adaptive devices
- Family & community support services
- In-home family therapy
- Respite

Elderly Waiver

The Elderly waiver provides services for elderly persons. An applicant must be, at least, 65 years of age. These are the services members may receive if there is a need for the following:

- Adult day care
- Assisted living
- Assistive devices
- Chore
- CDAC
- Home & vehicle modification
- Home-delivered meals
- Home health aide
- Homemaker
- Mental health outreach
- Nursing
- Nutritional counseling
- Personal emergency response
- Respite
- Senior companion
- Transportation

Health and Disability Waiver

The Health and Disability waiver provides services for persons who are blind or disabled. An applicant must be less than 65 years of age for this waiver. These are the services members may receive if there is a need:

- Adult day care
- Homemaker
- CDAC
- Interim medical monitoring & treatment
- Counseling

- Nursing
- Home & vehicle modification
- Nutritional counseling
- Personal emergency response
- Home-delivered meals
- Home health aide
- Respite

Intellectual Disability Waiver

This waiver provides services for persons who have been diagnosed with an intellectual disability. These are the services members may receive if there is a need for this waiver:

- Adult day care
- Personal emergency response
- CDAC
- Day habilitation
- Home & vehicle modification
- Home health aide
- Interim medical monitoring & treatment
- Prevocational services
- Respite
- Supported community living
- Supported community living residential based
- Supported employment
- Nursing
- Transportation

Physical Disability Waiver

This waiver provides services for individuals who have a physical disability determination. An applicant must be at least 18 years of age, but younger than 65. These are the services members may receive if there is a need for this waiver:

- CDAC
- Home & vehicle modification
- Personal Emergency response
- Specialized medical equipment
- Transportation

1915(i) State Plan - Habilitation Services

The 1915 (i) Habilitation Services for Members with Chronic Mental Illness State Plan provides home and community-based services for members with chronic mental illnesses. Habilitation Services are designed to assist members in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home- and community-based settings.

- Home-based habilitation
 - Adaptive skill development
 - Assistance with activities of daily living
 - Community inclusion
 - Transportation
 - Adult educational supports
 - Social and leisure skill development
 - Personal care
 - Protective oversight and supervision
- Day Habilitation
- Prevocational Habilitation
- Supported Employment Habilitation

Consumer Choices Option

The Consumer Choices Option is available under most of the HCBS waivers. It will give members control over some Medicaid dollars. Members will use these dollars to make a budget plan to meet their needs by hiring employees and/or purchasing goods and services to meet their assessed needs. The Consumer Choices Option gives members more choice, control and flexibility over their services as well as more responsibility. The members using CCO are self-directing their services. This means they have both budget and employer authority.

More help is available if members choose this option. They will choose an Independent Support Broker who will help members make their budget and help them recruit employees. They will also work with a Financial Management Service that will manage the budget for members and pay their workers on the member's behalf.

Money Follows the Person Rebalancing Demonstration (MFP)

The State of Iowa currently operates an MFP grant, which provides opportunities for individuals in Iowa to move out of ICF/IDs and nursing facilities and into their own homes in the community of their choice. Grant funds provide funding for the transition services and enhanced supports needed for the first year after an individual transition into the community. MFP assistance is available to individuals with a diagnosis of an intellectual disability or brain injury who lived in an ICF/ID or nursing facility for at least three months.

The MFP grant program will continue operating through a Fee-for-Service (FFS) structure for all HCBS services, enhanced MFP services, and certain State Plan Long Term Care Services for 365 days after the Medicaid member moves into the community. Care providers authorized to provide MFP HCBS and the included Long Term Care Services will continue to submit claims to the

IME. UnitedHealthcare will be responsible for all other medical services. Members enrolled in the MFP Program will continue to work with an MFP transition specialist. The transition specialist and UnitedHealthcare will work together to coordinate all Long Term Care services and medical services needed to support the member.

11.2 HCBS Care Provider Responsibilities

- HCBS care providers will provide services in accordance with the plan of care including the amount, frequency, duration and scope of each service in accordance with the member's service schedule.
- HCBS care providers using Electronic Visit Verification (EVV) will be responsible for monitoring and immediately addressing service gaps, to include back-up staff.
- HCBS care providers will use EVV when providing the following services: chore, home health aide, homemaker, immt, nursing, respite, senior companion, and supported community living.

11.3 Care Provider Credentialing/Verification

UnitedHealthcare Community Plan follows the care provider requirement guidelines defined in the Iowa Medicaid Provider Manual to credential nursing facility providers and care providers of HCBS services.

Initial Verification/Credentialing: The initial verification / credentialing process will include verification of required documents as outlined in the Iowa HCBS Provider Application in addition to care provider requirements as defined by the state. All care providers must submit the certificate and/or licensures as applicable to the services they are providing and each license will be verified with its issuing licensing board. Each care provider will provide proof of general liability insurance that meets the minimum required amount set by the state of Iowa as applicable to the services each care provider is contracting to provide. Care providers will also provide proof of malpractice insurance, as applicable, as required by state guidelines.

HCBS providers are not required to maintain malpractice insurance unless required to do so per state care provider requirements or applicable care provider licensing requirements.

Re-Verification/Credentialing: Every three years, all care providers are re-verified/credentialed unless otherwise specified. This process includes meeting all initial requirements of this verification/credentialing process and may be subject to review of history of potential quality of care/quality of service concerns within the re-credentialing cycle.

If a physician or other health care professional fails to meet our re-credentialing requirements, their participation with our network will terminate. We will give the physician or health care professional a written termination notice. The termination notice will include the reason for the termination, the effective date of that termination, and an explanation of their appeal rights, if applicable.

In the event an applicant fails to meet the verification/credentialing requirements, the applicant will be denied and notified in writing. An applicant has the right to appeal an adverse decision within 30 days of notification. Applicants have the right to be notified of the credentialing decision within 60 calendar days of the decision.

Electronic Visit Verification Requirements

The Electronic Visit Verification (EVV) system is an external scheduling and tracking system used by HCBS providers to manage their work based on authorizations that are approved by UnitedHealthcare. The system verifies that the services were delivered. Some of these services may be non-medical (atypical) in nature like chores and homemaker services. Typical services are provided with assistance with activities of daily living (ADL).

11.4 Home and Community Based Services:

A summary of the HCBS services, including benefit limitations, unit definitions and billing codes may be found in the Iowa HCBS Manual available at dhs.iowa.gov/sites/default/files/HCBS.pdf.

11.5 HCBS Settings Guidelines

Members may Choose the Setting for their HCBS

Members may choose from a variety of settings, including non-disability specific settings and a private unit in a residential setting. The setting should maximize their freedom to choose their daily activities, physical environment and personal interactions. Regardless of the setting, care providers are responsible for making sure the setting encourages the greatest possible independence and upholds the member's rights to privacy, dignity, respect and freedom.

Community Integration

All HCBS settings must be integrated into the community and provide opportunities for the member to:

- Seek employment with the ability to earn competitive pay in settings with coworkers who do not receive HCBS
- Engage in the community, such as attending cultural events and recreational activities
- Control their resources, including personal belongings and money

- Access services equal to what people who do not receive HCBS are able to access

To review the complete guidelines for outpatient settings for Long-Term Service and Supports, please visit [EFCR.gov](https://efcr.gov) > Libraries > The Public > Catalog of U.S. Government Publications > GPO's Federal Digital System: Searching and Finding tool > CFR 441.301.

11.6 Claim Filing Information for HCBS Care Providers

HCBS program codes and limits apply to all Home and Community Based Services, including non-medical waiver transportation. Covered services, service definitions, units and benefit limitations are consistent with the Iowa Department of Human Services (IDHS) HCBS Provider Manual. Please reference the IDHS HCBS manual for specific service definitions. HCBS care providers should use the CMS 1500 claim form or an accepted electronic equivalent when requesting payment for HCBS services. Claims may be received through your Electronic Data Interchange (EDI) vendor and communicated through the OptumInsight clearinghouse (formerly Ingenix) using payer ID 87726. Paper claims may be submitted to the claims address indicated below. You may submit claims directly through UnitedHealthcareOnline.com.

UnitedHealthcare
P.O. Box 5220
Kingston, NY 12402-5220

Documentation

UnitedHealthcare Community Plan follows the service documentation guidelines as defined in the Iowa DHS HCBS Provider Manual, including guidelines for electronic documentation and electronic signatures as defined in the HCBS Provider Manual. The Iowa provider manuals can be found at dhs.iowa.gov/ime/providers/rulesandpolicies.

Client Obligation

The state will communicate each member's client obligation, as applicable, to UnitedHealthcare Community Plan through the member enrollment file UnitedHealthcare receives from the state. Care providers who have been assigned the client obligation should not reduce the billed amount on the claim by the client obligation amount because it will be deducted as claims are processed.

UnitedHealthcare Community Plan makes every effort to assign the client obligation, as applicable, to the care provider that was historically assigned the client obligation by the state. The client obligation will typically be assigned to a single care provider (if a single care provider's services will offset the client obligation amount). In addition, we will make every effort to assign the client obligation to a single service, when possible, if the total services

provided each month for that service are sufficient to offset the monthly client obligation amount. In the absence of state direction, we will assign the client obligation to the care provider that has the largest cost of services for the month.

On a monthly basis, a notification letter will be mailed to each member and to each provider for whom client obligation has been assigned.

Date Span Billing

You may bill for date spans as you have in the past.

- You cannot overlap billed date spans, otherwise the claims may experience possible duplication edits and/or other claim errors.

On occasion, it may be necessary for UnitedHealthcare Community Plan to split an authorization for the month due to a current unit limitation in our system. If that is the case, you need to bill date spans consistent with the authorization date spans.

- You will experience claim payment issues if billing for services across multiple authorization date spans.

NPI Filing Requirements

A National Provider Identifier (NPI) is required for all Iowa medical providers, and all provider identifiers billed on claims must be valid NPI numbers.

This includes billing, servicing, rendering, attending, operating, referring, and prescribing a service. If a field is optional, you do not have to include an NPI number; however, if something is submitted in optional fields, it must follow the NPI requirements.

UnitedHealthcare Community Plan requires care providers to obtain an NPI only in those instances in which an NPI is required by the state for the services offered by the care provider. If the state has not required a provider NPI, UnitedHealthcare will treat those providers as atypical care providers for whom an NPI is not required.

Corrected Claims

To file a corrected claim electronically through the Front End Billing option:

- Create a new day claim through the Front End Billing option.
- Enter the UnitedHealthcare Original Claim Number (from the remittance advice) in the Timely Filing Override ICN Field.
- Provide all information that is correct for the claim and submit it as a new claim.
- The claim will be identified as a corrected claim due to the presence of the UnitedHealthcare Original Claim Number.

To file a paper claim:

- You may also file corrected claims on paper:
 - Write “CORRECTED” on the claim and add the original

claim number in Box22 of the 1500 form

Care Provider Claim Reconsideration and Dispute Requests

If you have questions relating to claims payments please contact Provider Services at 888-650-3462. A Provider Services Representative may be able to assist you without requiring additional administrative work. If you are requested to submit a payment reconsideration, requests can be forwarded to:

UnitedHealthcare Community Plan
P.O. Box 5220
Kingston, NY 12402-5220

See section 11.8 for Provider Claim Reconsideration and Dispute Requests.

Electronic Funds Transfer (EFT)

EFT is a method of transferring funds between bank accounts. EFT eliminates the need for paper checks and improves cash flow timing. You may request EFT by submitting the EFT Form which can be found on UHCCommunityPlan.com or requested through your Provider Advocate.

You are encouraged to return EFT forms as soon as possible to allow adequate time for processing.

11.7 Nursing Facility Admission/Discharge

Form 470-0042, Case Activity Report helps ensure prompt and accurate reporting on activities of individual Medicaid members that occur at the Nursing Facility. Complete the Case Activity Report and submit it to the DHS Centralized Facility Eligibility Unit when:

- A current resident applies for Medicaid
- A Medicaid-eligible resident:
 - Enters the facility
 - Changes level of care
 - Is discharged from facility
 - Dies

11.8 Claim Filing Information for Nursing Facilities and ICF/ID

Nursing facilities and ICF/ID should use the UB-04 claim form or accepted electronic equivalent when requesting payment for Nursing Facility services. Claims may be received through your electronic data interchange (EDI) vendor and communicated through the OptumInsight clearinghouse (formerly Ingenix) using payer ID 87726. Paper claims may be submitted to the claims address indicated below.

UnitedHealthcare Community Plan
 P.O. Box 5220
 Kingston, NY 12402-5220

The care coordinator who is assigned to the facility will validate those members eligible for Long Term Care (custodial) services with facility staff upon member enrollment and confirm the ongoing MCO census quarterly at a minimum. Long Term Care (custodial) members residing in nursing facilities will NOT require prior authorization of the custodial stay. Facilities do not need to submit any prior authorization information when claims are submitted. Note: Services or supplies that are included in the per diem rate (e.g. Oxygen) do NOT require separate prior authorization.

Revenue Codes

Daily Nursing Facility Care

100, 110, 119, 120, 129 and value code 80, 81.

Ventilator Incentive

100, 110, 119, 120, 129 and value codes 80, 81 along with ICD-10 diagnosis code J95.850, J95.851, J95.859, Z99.11 and Z99.12

Bed Hold Days

183, 185, 189 and value codes 80, 81.

- Bed hold days are only reimbursable for special population facilities

Nursing Facility Bill Types

Enter the three-digit number specific to the type of claim

1st digit:

- 2 – Skilled nursing
- 6 – Intermediate care

2nd digit:

If the 1st digit is a 2, the second digit is:

- 1 – Inpatient

If the 1st digit is a 6, the second digit is:

- 5 – Level 1
- 6 – Level 2

3rd digit:

- 0 – Nonpayment/zero claim
- 1 – Admit through discharge claim
- 2 – Interim – first claim
- 3 – Interim – continuing claim
- 4 – Interim – last claim through date to discharge date
- 7 – Replacement of a prior claim
- 8 – Void/cancel of a prior claim

Swing-Bed Facility Bill Types

Enter the three-digit number specific to the type of claim

1st digit:

- 2 – Skilled nursing

2nd digit:

If the 1st digit is a 2, the second digit is:

- 8 – Swing bed inpatient

3rd digit:

- 0 – Nonpayment/zero claim
- 1 – Admit through discharge claim
- 2 – Interim – first claim
- 3 – Interim – continuing claim
- 4 – Interim – last claim through date to discharge date
- 7 – Replacement of a prior claim
- 8 – Void/cancel of a prior claim

Nursing Facilities Services

No payment is made for medical supplies or DME for members receiving inpatient or outpatient care in a hospital. No payment is made for medical supplies or DME when the facility is receiving skilled nursing care payment, except for orthotic and prosthetic services, orthopedic shoes, and therapeutic shoes for diabetics.

