2018 Administrative Guide

Physician, Health Care Professional, Facility and Ancillary

KanCare Program

Chapter 4: Medical Management

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UnitedHealthcare® Community Plan

Welcome

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

Click the following links to access different manuals:

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

Easily find information in this manual using the following steps:

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

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

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

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

Important Information about the use of this manual

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

We amend the manual as policies change.

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4.1 Referral Guidelines

Providers caring for our members are generally responsible for initiating and coordinating referrals of members for medically necessary services beyond the scope of their practice. Providers are expected to monitor the progress of referred members' care and ensure that members are returned to their care as soon as medically appropriate.

4.2 Retro-Eligibility

Providers may request a retroactive prior authorization (PA) for a member if their eligibility was made retroactive by the state of Kansas.

If the member has received services requiring a PA, providers should request a retroactive prior authorization prior to submitting their claim.

Provider MUST indicate on the request for PA "RETROACTIVE ELIGIBILIY" or the retroactive prior authorization will not be accepted.

4.3 Emergency Care Resulting in Admissions

Prior authorization is not required for emergency services. Emergency care should be rendered at once. Please provide notification of any admissions by contacting the Prior Authorization Department at 866-604-3267 or by faxing the Prior Authorization Form (see form below) by 5 p.m. the following business day. Nurses in the Health Services Department review emergency admissions within one working day of notification. UnitedHealthcare Community Plan uses evidence based, nationally accredited, clinical criteria for determinations of appropriateness of care. UnitedHealthcare Community Plan does not reward for denials or provide financial incentives that encourage under-utilization. The criteria is available in writing upon request or by calling 866-604-3267.

Admission 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.

Care in the Emergency Room

UnitedHealthcare Community Plan members who visit an emergency room should be screened to determine whether a medical emergency exists. Prior authorization is not required for the medical screening. UnitedHealthcare Community Plan provides coverage for these services without regard to the emergency care provider's contractual relationship with UnitedHealthcare Community Plan. Emergency services are covered both within and outside UnitedHealthcare Community Plan's service area.

An emergency is defined as a medical or behavioral condition, which manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect in the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child), or in the case of a behavioral condition, perceived as placing the health of the person or others in serious jeopardy
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

4.4 Admission Authorization and Prior Authorization Guidelines

All UnitedHealthcare Community Plan admission authorizations must contain the following information:

- Member name and 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-CM, or its successor, diagnosis code; and
- Admission date.

All UnitedHealthcare Community Plan prior authorizations must contain the following information:

- Member name and ID number;
- Ordering physician or health care professional name and TIN/NPI;
- Rendering physician or health care professional and TIN/NPI;
- ICD-10-CM, or its successor, diagnosis code for which the service is requested;
- Anticipated date(s) of service;
- Type of service (primary and secondary) procedure code(s) and volume of service, when applicable;
- Service setting; and
- Facility name and TIN/NPI, when applicable.

For Behavioral Health and Substance Use Disorders authorizations, please see the current Network Manual and the KanCare Manual Addendum available on providerexpress.com.

Providers who are non-participating with UnitedHealthcare Community Plan are required to follow the same guidelines related to prior authorization as participating providers. Prior authorization is not required for all non-participating provider services, however it is required only for those services on the prior authorization list.

Beginning April 1, 2017, the following cosmetic and reconstructive procedure codes no longer require prior authorization: 15876, 21282, 67916, 21137, 21295, 67917, 21138, 21296, 67921, 21139, 36468, 67922, 21208, 67911, 67923, 21209, 67911, 67923, 21209, 67914, 67924, 21280, 67915. Although, prior authorization requirements are being removed, post-service determinations may still be applicable based on criteria published in medical policies and/or local and national coverage determination criteria.

Providers can obtain prior authorization in three ways:

1) Call the prior authorization number at 866-604-3267.