No payment is made for DME or supplies in an ICF/ID, or a facility receiving nursing facility payments, except with a physician's order for the following:

- Assistive technology
- Catheter (indwelling Foley)
- Colostomy and ileostomy appliances
- Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape
- Diabetic supplies
- Disposable catheterization trays or sets (sterile)
- Disposable bladder irrigation trays or sets (sterile)
- Disposable saline enemas
- Hearing aid batteries
- Orthotic and prosthetic services, including augmentative communication devices
- Orthopedic shoes
- Repair of member-owned equipment
- Oxygen services (Nursing facility only; No payment is made for oxygen in an ICF/ID as they are included in the per diem and are not payable separately)
- Therapeutic shoes for diabetics
- Wheelchairs for members in an ICF/ID
- Wheelchairs for members in a nursing facility are covered when the wheelchair is a customized wheelchair.

For members in nursing facilities who have member-owned equipment, replacement of components, parts, or systems for the equipment is allowed as long as:

- Cost does not exceed two-thirds the cost of a new item
- Replacement is not due to change in size or condition of the member

If it is medically necessary to dispense more than the amount allowed for a particular item, document the reason for additional units on a Certificate of Medical Necessity form and attach to your claim.

Admission, Transfer, and Discharge Rights of Residents in Adult Care Homes

Each licensee, administrator, or operator will comply with the state regulation in the admission, transfer and discharge rights of residents in adult care homes.

Paper Claim Submission Address

Initial paper claims and corrected paper claims should both be submitted to this address.

UnitedHealthcare Community Plan
P.O. Box 5220
Kingston, NY 12402-5220

Care Provider Claim Reconsideration Requests

If you have questions relating to claims payments, please contact Provider Services at 888-650-3462. A provider services representative may be able to assist you without requiring additional administrative work. If you are requested to submit a payment reconsideration, requests can be forwarded to:

UnitedHealthcare Community Plan
PO Box 5220
Kingston, NY 12402-5220

Mailing Care Provider Disputes

If you have filed a reconsideration request and are not satisfied with the outcome, you may file an appeal to the following address:

UnitedHealthcare Community Plan
Attn: Grievance and Appeals Dept.
P.O. Box 31364

Salt Lake City, UT 84131-0364
Fax: 801-994-1082

From and Through Service Dates Bill Both Header and Detail

Box 6 of the UB "Statement covers period" from and through dates must equal to the room and board units billed in Box 46. For example, if billing for 30 units in April, the Statement Covers Period must be April 1 to April 30. For those uploading through a billing software, the statement covers from and through date maps to the EDI837I Loop 2300 DTP*434*RD8 segment which covers a date range.

Box 45 must be completed if two or more line items are billed on the claim form.

Retro-Eligible Process for Filing Claims

Applies to both Behavioral Health and Medical services (do not submit medical records with claims submissions). To help ensure timely payments for claims submission, please:

Paper Claim

- Indicate "Retro-Eligible" in Form Locator 80 NTE/REMARKS (UB) or at the top of the claim form.

- Attach cover letter stating member is retro-eligible.
- When documentation is required for retro-eligible authorization review, the Medical Review Unit will request documentation from the care provider.

Electronic Claim

- Indicate "Retro-Eligible" in the NTE field in electronic file (Loop 2300 for UB).
- When documentation is required for a retro-eligible authorization review, the Medical Review Unit requires documentation from the care provider by fax.

Corrected Claims

Paper-Corrected Claim Resubmission Process

- Corrected claim should be mailed to:
UnitedHealthcare Community Plan
PO Box 5220
Kingston, NY 12402-5220
- Write "CORRECTED" on the claim.
- Update the third digit of the bill type to a 7.
- The change in bill type will flag the claim as a corrected claim.
- You may also update the third digit of the bill type to an 8 to void the claim.
- If billing a 217 or 218 Type of Bill, providers will need the original claim number in box 80. UnitedHealthcare can provide the claim number from the EDI tab in the claim screen. When billing a paper claim, the previous claim number should be entered in Box 57.

Electronic Corrected Claim Resubmission Process

UB Claims:

- You may submit a corrected claim electronically through their claim clearinghouse.
- Update the third digit in the bill type to a 7.
- The change in bill type will flag the claim as a corrected claim.
- You may also update the third digit of the bill type to an 8 to void the claim.
- If billing with a 217 or 218 Type of Bill, you will need the original claim number in box 80. UnitedHealthcare Community Plan can provide the claim number from the EDI tab in the claim screen. You should consult with their electronic claim vendor for the appropriate field to enter the original claim number for an electronic submission.

Electronic Funds Transfer (EFT)

EFT is a method of transferring funds between bank accounts. EFT eliminates the need for paper checks and improves cash flow timing. You may request EFT by submitting the EFT Form on UHCommunityPlan.com or through your provider advocate.

You are encouraged to return EFT forms as soon as possible to allow adequate time for processing.

11.9 Patient Client Participation

Some members have a patient liability, also referred to as client participation, which must be met before Medicaid reimbursement for services is available. Client participation is the amount of a member's income, as determined by IDHS, to be collected each month. This includes a portion of members eligible for Medicaid on the following bases:

- Members in an institutional setting
- 1915(c) HCBS waiver members

For HCBS waiver enrollees, the patient client participation amount will be assigned to one or more waiver services and the Notice of Decision will reflect that amount.

Expect to collect patient client participation amounts from the members, including veteran's aid and attendance, or a medical assistance income trust, and use appropriate legal actions to collect these amounts.

In the event a member fails to pay their patient client participation, you may refuse to continue to provide services. You must demonstrate to UnitedHealthcare you made a good faith effort to collect payment and must notify the member's Community-Based Case Manager prior to discharging the patient. The member should receive appropriate notice and education regarding the consequences of non-payment of patient liability, including potential disenrollment from the program.

11.10 Care Coordination

Care Coordination for Nursing Facility Residents

Care Coordinators are responsible for:

- Completing a comprehensive assessment that includes the member's functional ability, physical and behavioral health conditions, available informal supports, environmental considerations, social assessment as well as member and family preferences
- Initial assessment and care/service plan development within 30 days of member assignment and with significant changes, and/or reassessments
- Assisting with transition management following inpatient admissions
- Facilitating integration with Optum Behavioral Health as needed to support the member and family

Community Based Case Management for HCBS Program Members

Community-based case managers are responsible for:

- Completing a comprehensive assessment that includes the member's functional ability, physical and behavioral health conditions, available informal supports, environmental considerations, social assessment as well as member and family preferences
- Initial assessment and care/service plan development within 30 days of member assignment, contacts quarterly and with significant changes, annual reassessments
- Assisting with transition management following inpatient admissions
- Supporting and educating on chronic condition management
- Facilitating community resource linkages
- Submitting the authorization for HCBS services. You receive written confirmation of the authorization and services to be delivered
- Contacting contact HCBS members quarterly at minimum and with significant changes in condition; face-to-face visits occur every quarter at minimum

Additional Information Regarding Care Coordination for the HCBS Waiver Programs

UnitedHealthcare's Community-Based Case Managers will act as a resource to the Targeted Case Managers, case managers, and IHHs and the member/support team and will complete internal assessments and drive the integrated plan of care.

One of the key tasks a Community-Based Case Manager can assist with is helping the member and/or the Targeted Case Manager, case managers, and IHHs navigate the managed care system (for example: obtaining DME and assisted services, coordinating complex medical or behavioral healthcare needs, and making sure that covered benefits are acquired appropriately).

Until each HCBS member is transitioned to the MCO Community-Based Case Manager (by Dec. 31, 2016 at the latest) Targeted Case Managers, case managers, and IHHs will continue to complete tasks associated with the five areas CMS has outlined as Targeted Case Management:

- Assessment
- Development of a plan of care (PCSP)
- Referral and related activities
- Monitoring and following up
- Contacts

UnitedHealthcare's Community-Based Case Managers will collaborate with our members and their Targeted Case Managers to:

- Participate in person centered support planning either in person at the meeting (if invited) or providing resources before and after meeting
 - The person centered support planning should be led by the member, where possible, and should include the member's representative, as needed and defined by the member.
- Conduct member assessments and visits in the member's home or intermediate care facility setting
- Develop an integrated plan of care for each member
- Facilitate access to needed services/supports for members
- Coordinate transitions of care between institutions, facilities, different HCBS programs, and/or service providers as needed

11.11 Critical Incident Reporting

Pursuant to the state managed care contract and all applicable federal and State regulations, providers and subcontractors must comply with Critical Incident reporting and related requirements. Identified critical incidents for members receiving home- and community- based or habilitation services must be reported in accordance with UnitedHealthcare's Critical Incident reporting process. See Provider Training for the detailed reporting process at UHCCommunityPlan.com > For Health Care Professionals > Iowa > Provider Training > Critical Incident Reporting.

Critical Incidents may be reported by any of the following:

- Care provider
- Provider staff
- Case managers
- Members/member representative
- UnitedHealthcare employees
- State agency representative

The State of Iowa defines critical incidents as follows:

Major Incident

A major incident is an occurrence involving a member enrolled in a waiver service that:

- Resulted in the death of any person
- Requires emergency mental health treatment for the member
- Resulted in physical injury to or by the member that

requires physician treatment or admission to a hospital

- Requires the intervention of law enforcement
- Requires a report of child abuse pursuant to Iowa Code, section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3 (also needs to be reported to the appropriate state reporting agency). For additional information see; Abuse, Neglect and Exploitation Training Guide at UHCCommunityPlan.com > For Health Care Professionals > Iowa > [Provider Training](#).
- Constitutes a prescription medication error or a pattern of medication errors that lead to any outcomes stated above
- Involves a member's location being unknown by provider staff who are assigned protective oversight

Minor Incident

A minor incident is an occurrence that is not a major incident and involves a member enrolled in a waiver service that:

- Results in bruising
- Results in seizure activity
- Results in injury to self, to others or to property
- Constitutes a prescription medication error

When to Report

- Major incidents should be reported to UnitedHealthcare by the end of the next calendar day from the date of the incident occurred or was discovered.
- Minor incidents should be reported to the contracted provider's supervisor within 72 hours of the incident occurring or being discovered.

The Critical Incident Reporting Form can be found at UHCCommunityPlan.com > For Health Care Professionals > Iowa > [Provider Forms](#).

Chapter 12: Claims

12.1 Claims Billing Procedures

To submit claims (within 180 days of service) and electronic fund transfer payments and statements online at [UnitedHealthcareOnline.com](https://www.unitedhealthcareonline.com) > secure logon > [Claims & Payments](#). Use payor ID 87726.

For more information about electric data exchange including clearinghouses, visit [UnitedHealthcareOnline.com](https://www.unitedhealthcareonline.com) > Tools & Resources > [EDI Education for Electronic Transactions](#)

If a claim must be submitted on paper, you should send claims to the following address:

UnitedHealthcare Community Plan
Attn: Claims
P.O. Box 5220
Kingston, NY 12402-5220

To order CMS-1500 and UB-04 forms, contact the U.S. Government Printing Office at 202-512-0455, or visit the Medicare website at: [cms.gov](https://www.cms.gov) > Medicare > Billing > Electronic Billing & EDI Transactions.

12.2 Claims Format

Paper Claims for medical or hospital services must be submitted using the standard CMS Form 1500, UB04, 5010 format or respective electronic format.

12.3 Claim Processing Time

Clean claims are paid within 14 calendar days of receipt, unless otherwise specified in your network agreement contract.

We know that you want your claims to be processed promptly for the covered services you provide to our members. We work hard to process your claims timely and accurately. This is what you can do to help us:

1. Review the member's eligibility to help ensure that you submit the claim to the correct payer. There are multiple options for checking eligibility:
 - Call Provider Services at 888-650-3462
 - Online in the Eligibility and Benefits Center application on [UnitedHealthcareOnline.com/Link](https://www.unitedhealthcareonline.com/link)
 - Through electronic data interchange (EDI) using the Eligibility & Benefit Inquiry & Response (270/271)
2. When applicable, notify us in accordance with the Prior Authorization Requirements available online at [UHCCommunityPlan.com](https://www.uhccommunityplan.com) > For Healthcare Professionals > Iowa.

3. Prepare complete and accurate claims (see section 11.9)
4. Submit claims electronically for fast delivery and confirmation of receipt.
 - By [UnitedHealthcareOnline.com](https://www.unitedhealthcareonline.com) > secure login > Claims & Payments
 - By EDI and Clearinghouse Connections. Our payer ID is 87726.

12.4 Tax Identification Numbers/ Provider IDs

Please submit standard transactions using your tax identification number and your national provider identification (NPI). To help ensure proper claims adjudication, please use the ID that best represents the healthcare professional that performed the service.

Importance and Usage of EDI Acknowledgment/ Status Reports

Software vendor reports only show that the claim left the care provider's office and either was accepted or rejected by the vendor. Your software vendor report does not confirm claims have been received or accepted at clearinghouse or by the health plan. Acknowledgment reports show you the status of your electronic claims after each transmission. Analyzing these reports, you will know if your claims have reached the health plan for payment or if claim(s) have been rejected for an error or additional information.

You MUST review your reports, clearinghouse acknowledgment reports and the health plan's status reports to eliminate processing delays and timely filing penalties for claims that have not reached the health plan.

How do I get these reports?

Your software vendor is responsible for establishing your connectivity to our clearinghouse OptumInsight at [OptumInsight.com/connectivity](https://www.optuminsight.com/connectivity), and will instruct you in how your office will receive Clearinghouse Acknowledgment Reports.

How do I correct errors?

If you have a claim that rejects, you can correct the error and retransmit the claim electronically the same day, causing no delay in processing. It is very important that clearinghouse reports are reviewed and worked after each transmission.

These reports should be kept if you need documentation for timely filing later.

IMPORTANT: If a claim is rejected and corrections are not received by the health plan within 365 days from date of service

or EOB from primary carrier, the CLAIM WILL BE CONSIDERED LATE BILLED and denied as not allowed for timely filing.

Electronic Payments & Statements

We use this Optum platform to manage electronic payments. It is a free electronic funds transfer (EFT) and electronic remittance advice (ERA) service. You can access the following functions:

- View your electronic payments
- Receive confirmation of successful deposits into your bank account (or when a successful check is issued)
- View electronic remittance advices that you can print

For registration and additional information visit UnitedHealthcareOnline.com > Electronic Payments and Statements.

12.5 Span Dates

Exact dates of service are required when the claim spans a period of time, except for HCBS services. Please indicate the specific dates of service in Box 24 of the CMS1500, Box 45 of the UB-04, or the Remarks field. This will eliminate the need for an itemized bill and allow electronic submission.

12.6 Effective Date/Termination Date

Coverage will be effective on the date the member is effective with our health plan, as assigned by the Healthcare Authority. Coverage will terminate on the date the member's benefit plan terminates with us.

If a portion of the services or confinement take place prior to the effective date, or after the termination date, an itemized split bill will be required. For example, if a member is covered by us upon the date of admission, termination does not occur until discharge. Please be aware that effective dates for members are frequently revised, as individual members re-verify their Medicaid eligibility. You should verify eligibility at each visit, to ensure coverage for services.

12.7 Overpayments

Overpayments

If you identify an overpayment of a claim, you must refund the overpayment within 30 days. Send the credit balance to:

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

Please include the appropriate documentation that explains the overpayment, including member ID, check number, date of services and amount paid.

12.8 Reconsideration Requests

Care Provider Claim Reconsideration Requests

You must submit your claim reconsideration within 12 months (or as required by law or your participation agreement) from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) as required by law, together with a completed UnitedHealthcare claims reconsideration request form. A claim reconsideration request is typically the quickest way to address any concern you have with how we processed your claim. With a claim reconsideration request, we review whether a claim was paid correctly, including if your care provider information and/or contract are set up incorrectly in our system, which could result in the original claim being denied or reduced.

UnitedHealthcare acknowledges that care providers remain eligible to file claims reconsiderations, resubmissions, disputes or appeals as permitted under the terms of their participation agreement or this manual. A request for claims reconsideration is intended solely for convenience and administrative ease. In the event this claims reconsideration process conflicts in any way with your participation agreement, the terms and conditions of this manual will govern as to Iowa Medicaid and CHIP only. You are encouraged to review their participation agreement and this manual to understand all other available claims reconsideration, resubmission or appeals remedies.

The following is the method for submitting claim reconsideration requests.

Paper Claim Reconsideration Request

The paper Claim Reconsideration Request form can be downloaded from:

- UHCCommunityPlan.com > Claim Reconsideration
- Paper Claim Reconsideration instructions

Where to send claim reconsideration requests:

UnitedHealthcare
P.O. Box 5220
Kingston NY 12402-5220

Claim Dispute

If you do not agree with the outcome of the claim reconsideration decision, or an initial claim submission decision, you may submit a claim dispute. You must submit your claim dispute to us within 12 months (or as required by law or your participation agreement), from the date of the EOB or PRA.

The provider dispute form can be found on UHCommunityPlan.com. Forms should be mailed to:

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

Or the form can be faxed to 801-994-1082. A copy of the claim and supporting documentation will be required for review.

Note the process for provider claim reconsideration requests and claim disputes is intended to govern post-service claims disputes only. For pre-service grievances and appeals, please refer to the Member Appeals Process in Chapter 4 of the manual.

12.9 The Correct Coding Initiative

The health plan performs coding edit procedures, based primarily on the CCI (Correct Coding Initiative) and other nationally recognized and validated sources.

The edits basically fall into one of two categories:

1. Comprehensive and Component Codes

Comprehensive and component code combination edits apply when the code pair(s) in question appears to be inclusive of each other in some way. This category of edits can be further broken down into subcategories that explain the bundling rationale in more detail. Some of the most common causes for denials in this category include:

- Separate procedures. Codes that are, by CPT definition, separate procedures should only be reported when they are performed independently, and not when they are an integral part of a more comprehensive procedure.
- Most extensive procedures. Some procedures can be performed at different levels of complexity. Only the most extensive service performed should be reported.
- With/without services. It is contradictory to report code combinations where one code includes and the other excludes certain other services.
- Standards of medical practice. Services and/or procedures that are integral to the successful accomplishment of a more comprehensive procedure are bundled into the comprehensive procedure, and not reported separately.
- Laboratory panels. Individual components of panels or multichannel tests should not be reported separately.
- Sequential procedures. When procedures are often performed in sequence, or when an initial approach is followed by a more invasive procedure during the same session, only the procedure that achieves the expected result should be reported.

2. Mutually Exclusive Codes

These edits apply to procedures that are unlikely or impossible to perform at the same time, on the same patient, by the same physician. There is a significant difference in the processing of these edits versus the comprehensive and component code edits.

CCI guidelines are available in paper form, on CD ROM, and in software packages that will edit your claims prior to submission. Your CPT and ICD-10 vendor probably offers a version of the CCI manual, and many specialty organizations have comprised their own publications geared to address specific CCI issues within the specialty. CMS's authorized distributor of CCI information is the U.S. Department of Commerce's National Technical Information Service, or NTIS. They can be reached at 800-553-NTIS (6847), or on the Web at ntis.gov.

12.10 Immunizations Billing

Medicaid

Childhood immunizations are mandated. Immunization information is based on the recommended Advisory Committee schedule on Immunization Practices (ACIP) standards. You may find a current copy of the standards on UHCommunityPlan.com.

All Medicaid vaccines for members younger than 19 will be provided through Vaccines for Children (VFC), which will distribute vaccines to care providers willing to participate in the vaccine program.

Do not bill the vaccine cost to UnitedHealthcare. Bill the vaccine at \$0.00, plus you cost to administer the vaccine. Non-routine immunizations, such as influenza vaccine or tetanus booster due to an injury, are reimbursable. VFC information is located at Iowa's Immunization Registry Information System (IRIS) iris.iowa.gov>IRISPRDJ>portalInfoManager.do

hawk-i

Childhood immunizations are mandated. Immunization information is based on the recommended Advisory Committee schedule on Immunization Practices (ACIP) standards. A copy of the standards is online. You may find a current copy of the standards on UHCommunityPlan.com.

Vaccines for *hawk-i* members are not provided through VFC. The cost of the vaccine and administration are billable. Non-routine immunizations, such as influenza vaccine or tetanus boosters due to injury, should be billed the same as other covered services. Network providers, including doctor's offices, school-based nurses, and local health departments, may administer vaccines.

12.11 Subrogation and Coordination of Benefits

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

Subrogation - We reserve the legal right to recover benefits paid for a member's healthcare service when those services are related to an accident or workman's comp.

COB – Coordination of benefits is administered according to the member's benefit contract and in accordance with applicable statutes and regulations. Please update your office records with the patient's other insurance carrier information, at each visit. When billing claims, ensure COB information is provided on each claim form for accurate coordination of benefits and processing of payment.

Third Party Liability

UnitedHealthcare will follow the State's Third Party Liability policy. If the service code billed is listed on the Medicare non-covered list or defined as Pay and Chase per the state's Third Party Liability policy, a remittance advice or other documentation from the primary insurance is not required. If the service is not on the Medicare non-covered list or defined as Pay and Chase per the state's Third Party Liability policy, you should either bill the primary carrier to obtain the primary carrier's EOB/EOMB or care providers may continue to obtain other documentation historically accepted by the state for TPL purposes.

Third Party Liability – Billing Options

Applicable liable third parties include:

- Health insurance, including Medicare
- Worker's compensation
- Homeowner's insurance
- Automobile liability insurance
- Veteran's Aid and Attendance

When a member has primary insurance, you must file TPL information:

- If the service code billed is not listed on the Medicare non-covered list or defined as Pay and Chase per the state's Third Party Liability policy
 - You will need to file to the primary insurance and then submit the claim with the primary carrier EOB/EOMB information to UnitedHealthcare, or obtain other state-approved documentation in accordance with state policy

- You are encouraged to bill TPL electronically through EDI and Clearinghouse Connections
 - Payer ID 87726
 - You will need to submit all other payer information as identified on the EOB/EOMB
- You may also bill on paper (CMS-1500 or UB-04 form). When billing on paper, attach the primary insurance EOB/EOMB, remittance advice or other state-approved documentation to each claim.
- At this time, [UnitedHealthcareOnline.com](https://www.uhcare.com) does not support filing of initial claims with third party liability information.

(Important Notice: As the Iowa state Medicaid plan, the policy is always the payer of last resort.)

Chapter 13: Physician and Facility Standards and Policies

PCPs are an important partner in the delivery of care and members have the freedom to seek services from any participating physician. The program does require members to be assigned to PCPs and members are encouraged to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a “medical home” that they can access to optimize their care.

Network Referrals

UnitedHealthcare Community Plan has no network limitation on referrals to any in-network care provider. Referrals should be made to care providers, facilities and contractors who are contracted as in the UnitedHealthcare Community Plan and thereby in-network. If the member accesses care through a non-contracted care provider without prior authorization, note that the services may not be reimbursed unless the service is an emergency, urgently needed, post-stabilization or out-of-area renal dialysis.

Excluded Providers

As part of ongoing efforts to help ensure compliance with federal and state requirements, UnitedHealthcare Community Plan performs monthly screenings of the Office of Inspector General (OIG) (oig.hhs.gov/fraud/exclusions.asp), the Excluded Parties List System (EPLS), and other databases for individuals or entities that have been “excluded” or “debarred” from federal programs. Individuals or entities identified as excluded or debarred as a result of these screenings will be terminated from participation in the plan, immediately, upon discovery. Payments made to “excluded” or “debarred” providers will be recovered retroactive to the date of exclusion.

13.1 Credentialing and Recredentialing Process

UnitedHealthcare’s credentialing and recredentialing process is to determine the care provider’s competence and suitability for initial and continued inclusion in UnitedHealthcare’s provider network. All individual contracted care providers are subject to the credentialing and recredentialing process before they can evaluate and treat UnitedHealthcare members.

If a physician or other health care professional fails to meet our recredentialing requirements, their participation with our network will terminate. We will give the physician or health care professional a written termination notice. The termination notice will include the reason for the termination, the effective date of that termination, and an explanation of their appeal rights, if applicable.

13.2 Role of the Primary Care Provider

The PCP plays a vital role as a physician case manager in the UnitedHealthcare Community Plan system by improving healthcare delivery in four critical areas—access, coordination, continuity, and prevention. The PCP is responsible for the provision of initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide 24-hours/seven-days coverage and backup coverage when they are not available.

UnitedHealthcare Community Plan expects all physicians involved in the member’s care to communicate with each other and work to coordinate the member’s care; this includes communicating significant findings and recommendations for continuing care. Females have direct access (without a referral or authorization) to any OB/GYNs, midwives, physician assistants, or nurse practitioners for women’s healthcare services and any non-women’s healthcare issues discovered and treated in the course of receiving women’s healthcare services. This includes access to ancillary services ordered by women’s healthcare providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP.

UnitedHealthcare Community Plan works with members and care providers to help ensure that all participants understand, support, and benefit from the primary care case management system. The coverage includes availability of anytime access by telephone to a live voice (an employee of the care provider or an answering service) which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems during non-office hours. Recorded messages are not acceptable.

Office Hours

Care providers must offer office hours of operation to Medicaid members no less than those offered to commercial members.

Panel Roster

PCPs may print a monthly Primary Care Provider Panel Roster by visiting UnitedHealthcareOnline.com.

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

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

Females have direct access (without a referral or authorization) to any OB/GYNs, midwives, physician assistants, or nurse practitioners for women's health care services and any non-women's health care issues discovered and treated in the course of receiving women's health care services. This includes access to ancillary services ordered by women's health care providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP.

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

Assignment to PCP Panel Roster

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

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

13.3 Responsibilities of the Primary Care Provider

In addition to the requirements applicable to all care providers, the responsibilities of the PCP include:

- Offer access to office visits on a timely basis, in conformance with the standards outlined in the Timeliness Standards for Appointment Scheduling section of this manual.
- Conduct a baseline examination to include a biometric screening during the member's first appointment.
- Treat general healthcare needs of members. Use nationally recognized clinical practice guidelines as a guide for treatment of important medical conditions. Such guidelines are referenced on UHCCommunityPlan.com.
- Consult with other appropriate healthcare professionals to assess and develop individualized treatment plans for enrollees with special healthcare needs
- Help ensure the integration of clinical and non-clinical disciplines and services in the overall plan of care for special needs members.
- Take steps to encourage all members to receive all necessary and recommended preventive health procedures in accordance with the Agency for Healthcare Research and Quality, US Preventive Services Task Force Guide to Clinical Preventive Services, ahcpr.gov/clinic/uspstfix.htm.
- Make use of any member lists supplied by the Health Plan indicating which members appear to be due preventive health procedures or testing.
- Be sure to timely submit all accurately coded claims or encounters.
- For questions related to member lists, practice guidelines, medical records, government quality reporting, HEDIS, etc., call Provider Services at 888-650-3462.
- Provide all well-baby/well-child services.
- Screen members for behavioral health problems, using the Behavioral Health Toolkit for the Healthcare Professional found on our website. UHCCommunityPlan.com. File the completed screening tool in the patient's medical record.
- Coordinate each member's overall course of care.
- Be available personally to accept UnitedHealthcare Community Plan members at each office location at least 16 hours a week.
- Be available to members by telephone 24 hours a day, seven days a week, or have arrangements for live telephone coverage by another UnitedHealthcare participating PCP or answering service which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems during non-office hours. Recorded messages are not acceptable.
- Respond to after-hour patient calls within 30–45 minutes for non-emergent symptomatic conditions and within 15 minutes for emergency situations.
- Educate members about appropriate use of emergency services.
- Discuss available treatment options and alternative course of care with members.
- Refer services requiring prior authorization to the Prior Authorization Department, Behavioral Health Unit, or Pharmacy Department as appropriate.
- Inform UnitedHealthcare Community Plan Case Management at 888-650-3462 of any member showing signs of end stage renal disease.
- Admit UnitedHealthcare Community Plan members to the

hospital when necessary and coordinate the medical care of the member while hospitalized.