2) Providers may complete the prior authorization request form online at **UnitedHealthcareOnline.com**. Quick reference guides are available to assist providers. To access the quick reference guides, go to **UnitedHealthcareOnline.com** > Help >Quick Reference Guides.

3) Providers may complete a PA request form and fax in. Form provided below.

The prior authorization fax request form is posted at **UHCCommunityPlan.com**. A copy of the form can also be found in Chapter 20 of the Provider Manual.

If you have questions, please call the prior authorization intake line at 866-604-3267.

Kansas Acute and LTC/LTSS Prior Authorization Fax Request Form

Acute Fax: 866-943-6474
LTC/LTSS Fax: 877-950-6887
Phone: 866-604-3267

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Please complete this form and fax it to the appropriate number listed above. Include all relevant clinical data such as progress notes, treatments rendered, tests, lab results, and radiology reports with this form to support the request for services and avoid a delay in the determination. If you have any questions, please call Medicaid Prior Authorization at **866-604-3267.**

Please go to **UHCCommunityPlan.com** for the list of services that require prior authorization and to see the Provider Administrative Guide for more information regarding prior authorization requirements. Thank you.

Date:	Contact person:	Phone:
Requesting provider:		TIN/NPI:
Fax number:	Is this a HIPAA secure fax line? ☐ Yes ☐ No	

Member Information

Member name:		Member ID:
Date of birth:	Member phone number:	Is member pregnant? ☐ Yes ☐ No
Is request related to a motor vehicle accident/injury or work-related injury? ☐ Yes ☐ No		
Does the member have other insurance? ☐ Yes ☐ No	**If yes,** Medicare ☐ Part A ☐ Part B	
Other insurance name and policy number:	Is request due to member's retrospective eligibility? ☐ Yes ☐ No	

Type of Request

Choose One: ☐ Inpatient ☐ Outpatient ☐ Home Care

Choose One: ☐ Routine ☐ Expedited/Urgent*

** Expedited/Urgent requests must include a physician order that indicates that waiting for a decision within the standard timeframe could endanger the member's life, health, ability to regain maximum functionality or cause serious pain.*

Servicing Provider and Facility Information

Servicing provider:	TIN/NPI:
Address:	Fax:
Date of service:	☐ In-network ☐ Out-of-network
Servicing facility:	TIN/NPI:
Address:	☐ In-network ☐ Out-of-network
For out-of-network providers only: Do you accept Medicaid/Medicare default rate? ☐ Yes ☐ No	

Kansas Acute and LTC/LTSS Prior Authorization Fax Request Form

Acute Fax: 866-943-6474
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Clinical Information		
Diagnoses:	ICD-10 codes:	
Required CPT/HCPCS Code(s):		
Description required for miscellaneous and/or unlisted codes:		
Number of visits:	Start date:	End date:
Frequency:	DME Cost: $	
Number of previous visits, service description and CPT/HCPCS codes:		

Services Requiring Prior Authorization

For information on services requiring prior authorization, please go to **UHCCommunityPlan.com** > Health Care Professionals > Kansas > Provider Information > Prior Authorization.Community Plan's service area.

4.5 Determination of Medical Necessity

UnitedHealthcare Community Plan evaluates medical necessity according to the following standard.

Medically necessary services or supplies are those necessary to:

- Prevent, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition;
- Maintain health;
- Prevent the onset of an illness, condition or disability;
- Prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity;
- Prevent the deterioration of a condition;
- Promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capabilities that are appropriate for individuals of the same age;
- Prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member.

The services provided, as well as the type of 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 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.

Experimental services or services generally regarded by the medical profession as unacceptable treatment are considered not medically necessary. These specific cases are determined on a case-by-case basis.

The determination of medical necessity must be based on peer-reviewed publications, expert pediatric, psychiatric and medical opinion, and medical/pediatric community acceptance. Services must be provided to correct or improve the child's physical or mental condition. This is identified as a result of a comprehensive screening visit, as long as those services are appropriate for the age and health status of the child.

4.6 Utilization Management

Utilization Management decision making is based only on appropriateness of care and service and existence of coverage. The organization does not reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization. A provider may call UnitedHealthcare Community Plan Utilization Management at 866-604-3267 to answer any questions about Utilization Management or denials. Someone is available to take your calls 24 hours a day, seven days a week.

UnitedHealthcare Community Plan may delegate Medical Management to a medical group/Independent Practice Association (IPA) that demonstrates compliance with UnitedHealthcare Community Plan and has established standards for the medical management function. For more information on delegated medical management see Appendix I.

4.7 Care Coordination/Management

Our Care Management program is guided by the principles of the UnitedHealthcare Personal Care Model. We developed the Personal Care Model to address the needs of medically underserved and low-income populations. The Personal Care Model places emphasis on the individual as a whole, to include the environment, background and culture. If you need to directly refer a member who is not currently in the Care Management program, you may call 877-542-8997.

Our model of Care Coordination/Care Management provides a platform for systematic, comprehensive care that closes the gap in the treatment of acute, chronic, co-morbid and other conditions that impact health and self-care. This model is founded upon best practices and principles for the care of children with special needs, the disabled, elderly, chronically ill, and frail individuals. We apply an individualized, holistic approach to help members navigate complex delivery systems, stabilize or delay progression of their illnesses or conditions, and promote independence and quality of life. We utilize advanced technology to improve communications and streamline day-to-day operations.

Specialty Programs for Care Management include but are not limited to: High Risk Care Management, Care Coordination for members receiving LTSS benefits, Disease Management, Maternity Care Management (Healthy First Steps), Neonatal Intensive Care Unit (NICU) Care Management,Transplant Programs, Obesity Management/Bariatric Surgery Programs.

Our Care Coordination model:

- Incorporates health risk screening, medical/social assessment, care planning, and ongoing care plan monitoring to identify and address member needs.
- Assigns highest risk members, members experiencing transitions, and members receiving LTSS to a dedicated Care Coordinator who assists the member and their families to plan and coordinate care, provide education for enhanced self management, and refer to appropriate community resources for additional support
- Provides members with timely, medically necessary health care services in the least restrictive and most appropriate setting
- Focuses on preventive, primary, and secondary care that slows illness progression and disability
- Involves members, caregivers, physicians, and other providers in the care planning process
- Works in collaboration with providers, caregivers, community resources, and others who are involved in the care of the member.

If you need to directly refer a member who is not currently in the Care Management program, you may call 877-542-8997.

Identification and Stratification

All members who are enrolled in LTSS Waiver Programs - Frail Elderly (FE), Physical Disability (PD), Traumatic Brain Injury (TBI), Intellectual and Developmental Disability (I/DD), Technology Assisted (TA), Serious Emotional Disturbance (SED), and Autism — are immediately assigned to a Care Coordinator for comprehensive assessment and coordination of physical/behavioral health needs and LTSS.

The Health Risk Assessment and our predictive modeling and stratification system are the primary tools for identifying High Risk (Non LTSS/Waiver) members and those with other specialty needs for Care Management programs and/or assignment to a dedicated Care Coordinator.

Health Risk Assessment

The Health Risk Assessment is an initial assessment tool used for new and existing members, to identify a member's health risks. Based upon the member's response to a series of question, the health plan staff can identify if the member may benefit from care coordination and refer them appropriately.

Outreach and other Identification Processes

While Long Term Care/Waiver Program enrollment, Health Risk Assessments and retrospective data are the first line of identification of new members in the UnitedHealthcare Care Management Program, we have developed an extensive outreach program that supports real-time identification and referral for our Care Management services.

Through community partnerships and relationships, our staff encourages and educates providers, ER staff, and hospital discharge planners, and other community-based providers to refer program members for a greater intensity and frequency of Care Management interventions when the situation requires it. Our Care Management staff is responsible for collaborating with other community partners such as program care managers, clinic staff, other health care team community partners, and fiduciary entities in order to identify members.