- Respect the Advance Directives of the patient and document in a prominent place in the medical record whether or not a member has executed an advance directive form.
- Provide covered benefits in a manner consistent with professionally recognized standards of healthcare and in accordance with standards established by UnitedHealthcare Community Plan.
- Provide culturally competent care and services. All care providers must have a cultural competency program designed to educate and train its staff on addressing cultural and linguistic barriers to the delivery of healthcare services to members of all cultures.
- Document procedures for monitoring patients' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Copies of members' medical records must be provided to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records as per contract requirements for purposes such as: medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA regulations.
- 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.

13.4 Responsibilities of Specialist Physicians

In addition to the requirements applicable to all care providers, the responsibilities of specialist physicians include:

- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by the member's PCP or who self-refer.
- Be available to members by telephone 24 hours a day, seven days a week, or have arrangements for live telephone coverage by another UnitedHealthcare participating Specialist Physician or answering service which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems during non-office hours. Recorded messages are not acceptable.
- 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.

Medical Residents in Specialty Practice

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

24 Hours a Day, Seven Days a Week Coverage

PCP and obstetricians must be available to members by telephone 24 hours a day, seven days a week, or have arrangements for telephone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. A Medical Director or Physician Reviewer must approve coverage arrangements that vary from this requirement. PCPs and obstetricians are expected to respond to after-hour patient calls within 30-45 minutes for non-emergent symptomatic conditions and within 15 minutes for crisis situations. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability. UnitedHealthcare Community Plan also conducts periodic access surveys to monitor for 24/7 after-hours access. PCPs and obstetricians are required to participate in all activities related to these surveys.

13.5 Communicating with Members

As a contracted provider, you may share the following information with our members:

- General and factual information about UnitedHealthcare Community Plan and your participation in our network.
- Educational and promotional materials we have provided.
- Contact information for the Iowa Medicaid Enterprise (IME).

You may not interact with our members in the following ways:

- Share false or misleading information about UnitedHealthcare Community Plan and its services.
- Perform unsolicited marketing activities on behalf of UnitedHealthcare.
- Use and share educational and promotional materials that have not been approved by UnitedHealthcare or the State of Iowa Department of Human Services
- Assist with or make recommendations for enrollment with a specific Iowa Medicaid managed care organization.

13.6 Timeliness Standards for Appointment Scheduling/Wait Times

You need to comply with the following appointment availability standards:

Emergency Care

Immediately upon the member's presentation at a service delivery site.

Primary Care

PCPs and providers of primary care should arrange appointments for:

- Appointment times: Not to exceed six weeks from the date of a patient's request for a routine appointment, within 48 hours for persistent symptoms and urgent within one day.
- Non-urgent, symptomatic (i.e., routine care) office visits will be available from the member's PCP or another care provider within three weeks from the date of a patient's request. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.
- Non-symptomatic (i.e., preventive care) office visits will be available from the member's PCP or another care provider within three weeks from the date of a patient's request. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.
- Transitional health care by a PCP will be available for clinical assessment and care planning within seven calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program. Transitional healthcare by a home care nurse or home care registered counselor will be available within seven calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders, or discharge from a substance use disorder treatment program, if ordered by the member's PCP or as part of the discharge plan.

Specialty Care

Specialists and specialty clinics should arrange appointments for:

- Routine care within 30 days
- Urgent care within one day from request
- Non-urgent "sick" visit within 48–72 hours of request, as clinically indicated
- Non-urgent care within 30 days of request

Vision Services

Vision care providers should arrange appointments for:

- Routine optometry — not to exceed three weeks
- Urgent optometry within 48 hours

Laboratory and X-ray

Laboratory and X-ray care providers should arrange appointments for:

- Routine laboratory and X-ray services — not to exceed three weeks
- Urgent laboratory and X-ray services within 48 hours

Behavioral Health (Mental Health and Substance Use Disorders)

Behavioral health care providers should arrange appointments for:

Mental Health

- Post-stabilization services within one hour
- Emergent appointments within three hours
- Urgent within 24 hours
- Planned IP psychiatric within five working days
- Routine outpatient services within nine working days
- Routine care within three weeks
- Persistent symptoms within 48 hours

Substance Use Disorders

- Emergent appointments immediately
- Urgent within 24 hours
- Routine within 14 days
- Substance use disorder and pregnancy admitted within 48 hours

IV Drug Users

- Admitted no later than 14 days after making request for admission OR
- 120 days after date of request if no program has the capacity to admit the individual on the date of request and if interim services are made available to the individual not later than 48 hours after request

Prenatal Care

Providers of prenatal care should arrange appointments for the initial prenatal visit:

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

13.7 Timeliness Standards for Notifying Members of Test Results

You should notify members of laboratory or radiology test results within 24 hours of receipt of results in urgent or emergent cases. You should notify members of non-urgent, non-emergent laboratory and radiology test results within 10 business days of receipt of results.

13.8 Allowable Office Waiting Times

Members should not be routinely made to wait longer than:

- Routine appointments – 45 minutes after arrival
- Emergency – 15 minutes after arrival
- Mobile crisis – one hour after arrival or request
- Urgent non-emergency – one hour after arrival

13.9 Care Provider Office Standards

UnitedHealthcare Community Plan requires a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with

Disabilities (ADA) standards. Financial incentives for completing physical improvements to meet ADA accessibility standards are available to care providers that qualify as small businesses (up to 30 FTE employees or less than \$1 million gross revenue). Tax credits are available for “access expenditures” ranging from \$250 to \$10,250 and tax deductions are available up to \$15,000 per year for expenses associated with the removal of barriers.

13.10 Medical Record Charting Standards

All participating primary care UnitedHealthcare Community and State practitioners are required to maintain medical records in a complete and orderly fashion which promotes efficient and quality patient care. Participating practitioners are subject to UnitedHealthcare Community and State’s periodic quality review of medical records to determine compliance to the following medical record keeping requirements.

Screening and Documentation Tools

Most of these tools were developed by UnitedHealthcare Community Plan with assistance from the Provider Advisory Subcommittee to help you comply with regulatory requirements and practice in accordance with accepted standards.

Confidentiality of Records	<p>Office policies and procedures exist for the following:</p> <ul style="list-style-type: none"> • Confidentiality of the patient medical record • Initial and periodic training of office staff concerning medical record confidentiality • Release of information • Record retention • Availability of medical record when housed in a different office location (as applicable)
Record Organization	<p>An office policy exists that addresses a process to respond to and provide medical records upon request of patients to include a provision to provide copies within 48 hours in urgent situations</p> <ul style="list-style-type: none"> • Medical records are maintained in a current, detailed, organized and comprehensive manner. <p>Organization should include evidence of:</p> <ul style="list-style-type: none"> • Identifiable order to the chart assembly • Papers are fastened in the chart • Each patient has a separate medical record <p>Medical records are:</p> <ul style="list-style-type: none"> • Filed in a manner for easy retrieval • Readily available to the treating practitioner where the member generally receives care • Promptly sent to specialty care providers upon patient request and within 48 hours in urgent situations. • Stored in a manner that ensures protection of confidentiality • Released only to entities as designated consistent with federal requirements. • Kept in a secure area accessible only to authorized personnel

<p>Procedural Elements</p>	<p>Medical records are legible*</p> <ul style="list-style-type: none"> • All entries are signed and dated • Patient name/identification number is located on each page of the record • Linguistic or cultural needs are documented as appropriate • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the patient’s first language is something other than English • Mechanism for monitoring and handling missed appointments is evident • An executed advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information regarding advance directives • A problem list includes a list of all significant illnesses and active medical conditions • A medication list includes prescribed and over the counter medications and is reviewed annually* • Documentation of the presence or absence of allergies or adverse reactions is clearly documented*
<p>History</p>	<p>An initial history (for patients seen three or more times) and physical is present to include:</p> <ul style="list-style-type: none"> • Medical and surgical history* • A family history that minimally includes pertinent medical history of parents and/or siblings • A social history that minimally includes pertinent information such as occupation, living situations, education, smoking, ET OH, and/or substance abuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults <p>Screenings of/for:</p> <ul style="list-style-type: none"> • Recommended preventive health screenings/tests • Depression • High risk behaviors such as drug, alcohol and tobacco use; and if present, advise to quit • Medicare patients for functional status assessment and pain • Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate
<p>Problem Evaluation and Management</p>	<ul style="list-style-type: none"> • Documentation for each visit includes: • Appropriate vital signs (Measurement of height, weight, and BMI annually) • Chief complaint* • Physical assessment * • Diagnosis* • Treatment plan* • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines • Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets • Treatment plans are consistent with evidence-based care and with findings/diagnosis • Timeframe for follow-up visit as appropriate • Appropriate use of referrals/consults, studies, tests • X-rays, labs, consultation reports are included in the medical record with evidence of practitioner review • There is evidence of practitioner follow-up of abnormal results • Unresolved issues from a previous visit are followed up on the subsequent visit • There is evidence of coordination with behavioral health care provider • Education, including lifestyle counseling is documented • Patient input and/or understanding of treatment plan and options is documented • Copies of hospital discharge summaries, home healthcare reports, emergency room care, physical or other therapies, as ordered by the practitioner are documented.

13.11 Medical Record Review

On a routine basis, UnitedHealthcare Community Plan will conduct a review of the medical records you maintain for our members. Physicians are expected to achieve a passing score of 85% or better. Medical records should include:

- Initial health assessment, including a baseline comprehensive medical history, which should be completed in less than two visits and documented, and ongoing physical assessments documented on each subsequent visit.
- Problem list, includes the following documented data:
- Biographical data, including family history
- Past and present medical and surgical intervention
- Significant illnesses and medical conditions with dates of onset and resolution
- Documentation of education/counseling regarding HIV pre and post test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions are prominently noted. Also note if there are no known allergies or adverse reactions.
- Past medical history is easily identified and includes serious illnesses, injuries and operations (for patients seen three or more times). For children and adolescents (18 years or younger), past history relates to prenatal care, birth, operations and childhood illnesses.
- Medication record includes name of medication, dosage, amount dispensed and dispensing instructions
- Immunization record
- Document tobacco habits, alcohol use and substance abuse (12 years and older)
- Copy of Advance Directive, or other document as allowed by state law, or a notation that patient does not want one.
- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits
- Diagnosis and treatment plans consistent with findings
- Lab and other studies as appropriate
- Patient education, counseling and/or coordination of care with other physicians or healthcare professionals
- Notation regarding the date of return visit or other needed follow-up care for each encounter
- Consultations, lab, imaging and special studies initiated by primary physician to indicate review
- Consultation and abnormal studies including follow-up plans

Patient hospitalization records should include, as appropriate:

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

13.12 Protect Confidentiality of Member Data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all records and information about their healthcare. We disclose confidential information only to business associates and affiliates who need that information to fulfill our obligations and to facilitate improvements to our members' healthcare experience. We require our associates and business associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you as the holder of the medical records. You need to comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of member medical information. You 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 applicable state laws and regulations. UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to prevent unintentional disclosure of protected health information (PHI). This includes policies and procedures governing administrative and technical safeguards of protected health information. Training is provided to all personnel on an annual basis and to all new employees within the first 30 days of employment.

13.13 HIPAA Compliance – Provider Responsibilities

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is aimed at improving the efficiency and effectiveness of the healthcare system in the United States. While the portability and continuity of insurance coverage for workers and greater ability to fight healthcare fraud and abuse were the core goals of the act,

the Administrative Simplification provisions of HIPAA have had the greatest impact on the operations of the healthcare industry. UnitedHealthcare is a “covered entity” under the regulations, as are all healthcare providers who conduct business electronically.

1. Transactions and Code sets

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

2. Unique Identifiers

HIPAA also requires the development of unique identifiers for employers, healthcare providers, health plans and individuals for use in standard transactions. Please see the National Provider Identifier section of this chapter.

3. Privacy of Individually Identifiable Health Information

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

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

4. Security

The security regulations require covered entities to meet basic security objectives.

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

covered entity’s workforce.

UnitedHealthcare expects all participating care providers to comply with the HIPAA regulations that apply to their practice or facility within the established deadlines. Additional information on HIPAA regulations can be obtained at [cms.hhs.gov](https://www.cms.hhs.gov)

Privacy Regulations

HIPAA Privacy Regulations provide comprehensive federal protection for the privacy of healthcare information. These regulations control the internal uses and the external disclosures of health information. The Privacy Regulations also create certain individual patient rights.

Access to Protected Health Information

- UnitedHealthcare members have the right to access health information maintained in a designated record set held at the care provider’s office or at the health plan. Members may make a request to see and obtain a copy of certain health information UnitedHealthcare maintains electronically, such as medical records and billing records. They may also make a request of the provider of service to obtain copies of their health information maintained electronically. If members’ health information is maintained electronically, members can request the health plan or provider send a copy of their electronic health information in an electronic format. They can also request that a copy of their health information be provided to a third party they identify.

Amendment of PHI

- UnitedHealthcare members have the right to request information held by the provider or health plan be amended if they believe the information to be inaccurate or incomplete. Any request for amendment of PHI must be in writing and provide reasons for the requested amendment. The request must be acted on within 60 days. This limit may be extended for a period of 30 days with written notice to the member. If the request is denied, members may have a statement of disagreement added to the member’s health information.

Accounting of Disclosures

- UnitedHealthcare members have the right to request an Accounting of certain Disclosures of their PHI made by the provider or the Health Plan during six years prior to the request. This accounting must include disclosures by business associates. The accounting will not include disclosures of information made: (i) for treatment, payment and healthcare operations purposes; (ii) to members or pursuant to members’ authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require UnitedHealthcare to provide an accounting.

Right to Request Restrictions

- Members have the right to request restrictions to the care provider or health plan's uses and disclosures of the individual's PHI for treatment payment and healthcare operations. Such a request may be denied, but if it is granted, the covered entity is bound by any restriction to which is agreed and these restrictions must be documented. Care provider and health plan must agree to individual's request to restrict disclosure. Members have the right to request restriction on uses or disclosures of their information for treatment, payment, or healthcare operations. In addition, members may request to restrict disclosures to family members or to others who are involved in their healthcare or payment for their healthcare.

Right to Request Confidential Communications

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

We tell our members they have certain rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you. The three primary member responsibilities as required by the NCQA are:

1. A responsibility to supply information (to the extent possible) that the organization and its care providers need to provide care
2. A responsibility to follow plans and instructions for care that they have agreed to with their care providers
3. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

Member rights can be found at UHCommunityPlan.com, and are listed in the Quality Management chapter of this manual.

Chapter 14: Provider Communications

The UnitedHealthcare provider education and training program is built on 27 years of experience with care providers and multi-state managed care programs and includes the following training components:

- Provider website
- Provider forums/town hall meetings
- Provider office visits
- Provider bulletins
- Provider manual

14.1 Care Provider Website

UnitedHealthcare promotes the use of web-based functionality among its care provider population. UnitedHealthcare's web-based provider website, UHCCommunityPlan.com, facilitates care provider communications pertaining to administrative functions. Our interactive website enables care providers to electronically determine member eligibility, submit claims, and ascertain the status of claims. UnitedHealthcare has implemented an internet-based prior authorization system on UHCCommunityPlan.com which allows care providers who have internet access the ability to request their medical prior authorizations online rather than by telephone. The UnitedHealthcare Community Plan also contains an online version of the Manual, the Provider Directory, access to the Iowa Preferred Drug List (both searchable and comprehensive listing), clinical practice guidelines, quality and utilization requirements and educational materials such as newsletters, recent fax service bulletins and other care provider information. UnitedHealthcare also posts notifications regarding changes in laws, regulations and subcontract requirements to the portal such as the Issues Log, which is located at UHCCommunityPlan.com/health-professionals/ia.html.

A website is also available to members including access to the Member Handbook, newsletters, provider search tool and other important Health Plan bulletins.

14.2 Provider Office Visits

Provider Advocates visit PCPs, specialist and ancillary provider offices on a regular basis. Each Provider Advocate is assigned to a geographic territory to deliver face-to-face support to our care providers across the state. The prioritization and quantity of care provider office visits by these staff is determined based on a variety of demographic factors, including size of member population, special cultural/linguistic needs, geography, and other special needs. Our primary reasons for face-to-face office visits are to create program awareness, promote program compliance, and minimize healthcare disparities. Provider Advocate maps are available at UHCCommunityPlan.com/health-professionals/ia.html.

14.3 Care Provider Bulletins

We communicate policy updates to you through news Bulletins located at UHCCommunityPlan.com > For Healthcare Professionals > Select your State > Iowa > Bulletins.

14.4 Manual/Provider Administrative Guide

UnitedHealthcare publishes this manual online, which includes an over view of the program, toll free number to our provider services hotline, a removable quick reference guide, and a list of additional provider resources and incentives. You may request a hard copy of this manual by contacting Provider Services.

Chapter 15: Covered Benefits

Health benefits are governed by our contract with the Iowa Department of Human Services and include medical, vision, behavioral health including HCBS and habilitation, and pharmacy services. All covered services are available regardless of pre-existing conditions, prior diagnoses, or receipt of any prior health care services. UnitedHealthcare Community Plan will impose copayments for Iowa Health and Wellness Plan participants in accordance with the state's 1115 waiver and *hawk-i* members in accordance with the state's CHIP State Plan. For all other enrolled populations, UnitedHealthcare Community Plan may elect, but is not required, to impose copayments as outlined in the state plan. Members may state they are unable to pay the co-payment. You may not deny care or services to any members because of an inability to pay the copayment.

We provide a benefit package which includes Fee-for-Service (FFS) services covered under the Iowa Medicaid program. Services for members are limited to those that are medically necessary and appropriate, and which conform to professionally accepted standards of care, our (policies), reimbursement policies and clinical practice guidelines. Please refer to the current Iowa Medicaid Provider Manual located at dhs.iowa.gov for listing of limitations and exclusions.

Value-Added Services

We offer additional services at no cost to the member. These special services are selected to address member needs and experiences in an effort to help them live healthier lives. Members are informed of these services through their UnitedHealthcare Community Plan of Iowa welcome packet. Value-added services are highlighted in the member newsletter, listed in the member handbook and at UHCCommunityPlan.com. Information about services that are diagnosis-specific, such as diabetes and pregnancy, are mailed to the member's home.

Members may directly access most of these services. Some services require assistance from your office. All are limited to in-network care providers. For the most current value-added services, please visit UHCCommunityPlan.com > For Healthcare Professionals > Iowa > Billing & Reference Guides > Value Added Services. You may also call Provider Services at 888-650-3462.

Benefits

Health benefits are governed by UnitedHealthcare Community Plan's contract with the Iowa Department of Human Services and include medical, vision, behavioral health including HCBS and Habilitation and pharmacy services. All covered services are available regardless of pre-existing conditions, prior diagnoses, or receipt of any prior health care services. UnitedHealthcare Community Plan provides a benefit package which includes FFS services currently covered under the Iowa Medicaid program. Services for members are limited to those that are medically necessary and appropriate, and which conform to professionally accepted standards of care. Please refer to the current Iowa Medicaid Provider Manual located at dhs.iowa.gov for listing of limitations and exclusions. The Iowa Medicaid manual includes minimum service requirements.

The following benefit information is a summary. Some procedures, including certain medical services or benefits provided, require prior authorization by UnitedHealthcare before rendering services. Call Provider Services to check eligibility coverage for Iowa Medicaid members.

For a comparison summary of the benefits by eligibility category please refer to the Benefits at a Glance Summary located at UHCCommunityPlan.com > For Healthcare Professionals > Iowa > Provider Administrative Manual.

Medicaid and Iowa Wellness Plan Covered Services

A complete list of services requiring prior authorization is available online at UHCCommunityPlan.com > For Healthcare Professionals > Iowa.

Service	
Children's Care	
Newborn Care	Newborn screenings are covered. Circumcisions performed on male newborns before leaving the hospital are covered then up to six weeks of age at the doctor's office.
Immunizations & Vaccines (shots)	You can get these at the doctor's office or the local health department. Immunizations and vaccines are covered according to the Centers for Disease Control and Prevention (CDC) and American Academy of Pediatrics vaccination schedule.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (under 21 years old)	Covered services include: <ul style="list-style-type: none"> • Well-child visits • Developmental screening • Vision testing • Behavioral screening • Immunizations • Hearing testing • Private duty nursing/Personal cares • Child care medical services
Lead Screening	Lead screenings can be done at the doctor's office or local health department.
Office Visits	Well-child visits, routine visits and sick visits are covered.
Women's Care	
Family Planning	Family planning offers counseling, supplies, routine care and treatment for sexually transmitted infections (STIs). This care is private. The member can go to any care provider that offers these services. Also includes family planning drugs, supplies and devices. These include, but are not limited to, generic birth control pills, shots, IUDs and diaphragms.
Obstetric & Maternity Care	<p>You are covered for</p> <ul style="list-style-type: none"> • Doctor and hospital care before your baby is born (prenatal care) • Delivery • Care after birth (postpartum care) • Certified nurse midwife services • Birthing and parenting classes <p>You may go to your OB/GYN for care without a referral.</p> <p>You can stay in the hospital up to two days after a normal vaginal delivery and up to four days after a Cesarean delivery.</p>
Well-Care for Women	You may see an OB or OB/GYN for routine office visits, mammograms, Pap tests and family planning. No referral is needed.

Service	
Sterilization	The Iowa Department of Human Services Consent form is required. You must submit the consent form with the claim.
Abortions	Abortion services are limited to coverage based on federal and state laws and regulations. No services associated with an abortion will be covered unless criteria are met. The appropriate Certification of Medical Necessity for Abortion form must be complete and submitted, along with supporting document and the claim.
Emergency and Urgent Hospital Care	
Ambulance Services	Emergent and non-emergent transportation by an ambulance is covered.
Emergency Room Care	<p>Emergency care is for a medical issue that is a threat to your life or that can badly harm your health if you do not get care right away. Here are some examples of emergencies:</p> <ul style="list-style-type: none"> • Convulsions • Chest pain • High fever • Serious breathing problems • Broken bones • Loss of consciousness (fainting or blackout) <p>Emergency care does not need prior authorization and you can get care anywhere in the USA. This includes post-stabilization care. Post-stabilization care includes the care you get after an emergency to make you stable or to maintain, improve or resolve your health condition.</p> <p>For Iowa Wellness plan members, there is an \$8.00 copayment for emergency room service use for non-emergencies. This copayment is waived for members younger than 21 and pregnant women.</p> <p>The hospital providing care must first conduct a medical screening to determine if the member does not need emergency services. Before providing non-emergency treatment and imposing cost-sharing, the hospital must:</p> <ul style="list-style-type: none"> • Inform member of cost sharing obligation for non-emergency services provided in the emergency department; • Provide member with the name and location of an available and accessible alternative non-emergency services provider. If geographical or other circumstances prevent the hospital from meeting this requirement, you may not impose cost-sharing; • Determine if an alternative care provider can provide non-emergency services to the member in a timely manner with a lesser cost-sharing amount. The assessment of timely services access is based on the member's medical needs (see Chapter 12.4 for details on timely services). • Refer alternative care provider and schedule treatment.
Medical Inpatient Care	Hospital inpatient care is covered when medically necessary. Includes medical, surgical, post-stabilization, acute and rehabilitative services. The hospital must notify UnitedHealthcare.

Service	
Urgent Care Visits	<p>Urgent care is for problems that need prompt medical attention, but are not life threatening. Here are some examples of urgent care.</p> <ul style="list-style-type: none"> • Sore throat or cough • Back pain • Earache • Flu or cold symptoms • Minor injury <p>Visits to an urgent care center are covered.</p>
Outpatient Care	
Doctor Visits	Routine and preventive care services including doctor visits, preventive services, clinic visits and outpatient doctor care are covered.
Cardiac & Pulmonary Rehab	Covered when medically necessary.
Home Health Services	Services in the home include visits by aides, private duty nursing, physical/occupational/speech therapy, skilled nursing, social workers and home infusion. Limitations may apply.
Rehabilitative Therapy	<p>This type of care is given after serious illness or injury to restore function. Covered therapy includes physical, occupational and speech. These are covered when medically necessary. Limitations may apply.</p> <p>Physical, occupational and speech therapy is limited to 60 visits per year per therapy type for Iowa Wellness Plan members.</p> <p>Therapy provided by Rehabilitation Agencies is not specifically limited on the number of visits covered as long as the amount of service:</p> <ul style="list-style-type: none"> • Is medically necessary in the individual case, and • Is related to a diagnosed impairment or disabling condition, and • Meets current standard of practice in each related field. <p>Therapy provided by independently practicing physical, occupational and speech-language pathologists will not exceed the therapy cap as disclosed by the Centers of Medicare and Medicaid Services (CMS). Current therapy cap information can be found at cms.gov > Research, Statistics, Data and Systems > Medicare Fee-for-Service Compliance Programs > Medical Review and Education > Therapy Cap.</p>
Specialty Care (Office Visits & Clinics)	Care with a specialist is covered. Talk to your doctor to see if you need specialty care. You do not need a referral to go to a network specialist.
Diagnostic Testing	Diagnostic lab tests are covered.
Surgery	
Outpatient Surgery	Medically necessary outpatient surgeries may be performed in a hospital or in an ambulatory surgery center.

Service	
Hospice	
Hospice Care	Hospice care is for people with an illness causing limited life expectancy as decided by your doctor. It is most often given in the home. Your doctor will help you arrange the care.
Other Covered Care & Programs	
Asthma Care	<p>Covered equipment, supplies and services include:</p> <ul style="list-style-type: none"> • Peak flow meters • Spacers • Nebulizers & masks • Regular doctor visits • Specialist visits • Other supplies needed to manage asthma
Chiropractic Services	<p>Chiropractic manipulative therapy eligible for reimbursement is specifically limited to the manual manipulation of the spine for the purpose of correcting a subluxation demonstrated by x-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.</p> <p>X-rays are limited to one per condition. Additional x-rays are not covered.</p> <p>Routine adjustments are not covered.</p> <p>Services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing are not covered.</p>
Diabetic Supplies	Diabetic supplies are covered including, but not limited to, alcohol swabs, needles and syringes, glucose test strips, and lancets. Diabetic supplies can be obtained from a network pharmacy.
Durable Medical Equipment (DME) and Supplies	Equipment and supplies for medical purpose. May include, but are not limited to: oxygen tanks, ventilators, wheelchairs, crutches, orthotic devices, prosthetic devices, pacemakers, and medical supplies.

Service

Vision Services

Vision exams, prescription lenses, eyeglasses, cataract removal, and prosthetic eyes, if prescribed.

Routine eye exams are covered once per year. Nonroutine eye exams are covered when the exam is the result of a complaint or symptom of an eye disease or injury.

New eyeglasses are covered as follows:

- Up to three times for children up to one year of age
- Up to four times per year for children one through three years of age
- Once per year for children four through seven years of age
- Once per 24 months after eight years of age
- Safety frames are allowed for children through seven years of age
- When there is a covered lens change and the new lenses cannot be accommodated in the current frame.

Eyeglasses are not covered for Iowa Wellness Plan members.

Repairs and replacement frames, lenses, or component parts are covered. Replacement of lost or damaged glasses for adults age 21 and over is limited to once every 12 months, except in certain circumstances. Replacement of lost or damaged glasses for children under 21 years of age is not limited.

Gas permeable contact lenses are limited as follows:

- up to 16 lenses for children up to 1 year of age,
- up to eight lenses every 12 months for children one to 3 years of age,
- up to six lenses every 12 months for children 4 to 7 years of age,
- two lenses every 24 months for members 8 years of age and over.

Artificial eyes are covered. For routine vision services, contact Superior Vision Provider Services at **800-243-1401**.