Finally, in addition to claims and pharmacy data, we integrate authorization and pre-certification information into the Care Management software system. This data provides real-time identification of members experiencing health care barriers and self-care deficits.

Care Management Interventions

After a member has been identified, the Care Coordinator contacts the member, member's parent or caregiver by telephone to engage them in the Care Management Program. Program and health education materials targeted to the member's specific care opportunities and Care Management interventions are shared with the member.

Members have the right to opt out of Care Management programs if they do not wish to participate, however to be eligible to receive LTSS, the member must consent to in-home assessment and ongoing reassessment by the Care Coordinator.

Because our High Risk Care Management and Specialty Programs provide benefits and quality-of-life improvements that ultimately impact the overall costs in care, our enrollment staff makes every attempt to enroll members in the available programs. We employ a number of strategies to locate and contact the member's parents or caregivers, including after-hour calls; searching for updated member information by contacting the PCP/specialist office and reviewing prior authorization information; and sending written correspondence. We document and track contacts to ensure that all options have been exhausted prior to reporting failure to contact.

As part of full engagement in the Care Management Programs, the Care Coordinator performs a comprehensive health risk and needs assessment that identifies additional risk factors, current and past medical history, personal behaviors, family history, social history, functional capabilities, and environmental risk factors. This information is used to augment and validate the risk stratification of members. We also institute disease specific assessments to augment the Health Risk Assessment.

We deploy evidence-based interventions for our Care Management Programs. The following general interventions have been structured to improve members' health status:

- Health Risk Assessment;
- Health and Care Plan reviews via in home assessment or phone calls;
- Provide assigned Care Coordinator's contact information to the member/family;
- Ongoing monitoring of claims and other tools to re-assess risk and needs;
- Access to program websites for members;
- Post-hospitalization and emergency room assessment;
- Educational materials sent to the member for preventive care & other condition specific self-care reference;
- Communication with the PCP identifying the member's involvement, intervention and point of contact for Care Management Programs; and
- Additional and/or specific interventions conducted to individualize the plan of care.

Person Centered Integrated Service Plan (PCISP)

The Care Coordinator develops and implements an individualized plan of care for Long Term Services and Supports (LTSS) members requiring services, reviews the member's progress and adjusts the plan of care, as necessary, to help ensure the member continues to receive the appropriate care in the least restrictive setting. The Care Coordinator uses a person-centered planning approach which involves the member, member's family, provider(s), and anyone else the member wishes to be involved, caring for our member in the plan of care development process. Care Coordinators assist providers, when necessary, to direct evidence-based clinical treatment that supports our Care Management Program. The plan of care addresses the following areas for the member's needs:

- LTSS (for members enrolled in waiver programs) based on functional ability and available community supports
- Behavioral health
- Nutrition
- Medication
- Preventive Care
- Symptom self-monitoring, vital signs and early identification of potential complications
- Emergency management/co-morbid condition action plan
- Caregiver backup and/or disaster plans
- Routine follow-up with PCP or specialty providers
- Other authorized services or treatments

When the plan of care is implemented, our goals are to:

- Help ensure the member is leveraging personal, family, and community strengths when able and available
- Help ensure we are using evidence-based guidelines and best practices for education and self-management information while adding co-morbidity interventions
- Modify our approach or services based on the feedback from the member, family, and other health care team members
- Document modified services and outcomes
- Communicate effectively with the primary care provider/specialist and other providers involved in the member's care
- Support member adherence to treatment plans and self-care best practices
- Monitor member satisfaction with services, adjusting as needed

Our Care Management Program is supported by UnitedHealthcare Community Plan's integrated clinical system, which includes basic and comprehensive supplemental assessments, facilitates the development of integrated care plans, and includes ongoing monitoring and evaluation tools.