Service	
Hearing Services	<p>Includes diagnostic screening, preventive visits and hearing aids. One routine visit every 12 months.</p> <p>Hearing aids, both analog and digital, are covered. Hearing aids are not covered for Iowa Wellness Plan members.</p> <p>Lost, broken or destroyed hearing aids will be replaced one time during a four-year time period with a prior authorization.</p> <p>Binaural hearing aids are covered. One hearing aid per ear every four years. Requires specific medical necessity documents.</p> <p>Hearing aid repairs are covered.</p> <p>Hearing aid batteries are covered when obtained from a participating care provider, but limited to 30 batteries within a 90-day period for monaural and 60 batteries within a 90-day period for binaural.</p>
Nutritional Classes/Counseling	<p>Nutritional services/counseling must be given by a licensed dietitian. It is covered for certain medical conditions, like diabetes.</p>
Mental Health Services	<p>Mental health and substance abuse services are covered. This includes: Inpatient and outpatient services</p> <ul style="list-style-type: none"> • Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses. • Prescription drugs for therapeutic purposes • Partial hospitalization and day treatment services <p>Some services have limitations.</p>
Prescription and Over-the-Counter (OTC) Drugs	<p>Prescriptions and OTC drugs are covered according to the State's Preferred Drug List (PDL).</p>
Non-Emergency Transportation	<p>Transportation to and from medical appointments are covered if you qualify and have no other way to get there. Must be medically necessary appointments or to go to the pharmacy. Prior authorization may be required. To schedule a Non-Emergency Medical Transportation trip, please call MTM at 888-513-1613.</p>
Podiatry (Foot) Care	<p>Medically necessary podiatry (foot/ankle) care services are covered. Routine foot care, such as toenail trimming, is not covered for Medicaid or Iowa Wellness Plan members unless it is part of a member's overall treatment related to certain health conditions.</p>

HCBS Benefits

In addition to the Medicaid benefits you provide, as an HCBS Waiver provider, you will provide some of the following services. The following benefit chart shows what waivers cover each service.

Prior authorization is required for all of the following services. Some limitations may apply.

Service	Description	Home and Community-Based Services (HCBS) Waivers
Adult Day Care	Program of support care in a group environment with supervision and assistance on a regular or intermittent basis in a day care center.	<ul style="list-style-type: none"> • AIDS/HIV • Brain Injury • Elderly • Health & Disability • Intellectual Disability
Assistive Devices	Equipment to assist members with activities of daily living to allow the member more independence. Devices include, but are not limited to: <ul style="list-style-type: none"> • Long-reach brush • Extra-long shoe horn • Non-slip grippers to pick up and reach items • Dressing aids • Transfer boards • Shampoo rinse tray and inflatable shampoo tray • Double-handled cup and sipper lid 	<ul style="list-style-type: none"> • Elderly
Assisted Living	Unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, non-institutional setting. The service is not reimbursable if performed at the same time as any service included in an approved CDAC agreement.	<ul style="list-style-type: none"> • Elderly
Behavioral Programming	Individually designed programs to increase the member's appropriate behaviors and decrease the member's maladaptive behaviors that have interfered with the member's ability to remain in the community.	<ul style="list-style-type: none"> • Brain Injury
Chore	Assist with the household maintenance activities as necessary to allow a member to remain in their own home safely and independently.	<ul style="list-style-type: none"> • Elderly
Consumer-directed Attendant Care (CDAC)	Activities performed by a person to help a member with self-care tasks that the member would typically do independently if the member were otherwise able. CDAC services must be cost-effective and necessary to prevent institutionalization.	<ul style="list-style-type: none"> • AIDS/HIV • Brain Injury • Elderly • Health & Disability • Intellectual Disability • Physical Disability

Service	Description	Home and Community-Based Services (HCBS) Waivers
Counseling	<p>Face-to-face non-psychiatric mental health services necessary to:</p> <ul style="list-style-type: none"> • Manage depression, • Assistance with the grief process, • Alleviation of psychosocial isolation, and • Support to cope with a disability or illness, including terminal illness. 	<ul style="list-style-type: none"> • AIDS/HIV • Health & Disability
Day Habilitation	<p>Regularly scheduled activities in a non-residential setting, separate from the member's private residence or other residential living arrangement, such as:</p> <ul style="list-style-type: none"> • Assist with acquisition, retention, or improvement in self-help; • Socialization and adaptive skills that enhance social development; and • Develop skills in performing activities of daily living and community living. 	<ul style="list-style-type: none"> • Intellectual Disability
Environmental Modifications and Adaptive Devices	<p>Items installed or used within the member's home that address specific, documented health, mental health, or safety concerns.</p>	<ul style="list-style-type: none"> • Children's Mental Health
Family and Community Support	<p>Support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.</p>	<ul style="list-style-type: none"> • Children's Mental Health
Family Counseling and Training	<p>Services are face-to-face mental health services provided to the member and the family with whom the member lives (or who routinely provides care to the member) to increase the member's or family members' capabilities to maintain and care for the member in the community.</p>	<ul style="list-style-type: none"> • Brain Injury
Home Delivered Meals	<p>Each meal will help ensure the member receives a minimum of one-third of the daily-recommended dietary allowance, as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard. A maximum of two meals per day or 14 meals per week is allowed.</p>	<ul style="list-style-type: none"> • AIDS/HIV • Elderly • Health & Disability

Service	Description	Home and Community-Based Services (HCBS) Waivers
Home Health Aide	Unskilled medical services that provide direct personal care.	<ul style="list-style-type: none"> • AIDS/HIV • Elderly • Health & Disability • Intellectual Disability
Homemaker	Provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions.	<ul style="list-style-type: none"> • AIDS/HIV • Elderly • Health & Disability
Home/Vehicle Modifications	Physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.	<ul style="list-style-type: none"> • Brain Injury • Elderly • Health & Disability • Intellectual Disability • Physical Disability
In-home Family Therapy	Skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.	<ul style="list-style-type: none"> • Children's Mental Health
Interim Medical Monitoring & Treatment (IMMT)	Services are monitoring and treatment of a medical nature requiring specially trained caregivers.	<ul style="list-style-type: none"> • Brain Injury • Health & Disability • Intellectual Disability
Mental Health Outreach	Services provided in a member's home to identify, evaluate, and provide treatment and psychosocial support. The services can be provided only on the basis of a referral from the member's interdisciplinary team.	<ul style="list-style-type: none"> • Elderly
Nursing	Services provided to a member by licensed agency nurses in the home. Must be included in the treatment plan established by the physician. The services must be reasonable and necessary to the treatment of an illness or injury. Services should be based on medical necessity of the member.	<ul style="list-style-type: none"> • AIDS/HIV • Elderly • Health & Disability • Intellectual Disability

Service	Description	Home and Community-Based Services (HCBS) Waivers
Nutritional Counseling	Services provided for a nutritional problem or condition of such severity that nutritional counseling beyond that normally expected as part of the standard medical management is needed.	<ul style="list-style-type: none"> • Elderly • Health & Disability
Personal Emergency Response System	<p>A call button so the member can get help in an emergency. Use it when the caregiver is not around. This service is not available if the member:</p> <ul style="list-style-type: none"> – Lives in a nursing home, or – The facility already has a way to help the member when needed. 	<ul style="list-style-type: none"> • Brain Injury • Elderly • Health & Disability • Intellectual Disability • Physical Disability
Prevocational Services	Services that provide learning and work experiences, including volunteer work, where the member can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the member and the member’s service and supports planning team through an ongoing person-centered planning process.	<ul style="list-style-type: none"> • Brain Injury • Intellectual Disability
Respite: Basic Individual	<p>Services provided to the member that give temporary relief to the usual caregivers and give all the necessary care that the usual caregiver would during that time. The purpose of respite care is to enable members to remain in their current living situation.</p> <p>Individual respite is provided on a ratio of one staff-to-one member. The member does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.</p>	<ul style="list-style-type: none"> • AIDS/HIV • Brain Injury • Children’s Mental Health • Elderly • Health & Disability • Intellectual Disability

Service	Description	Home and Community-Based Services (HCBS) Waivers
Respite: Group	<p>Services provided to the member that give temporary relief to the usual caregivers and give all the necessary care that the usual caregiver would during that time. The purpose of respite care is to enable members to remain in their current living situation.</p> <p>Group respite provided on a ratio of one staff-to-two or more members receiving respite. These members do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.</p>	<ul style="list-style-type: none"> • AIDS/HIV • Brain Injury • Children’s Mental Health • Elderly • Health & Disability • Intellectual Disability
Respite: Specialized	<p>Services provided to the member that give temporary relief to the usual caregivers and give all the necessary care that the usual caregiver would during that time. The purpose of respite care is to enable members to remain in their current living situation.</p> <p>Respite provided on a staff-to-member ratio of one-to-one or higher to members with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.</p>	<ul style="list-style-type: none"> • AIDS/HIV • Brain Injury • Children’s Mental Health • Elderly • Health & Disability • Intellectual Disability
Senior Companion	<p>Include nonmedical care supervision, oversight, and respite services. Companions may assist with meal preparation, laundry, shopping, and light housekeeping tasks. This service cannot provide hands-on nursing or medical care.</p>	<ul style="list-style-type: none"> • Elderly
Specialized Medical Equipment	<p>Medically necessary items for personal use by a member for the member’s health and safety, such as:</p> <ul style="list-style-type: none"> • Electronic aids and organizers • Medicine dispensing devices • Communication devices • Bath aids • Environmental control units • Repair and maintenance of items purchased through the waiver 	<ul style="list-style-type: none"> • Brain Injury • Physical Disability
Supported Community Living (SCL)	<p>Services provided within the member’s home and community, according to the individualized member’s needs as identified in the approved service plan.</p>	<ul style="list-style-type: none"> • Brain Injury • Intellectual Disability

Service	Description	Home and Community-Based Services (HCBS) Waivers
Supported Community Living: Residential-Based (RBSCL)	Medical or remedial services provided to children under the age of 18 while living outside their family home. The residential-based living environment is furnished by the residential-based supported community living service provider. The services remove barriers to family reunification or develop self-help skills for maximum independence.	<ul style="list-style-type: none"> • Intellectual Disability
Supported Employment (SE)	Individual employment support services for members who, due to disabilities, need ongoing support to obtain and maintain an individual job.	<ul style="list-style-type: none"> • Brain Injury • Intellectual Disability
Transportation	Transportation services may be provided for members: <ul style="list-style-type: none"> • To conduct business errands and essential shopping, • To receive medical services not reimbursed through medical transportation, • To travel to and from work or day programs (BI, ID, and PD), or • To reduce social isolation. 	<ul style="list-style-type: none"> • Brain Injury • Elderly • Intellectual Disability • Physical Disability

Covered and non-covered services *hawk-i* program

Deductible	None
Maximum Out of Pocket Expense (calendar year)	None
Lifetime Maximum	None

A complete list of services requiring prior authorization is available online at UHCCommunityPlan.com > For Healthcare Professionals > Iowa.

Covered Services	Notes	UnitedHealthcare Community Plan
Emergency Room Facility	<p>Emergency services for non-emergent conditions are subject to a \$25 Copayment if the family pays a premium for the <i>hawk-i</i> program.</p> <p>To impose cost-sharing for non-emergency use of the emergency room, the hospital providing care must first conduct an appropriate medical screening (see 42 C.F.R. § 489.24) to determine the member does not need emergency services. Before providing non-emergency treatment and imposing cost-sharing for such services, the hospital must:</p> <ul style="list-style-type: none"> – Inform the member of the cost sharing cost for providing non-emergency services in the emergency department; – Provide the member with the name and location of an available and accessible alternative non-emergency services care provider. If geographical or other circumstances prevent the hospital from meeting this requirement, cost-sharing may not be imposed; – Determine the alternative care provider can provide services to the member in a timely manner (see Chapter 12.4 for more information on timely manner) with less cost sharing. The assessment of access to timely services will be based on the medical needs of the member; – Refer alternative care provider and schedule treatment. 	Covered in or out of network for emergency services. Follow up care in the emergency room is not covered. Follow up services must be provided by a network provider.
Ambulance		Covered in a medical emergency.
Urgent Care Facility		Covered in a network facility.

Covered Services	Notes	UnitedHealthcare Community Plan
Routine Preventive Physical Examinations including Well-Child Care and Gynecological exam		Covered at a network provider.
Physician Services		
Office visits		Covered at a network provider.
Physician Emergency Room Visits		Covered at a network provider.
Inpatient Hospital Visits and Consultations		Covered at a network provider.
Outpatient Physician Services		
Home Visits or Nursing Facility Visits		Covered at a network provider.
Allergy Testing		Covered at a network provider.
Allergy Injections		Covered at a network provider.
Immunizations	Cannot use VFC vaccines	Covered at a network provider. <i>hawk-i</i> does not participate in the VFC program.
Injections		
Physician's Office		Covered at a network provider.
Hospital (inpatient or outpatient)		Covered at a network provider.
Hospital Inpatient Services		
Room & Board (semi-private)		Covered at a network facility. Inpatient services requires pre-certification.
Miscellaneous		Covered at a network provider.
Outpatient Facility or Surgical-Center		Covered at a network facility.
Anesthesia		Covered.
Physician Surgical Services		
Office		Covered at a network provider.

Covered Services	Notes	UnitedHealthcare Community Plan
Outpatient		Covered at a network provider.
Inpatient		Covered at a network provider.
X-Ray Imaging & Laboratory Services		
Hospital (inpatient or outpatient)		Covered at a network provider.
Office		Covered at a network provider.
Radiation Therapy and Chemotherapy		Covered at a network provider.
Maternity Services		
Physician Medical Services		Covered at a network provider.
Hospital Inpatient Service for Maternity <ul style="list-style-type: none"> • Room & Board • Miscellaneous 		Covered at a network facility. Inpatient services requires pre-certification.
Vision Services		
Medically Necessary Vision Services		Covered at a network provider.
Routine Vision Services	For Routine Vision Services, contact Superior Vision Provider Services at 800-243-1401 .	Covered at a network provider for one exam per calendar year. UnitedHealthcare contracts with Superior Vision for routine vision services, including eyewear.
Eyewear (glasses/contacts)	For Routine Vision Services, contact Superior Vision Provider Services at 800-243-1401 .	Covered at a network provider for up to \$100 per calendar year. UnitedHealthcare contracts with Superior Vision for routine vision services, including eyewear. Replacement eyewear is not covered.

Covered Services	Notes	UnitedHealthcare Community Plan
Other Covered Care & Programs		
Outpatient Rehabilitative Therapy (Physical, Occupational, Speech, Cardiac and Pulmonary)		<p>Covered at a network provider. Maximum 60 combined outpatient treatment days per calendar year per disability.</p> <p>Occupational therapy does not include vocational therapy, vocational rehabilitation, educational, or recreational therapy. Occupational therapy performed by an occupational therapist will be covered to the extent that such therapy is performed to regain use of the upper extremities.</p> <p>Speech therapy is only covered for residual speech impairment resulting from a stroke, accidental injury or surgery to the head or neck.</p>
Prosthetic Devices		Covered. Prosthetic device must be ordered, supplied and repaired by a network provider.
Durable Medical Equipment (DME)		Covered. Durable medical equipment must be ordered and supplied by a network provider. DME with a retail purchase or a cumulative rental cost of more than \$500 requires prior authorization.
Nursing Facility		Covered at a network facility. Maximum 100 days per calendar year.
Home Health Services		Covered at a network provider.
Hospice		Covered at a network provider.
Organ Transplants		Covered at a network provider.
Chiropractic		Covered at a network provider. Coverage is limited to therapeutic application of chiropractic manipulative treatment rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition. Coverage is not available for health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing.

Covered Services	Notes	UnitedHealthcare Community Plan
Mental Health and Substance Abuse Services (inpatient, outpatient and office)		Covered at a network provider. Inpatient services requires pre-certification.
Prescription Drugs		Covered at a network pharmacy when ordered by a network provider and listed on the preferred drug list. Prescription drugs are covered from out of network providers when prior authorized or in the case of an emergency. Drugs covered are listed on the preferred drug list; some limitations apply.
Hearing Evaluation, Test and Hearing Aids		Covered at a network provider.
Dental Services	Outpatient hospital or ambulatory surgical center charges and anesthesia if criteria are met. Covered for accidental injury.	Medically-necessary dental services are covered at a network provider, including anesthesia and hospital or ambulatory surgical center charges. Routine dental services are not covered by UnitedHealthcare.

Covered Services	Notes	UnitedHealthcare Community Plan
<p>Exception for Certain Clinical Trials for Treatment Studies on Cancer, approved by National Cancer Institute or National Institutes of Health</p>	<p>Must meet criteria</p>	<p>Covered at a network provider. Coverage is limited to patient costs that are medically-necessary and incurred during participation in a phase III clinical trial for treatment studies on cancer, including ovarian cancer trials, but only when ALL of the following conditions are met:</p> <ol style="list-style-type: none"> 1. There is no clearly superior, non-investigational treatment alternative; and 2. The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative; and 3. The member and member’s participating physician conclude that the member’s participation in the clinical trial would be appropriate; and 4. A prior authorization is obtained in advance from UnitedHealthcare; and 5. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise; and 6. The treatment is provided by a clinical trial approved by one of the following: (a) the NCI or (b) an NCI “cooperative group” or an NCI center or the federal Department of Veterans Affairs. “Cooperative group” means a formal network of facilities that collaborate on research projects and have an established NCI-approved peer review program operating within the group. “Cooperative group” includes the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program.

Covered Services	Notes	UnitedHealthcare Community Plan
		<p>Patient cost does not include: (a) the cost of non-healthcare services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial; (b) costs associated with managing the research associated with the clinical trial; (c) the cost of the investigational procedure, drug, pharmaceutical, device, or clinical trial therapies, regimens, or combinations thereof; (d) costs associated with the provision of any goods, services, or benefits that are generally furnished without charge in connection with an approved clinical trial program for treatment of cancer; (e) additional costs associated with the provision of any goods, services, or benefits that previously have been provided to, paid for, or reimbursed, or any similar costs; or (f) treatments or services prescribed for the convenience of the member or their attending physician.</p>
Diabetes Self-Management and education		<p>Covered at a network provider. Covered benefits are provided for equipment and supplies (blood glucose monitors and supplies including those for the legally blind), regular foot care examinations, and outpatient self-management training and education, including nutritional education, for treatment of insulin-dependent, insulin-using, gestational, and non-insulin using diabetes. Outpatient self-management training and education must be provided in person by a certified, registered, or licensed healthcare professional which is part of a UnitedHealthcare approved diabetes education program.</p>
Abortion	If meets federal requirements	<p>Covered at a network provider. Abortion services are limited to coverage based on federal and state laws and regulations. No services associated with an abortion will be covered unless criteria are met. The appropriate Certification of Medical Necessity for Abortion form must be complete and submitted, along with supporting document and the claim.</p>
Contraceptives		See Prescription Drug section above.

Covered Services	Notes	UnitedHealthcare Community Plan
Dialysis		Covered at a network provider.
Inhalation therapy		Covered at a network provider.
Reconstructive Surgery	To restore function lost or impaired as the result of an illness, injury or a birth defect (even if there is an incidental improvement in physical appearance)	Covered at a network provider. Limited to reconstructive surgical procedures which are medically necessary to repair a functional disorder as a result of disease, injury or congenital anomaly. Benefits are also provided for: all stages of reconstructive breast surgery as a result of a mastectomy; reconstructive surgery on the other breast necessary to re-establish symmetry between the two breasts; prostheses; and treatment of physical complications, including medically necessary treatment of lymphedemas, at all stages of the mastectomy.
Sleep apnea treatment		Covered at a network provider when medical criteria are met.
Temporomandibular Joint Disorder (TMJ)	Services that are medically necessary, osteotomy not covered.	Covered at a network provider. Treatment of temporomandibular or craniomandibular joint syndrome or disorders (hereafter "TMJ syndrome") is limited to services which are medically necessary in connection with fractures, neoplasms, rheumatoid arthritis, ankylosing spondylitis, disseminated lupus erythematosus, and acute dislocation of the mandible (but not dislocation of the cartilage without dislocation of the mandible) from direct and extrinsic trauma.
Blood and Blood Administration		Covered at a network provider.
Not Covered Services		Services received by an out of network provider are not covered, unless prior authorization was approved or in an emergency services.
EPDST services		Not covered.
PMIC or residential care		Not covered.
Acupuncture		Not covered.
Cosmetic Procedures		Not covered.

Covered Services	Notes	UnitedHealthcare Community Plan
Counseling and Education Services		Not covered.
Custodial Care		Not covered.
Orthotics	Not covered arch supports, or in-shoe supports, orthopedic shoes, elastic support, or examinations to prescribe or fit such devices	Not covered.

Behavioral Health Benefits

Mental Health Services

- Outpatient therapy provided by a licensed qualified provider including family therapy and in-home family therapy as medically necessary to address the needs of the child or other members in the family;
- Medication management provided by a professional licensed to prescribe medication;
- In-patient hospital psychiatric services including, except as limited, services in the state mental health institutes;
- Services that meet the concurrent substance use disorder and mental health needs of individuals with co-occurring condition;
- Community-based and facility based sub-acute services;
- Crisis services including, but not limited to:
 - 24-hour crisis response;
 - Mobile crisis services;
 - Crisis assessment and evaluation;
 - Non-hospital facility based crisis services;
 - 23-hour observation in a 24-hour treatment facility;
- Care consultation by a psychiatric physician to a non-psychiatric physician;
- Integrated health home mental health services and supports;
- Intensive psychiatric rehabilitation services;
- Peer support services for persons with serious mental illness;
- Community support services including, but not limited to:
 - Monitoring of mental health symptoms and functioning/ reality orientation,
 - Transporting to and from behavioral health services and placements,
 - Establishing and building supportive relationship,
 - Communicating with other care providers,
 - Ensuring member attends appointments and obtains medications, crisis intervention and developing a crisis plan, and
 - Developing and coordinating natural support systems for mental health support;
- Habilitation program services;
- Children's mental health waiver services;
- Stabilization services;
- In-home behavioral management services;
- Behavioral interventions with child and with family including behavioral health intervention services (BHIS) and both
- Medicaid and non-Medicaid funded applied behavior analysis

(ABA) services for children with autism, including MHDS Autism Support program;

- Psychiatric Medical Institutions for Children (PMIC);
- Community-based neurobehavioral rehabilitation services
- Assertive Community Treatment (ACT)

Substance Use Disorder Services

- i. Outpatient treatment;
- ii. Ambulatory detoxification;
- iii. Intensive outpatient;
- iv. Partial hospitalization (day treatment);
- v. Clinically managed low intensity residential treatment;
- vi. Clinically managed residential detoxification;
- vii. Clinically managed medium intensity residential treatment;
- viii. Clinically managed high intensity residential treatment;
- ix. Medically monitored intensive inpatient treatment;
- x. Medically monitored inpatient detoxification;
- xi. Medically managed intensive inpatient services;
- xii. Detoxification services including such services by a care provider licensed under chapter 135B;
- xiii. Peer support and peer counseling;
- xiv. PMIC substance use disorder services consisting of treatment provided by a substance use disorder licensed PMIC and consistent with the nature of care provided by a PMIC as described in Iowa Code chapter 135H;
- xv. Emergency services for substance use disorder conditions;
- xvi. Ambulance services for substance use disorder conditions;
- xvii. Intake, assessment and diagnosis services, including appropriate physical examinations, urine screening and all necessary medical testing to determine a substance use disorder diagnosis, identification of medical or health problems, and screening for contagious diseases;
- xviii. Evaluation, treatment planning and service coordination;
- xix. Substance use disorder counseling services when provided by approved opioid treatment programs that are licensed under Iowa Code Chapter 125;
- xx. Substance use disorder treatment services determined necessary subsequent to an EPSDT screening;
- xxi. Substance use disorder screening, evaluation and treatment for members convicted of Operating a Motor Vehicle While Intoxicated (OWI), Iowa Code Section 321J.2 and members whose driving licenses or non-resident operating privileges are revoked under Chapter 321J, provided that such treatment service meets the criteria for service necessity;

- xxii. Court-ordered evaluation for substance use disorder;
- xxiii. Court-ordered testing for alcohol and drugs;
- xxiv. Court-ordered treatment which meets criteria for treatment services; and
- xxv. Second opinion as medically necessary and appropriate for the member's condition and identified needs from a qualified healthcare professional within the network or arranged for outside the network at no cost to the member.

15.1 Verifying Eligibility and Prior Authorizations

It is your responsibility to verify member eligibility and to secure any necessary authorizations prior to delivering a service to ensure payment.

Link is our single point of online entry to see whether a patient of yours is a current member of our health plan and to see if a service requires a prior authorization. A pop-up will prompt you to make the request for any service that requires prior authorization. Visit UnitedHealthcareOnline.com and sign in using your Optum ID. Select the eligibilityLink app.

Please know that payment may be denied for services you provided which we determined to be medically unnecessary. You may not bill our members for such services unless the member has, with knowledge of our determination of a lack of medical necessity, understands and agrees in writing to be responsible for payment of those charges prior to the delivery of those services. You may also verify member eligibility and request a prior authorization over the phone by calling 888-650-3462.

Prior authorization requests for medical necessity review may also be faxed to 888-899-1680.

Prior authorizations may be completed online, by phone or fax.

Online: UnitedHealthcareOnline.com > Sign in with your Optum ID > Notifications/Prior Authorizations.

Acute/Medical Prior Authorization

Fax forms are located at UHCCommunityPlan.com > For Healthcare Professionals > Iowa > Provider Forms > [Prior Authorization Request Form - Acute Medical](#). Use this form for services or drugs requiring authorization through the member's medical benefit. Fax the form to 888-899-1680 or call 888-650-3462.

Drug Specific - Pharmacy Benefit Authorization

Drug specific-fax forms are located at UHCCommunityPlan.com > For Healthcare Professionals > Iowa > [Pharmacy Program](#). These forms are for drugs authorized through the UnitedHealthcare Pharmacy Program. Fax the form to

866-940-7328 or call 800-310-6826.

Radiology and Cardiology Authorization

Radiology and Cardiology have a unique prior authorization process. Follow the instructions at UnitedHealthcareOnline.com > Link > UnitedHealthcare Community Plan > For Healthcare Professionals > Iowa > Radiology or Cardiology. Information is also available at UHCCommunityPlan.com > For Health Care Professionals > Iowa > Radiology or Cardiology.

Long term services and support services for Home and Community-Based Waiver program authorizations are secured by the case manager-based on assessment of need and within the member care plan.

A complete list of services that require authorizations is posted to UHCCommunityPlan.com > For Healthcare Professionals > Iowa > Billing and Reference Guides.

Please note that UnitedHealthcare Community Plan does not reward for denials or provide financial incentives that encourage underutilization. The criteria are available in writing upon request or by calling 888-650-3462.

The services provided, as well as the type of care provider and setting, must reflect the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the member and not solely for the convenience of the member or care provider of service. In addition, the services must be in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective.

Prior authorization Resources

- MCG are followed for medical necessity criteria located at careguidelines.com
- See our Clinical Practice Guidelines located at UHCCommunityPlan.com > For Healthcare Professionals > Iowa > Clinical Practice Guidelines
- The Iowa Medicaid Provider Procedures Manual at DHS.Iowa.Gov > Policy Manual > [Medicaid Provider](#)
- Covered CPT codes are located at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Community Plan Medical Policies and Coverage Determination Guidelines
- Reimbursement Policy considerations are located at UHCCommunityPlan.com > For Healthcare Professionals > Iowa > Reimbursement Policies

Rehabilitation Therapy Prior Authorization Components

Physical, therapy, occupational therapy and speech therapy requests for prior authorization for services should include the following components:

A copy of the physician's order for physical therapy, occupational therapy and speech/language pathology services must be retained with the medical record.

To verify services provided in the course of a post payment review, documentation in the beneficiary's medical record must support the service billed. Documentation must be legible and complete. Proper documentation does not need to be in any specific format. However, it must include the following:

- Pertinent past and present medical history with approximate date of diagnosis
- Identification of expected goals or outcomes
- Description of therapy and length of time spent on treatment
- Beneficiary's response to therapy
- Progress toward goal(s)
- Date and signature of therapist by each entry

15.2 Transition of Care and Continuity of Care

The Transition of Care policy allows a newly enrolled member a transition period to transfer from an Out-of-Network (OON) care provider to an In-Network (INN) care provider to receive INN benefits under the terms of the member's benefit plan.

During a TOC period, the member is eligible for INN benefits for covered services rendered by an OON care provider for continuation of treatment through the current period of active treatment or for a period of time as outlined below, whichever is less.

- For members enrolling with plan prior to April 1, 2017:
 - Up to 90 calendar days from the member's original eligibility date
 - Up to one year for members receiving care from a residential care provider
- For members enrolling with plan after April 1, 2017:
 - Up to 30 calendar days from the member's original eligibility date
 - At least 30 calendar days for member's receiving care from a residential provider, pending seamless transition to an INN care provider
- At least three months for members with a dual diagnosis of a behavioral health condition and developmental disorder for

outpatient behavioral health services

- Through the postpartum period for members who are in the 2nd or 3rd trimester at the time of initial enrollment with the plan

The Continuity of Care (CoC) policy allows current members a transition period when the participating treating care provider leaves the UnitedHealthcare Network.

The member may be eligible for INN benefits for covered services rendered by an OON care provider for continuation of treatment through the current period of active treatment or for a period of time as outlined below, whichever is less.

- Up to 90 calendar days from the INN care provider's termination date
- Through the postpartum period for members who are in the second or third trimester at the time of the INN care provider's termination

15.3 Pharmacy Services

Our Preferred Drug List (PDL) is comprised of drugs recommended to the Iowa Department of Human Services by the Iowa Medicaid Pharmaceutical and Therapeutics Committee that have been identified as being therapeutically equivalent within a drug class and that provide cost benefit to the Medicaid program. Any changes to the PDL or the prior authorization process will be communicated to you with a minimum of 30 days advanced notice by a bulletin posting to the UHCCommunityPlan.com > For Healthcare Providers > Iowa > Pharmacy Program.

The Iowa Department of Human Services developed a Recommended Drug List (RDL) as recommended by the Iowa Medicaid Pharmaceutical and Therapeutics Committee. This voluntary list of drugs represents the most cost-effective drugs in those categories.

The formulary of approved drugs is posted with the PDL at UHCCommunityPlan.com > For Healthcare Professionals > Iowa > Pharmacy.

Pharmacists receiving a prescription for a drug which requires prior authorization but for which the authorization has not been obtained, should work with the prescribing physician to see if the prescription can be changed to a preferred alternative medication. If a preferred alternative is not appropriate, the physician should then be instructed to contact the Pharmacy Provider Services at 877-495-2272 with questions concerning the prior authorization process.

Day Supply Dispensing Limitations

Members may receive up to a one-month supply (31 days) of medication per prescription order or prescription refill. A medication may be reordered or refilled when 90 percent of the medication has been utilized. If a claim is submitted before 90 percent of the medication has been used, based on the original day supply submitted on the claim, the claim will reject with a “refill too soon” message. Please call the Provider Services at 888-650-3462 with questions or for help with dosage change authorization.

Emergency Prescriptions

In cases of urgent need, you may dispense a one-time 72-hour emergency supply for medications requiring prior authorization. This allows prior authorization processing. See PA criteria, this excludes Hepatitis C agents and smoking cessation products.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

You will receive a response by telephone or other telecommunication device within 24 hours of a request for prior authorization.

Quantity Limitations

Coverage is up to a 31-day supply at a time, except oral contraceptives at a 90-day supply.

Some drugs are limited to an initial 15-day supply, and quantity limits. See lists at: iowamedicaidpdl.com > preferreddruglists; and iowamedicaidpdl.com > billingquantitylimits. More information regarding drug-specific quantity limits can be UHCCommunityPlan.com.

Chapter 16: Glossary

Action – As defined in 42 C.F.R. § 438.400(b) is the:

- (i) denial or limited authorization of a requested service, including the type or level of service;
- (ii) reduction, suspension or termination of a previously authorized service;
- (iii) denial, in whole or in part, of payment for a service;
- (iv) failure to provide services in a timely manner;
- (v) failure of UnitedHealthcare Community Plan to act within the required time frames or
- (vi) for a resident of a rural area with only one Medicaid managed care contractor, the denial of a member's request to exercise their rights to obtain services outside the network (if applicable).

Acute Inpatient Care – Care provided to persons sufficiently ill or disabled requiring:

1. Constant availability of medical supervision by attending care provider or other medical staff
2. Constant availability of licensed nursing personnel
3. Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to ensure proper medical management by the care provider

Ambulatory Care – Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term “ambulatory care” usually implies that the patient has come to a location other than their home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility – A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.

Ancillary Services – Health services ordered by a care provider, including, but not limited to, laboratory services, radiology services, and physical therapy.

Appeal – An oral or written request by a member or member's personal representative received by UnitedHealthcare Community Plan for review of an action.

Authorization – All authorization reviews and communications will be conducted by UnitedHealthcare Community Plan in compliance with all applicable state and federal laws, the state contract and applicable attachments. UnitedHealthcare Community Plan will establish a process that will allow providers to submit and receive determination through a secure electronic transmission. Used interchangeably with preauthorization or prior authorization.

Average Length of Stay (ALOS) – Measure of hospital utilization calculated by dividing total patient days incurred by the number of admissions/discharges during the period.

Capitation – A prospective payment based on a certain rate per person paid on a monthly basis for a specific range of healthcare service.

Centers for Medicare & Medicaid Services (CMS) – A federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and SCHIP programs.

Children's Health Insurance Plan (CHIP) – A federal/state funded health insurance program authorized by Title XXI of the SSA and administered by the Iowa Department of Health & Environment/Division of Healthcare Finance

Claim – A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04, or successor, submitted electronically or by mail.

Clean Claim - A claim submitted in accordance with 42 C.F.R. 447.45, as amended from time to time, that can be processed without obtaining additional information from the care 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 or abuse, or a claim under review for medical necessity.

Continuity of Care – is concerned with the quality of care over time.

Coordination of Benefits (COB) – Applies when a person is covered under more than one group medical plan. The plans coordinate with each other to avoid duplicate payments for the same medical services.

Complaint – Any written or oral expression of dissatisfaction by a care provider.

Contracted Services – Services to be provided by UnitedHealthcare under the terms of our contract.

Covered Services – Medically necessary services included in the state contract. Covered services change periodically as mandated by federal or state legislation.

Credentialing – The verification of applicable licenses, certifications, and experience to assure that provider status is extended only to professional, competent providers who continually meet the qualifications, standards, and requirements established by UnitedHealthcare Community Plan.

Current Procedural Terminology (CPT®) Codes – American Medical Association (AMA)-approved standard coding for billing of procedural services performed.

Delivery System – The mechanism by which healthcare is delivered to a patient. Examples include, but are not limited to, hospitals, providers' office and home healthcare.

Denied Claims Review – The process for care providers to request a review of a denied claim.

Discharge Planning – Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Durable Medical Equipment (DME) – Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It also is equipment that is appropriate for use in the home and prescribed by a care provider.

Dual Coverage – When a member is enrolled with two UnitedHealthcare plans at the same time.

Dual Eligible – When a member has Medicare as the other insurance that is primary to Medicaid.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT) – A package of services in a preventive (well child) exam covered by Medicaid for individuals under younger than 21 as defined in SSA section 1905 (R). This benefit is not available to hawk-i members. Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for vision, dental, substance abuse, mental health and hearing, as well as any medically necessary services found during the EPSDT exam.

Electronic Data Interchange (EDI) – The electronic exchange of information between two or more organizations.

Emergency Care – The provision of medically necessary services required for immediate attention to evaluate or stabilize a medical emergency (see definition below).

Expedited Appeal – An oral or written request by a member or member's personal representative received by UnitedHealthcare Community Plan requesting an expedited reconsideration of an action when taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Expedited Grievance – An expedited grievance is a non-standard time frame request for review of an Adverse Determination; communicated verbally or in writing by a member, a representative of a member or a care provider; where the application of the standard time frame would seriously jeopardize a member's life, health, or ability to attain, maintain, or regain maximum function.

Federally Qualified Health Center (FQHC) – A facility that is:

1. Receiving grants under section 329, 330, or 340 of the Public Health Services Act; or
2. Receiving such grants based on the recommendation of Iowa Department of Health and Environment, Division of Healthcare Finance (KDHE-D HCF) within the Public Health Service, as determined by the Secretary to meet the requirements for receiving such a grant; or
3. A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638).

Fee-For-Service (FFS) – FFS is a term UnitedHealthcare Community Plan uses to describe a method of reimbursement based upon billing for a specific number of units of services rendered to a member.

Grievance – An oral or written expression of dissatisfaction by a member, or representative on behalf of a member, about any matter other than an action received at UnitedHealthcare Community Plan.

Health Plan Employer Data and Information Set (HEDIS) – Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers' needs as purchasers of healthcare. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

Hearing – An outside hearing conducted by the Office of administrative Hearings available to all UnitedHealthcare Community Plan members. The member presents their appeal to an Administrative Law Judge. Members may ask for a State Fair Hearing instead of a UnitedHealthcare Community Plan appeal or at the same time as the UnitedHealthcare Community Plan appeal. Care providers must complete the UnitedHealthcare Community Plan appeal process before filing a State Fair Hearing.

HIPAA – Health Insurance Portability and Accountability Act. HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs, and mandates the privacy and security of patient information.

Independent Practice Association (IPA) – A legal entity, the members of which are independent providers who contract with the IPA for the purpose of having the IPA contract with one or more health plans.

Independent Review Organization (IRO) – A review process by a state-contracted independent third party.

Integrated Provider Network Database (IPND) – A database developed to provide verified and integrated provider information for all health plans serving Iowa Department of Health and Environment, Division of Healthcare Finance through the Internet and an internal user interface.

Interdisciplinary Care Team (ICT) – Medical/professional staff, friends, neighbors, family members, etc. that participate in the development of an individual's care plan. The ICT assists the individual in identifying and accessing a personalized mix of paid and non-paid services and supports that will help the member achieve personally-defined outcomes in the most inclusive community setting.

Long Term Care (LTC) or Long Term Services and Supports (LTSS) – The services of a nursing facility (NF), an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/ID), State Resource Centers or services funded through 1915(c) home and community based services waivers.

Medicaid – The state and federally funded medical program created under Title XIX of the SSA.

Medical Emergency – A medical condition manifesting itself by acute symptoms of sufficient verity (including severe pain) that a prudent layperson, which possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

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

Medical Records – A confidential document containing written documentation related to the provision of physical, social and mental health services to a member.

1. A health intervention that is otherwise a Covered Service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:
 - a. “Authority.” The health intervention is recommended by the treating physician and is determined to be necessary.
 - b. “Purpose.” The health intervention has the purpose of treating a medical condition.
 - c. “Scope.” The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.
 - d. “Evidence.” The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness will be determined by scientific evidence as provided in paragraph three. For existing interventions, effectiveness will be determined as provided in paragraph four.
 - e. “Value.” The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. “Cost-effective” shall not necessarily be construed to mean the lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this definition of medical necessity. Interventions that do not meet this definition of medical necessity may be covered at the choice of United. An intervention shall be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.
2. The following definitions shall apply to these terms only as they are used in this subsection;
 - a. “Effective” means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
 - b. “Health intervention” means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For this definition of medical necessity, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.
 - c. “Health outcomes ” means treatment results that affect health status as measured by the length or quality of a person’s life.

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the SSA. Medicare has two parts:

- a. Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- b. Part B is the supplementary medical insurance benefit (SM B) covering the Medicare provider’s services, outpatient hospital care, outpatient physical therapy and speech pathology services, home healthcare, and other health services and supplies not covered under Part A of Medicare.

Member – A current or previous member of UnitedHealthcare Community Plan.

NCQA – National Committee for Quality Assurance

Participating Care Provider – A care provider that has a written agreement with UnitedHealthcare Community Plan to provide services to members under the terms of their agreement.

Provider Group – A partnership, association, corporation, or other group of care providers.

Physician Incentive Plan – Any compensation arrangement between a health plan and a provider or care provider group that may directly or indirectly have the effect of reducing or limiting services to members under the terms of the agreement.

Preventive Care – Healthcare emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.

Primary Care Provider (PCP) – A participating provider responsible for supervising, coordinating, and providing primary healthcare to members, initiating referrals for specialist care, and maintaining the continuity of member care. PCPs include, but are not limited to; pediatricians, family providers, general providers, internists, provider assistants (under the supervision of a provider), or advanced registered nurse practitioners (ARNP), as designated by UnitedHealthcare Community Plan.

Quality Improvement Program (QIP) – A formal set of activities provided to assure the quality of clinical and non-clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

Remittance Advice (RA) – Written explanation of processed claims.

Referral – The practice of sending a patient to another care provider for services or consultation which the referring care provider is not prepared or qualified to provide.

Rural Health Clinic (RHC) – A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics are entitled to receive enhanced payments for services provided to enrolled members.

Service Area – A geographic area serviced by UnitedHealthcare Community Plan, designated and approved by Iowa Department of Health

Specialist – Any licensed care provider, who practices in a specialty field such as Cardiology, Dermatology, Oncology, Ophthalmology, Radiology, etc.

Sub-Contract – A written agreement between a health plan and a participating provider, or between a participating provider and another sub-contractor, to perform all or a portion of the duties and obligations a plan is required to perform pursuant to the agreement.

Tertiary Care – Care requiring high-level intensive, diagnostic and treatment capabilities for adults and/or children, typically administered at highly specialized medical centers.

Third Party Liability (TPL) – A company or entity other than UnitedHealthcare Community Plan liable for payment of healthcare services rendered to members. UnitedHealthcare Community Plan will pay claims for covered benefits and pursue a refund from the third party when liability is determined.

Title V – The portion of the federal SSA that authorizes grants to states for the care of Children with Special Healthcare Needs.

Title XIX – The portion of the federal SSA that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Title XXI – The portion of the federal SSA that authorizes grants to states for State Children's Health Insurance Program.

Utilization Management (UM) – The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to ensure appropriate use of resources. UM includes prior Authorization, concurrent review, retrospective review, discharge planning and case management.

Women's Healthcare Services – Women's Healthcare Services is defined to include, but need not be limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. General examinations, preventive care, and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations. Women's healthcare services also include any appropriate healthcare service for other health problems, discovered and treated during the course of a visit to a women's healthcare practitioner for a women's healthcare service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include, contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.