Pharmacy

UnitedHealthcare Community Plan's pharmacy management is integrated into our Care Management Program and, like the Care Management Program, is based on our Personal Care Model which emphasizes the whole individual, including environment, background and culture.

UnitedHealthcare Community Plan integrates pharmacy management for asthma into our regular Care Management Program.

With the exceptions of the asthma component, pharmacy management services, UnitedHealthcare Community Plan provides pharmacy management through OptumRx, our pharmacy benefit manager, and a United Health Group company. OptumRx administers Disease Therapy Management (DTM) programs that are clinical, patient-focused programs offered as part of Specialty Pharmacy Care Management services. The objective of our DTM programs is to improve patient quality of care through education and communication.

OptumRx Specialty Pharmacy offers DTM programs for the following disease states/conditions required by the Board for the Kansas Medicaid plan programs:

- Rheumatoid arthritis
- Growth disorders
- Hemophilia
- Risk of respiratory syncytial virus due to prematurity

Additional programs to be provided to Kansas Medicaid plan program members include:

- Hepatitis C
- Multiple sclerosis
- Anemia related to chemotherapy

4.8 Coordination of Care With Providers

Each member is encouraged to select a medical home for community-based health and preventive services. Providers caring for our members receive reports regarding the health status of members participating in our Care Management Program. As this link is established, we involve the provider in the plan of care development process and assist them in directing the course of treatment in accordance with evidence-based clinical guidelines.

The Care Manager collaborates with the member's provider on an ongoing basis to ensure integration of physical and behavioral health issues. In addition, the care manager will ensure the plan of care supports the member's/caregiver's preferences for psychosocial, educational, therapeutic and other non-medical services. The Care Manager ensures the plan of care supports providers' clinical treatment goals and builds the plan of care to reflect personal, family and community strengths.

The Care Manager and member will review the member's compliance with the treatment during each assessment cycle. Treatment, including medication compliance, is established as a health care goal with interventions and progress towards that goal documented in each assessment session. At any point that the care manager recognizes that the member is non-compliant with part or all of the treatment plan, the care manager will:

- Work to identify and understand the member's barriers to success;
- Problem solve for alternative solutions with the member;
- Report non-compliance to the treating provider/specialist, offer potential solutions and integrate provider feedback;
- Facilitate agreement for change between all parties and monitor progress of the change.

As the member's medical home, the provider caring for our member is continuously updated on the member's participation in the Care Management Program, the member's compliance with the plan of care and any unscheduled hospital admissions and emergency room visits. The provider receives notifications of when members are enrolled and disenrolled from the Care Management Program the assigned Care Manager for the Care Management Program, and how to contact the Care Manager. In addition, the provider receives notification of members who have generated care opportunities related to the Care Management Program. These evidence-based medical guidelines are generated from our multi-dimensional, episode-based predictive modeling tool.

We also distribute clinical practice guidelines upon the provider's request and provide training for providers and their staff on how best to integrate practice guidelines into everyday physician practice. When a provider demonstrates a pattern of non-compliance with clinical practice guidelines, the Medical Director may contact the provider by phone or in person to review the guideline and identify any barriers that can be resolved.

Local Health Departments

Local Health Departments are required to coordinate care with United Healthcare Community Plan and complete standard reporting to the State Health Department anytime a member is diagnosed with a sexually transmitted disease or tuberculosis.

4.9 Care Management Programs: Whole Person Care (WPC) Model and Disease Management

4.9.1 Whole Person Care (WPC) Model

The WPC Model seeks to empower members, providers and community partners to improve care coordination and outcomes for individuals enrolled in Medicaid programs and identified as having chronic or complex conditions.
Program goals include:

- Reduced avoidable admissions and ER visits
- Improved access to Primary Care Provider (PCP)
- Increased identification and intervention for behavioral health needs
- Identification and referrals around social and environmental barriers to care
- Increased closure of HEDIS gaps in care
- Member empowerment managing complex or chronic condition with individual goal setting and attainment

These goals are accomplished by incorporating best practices for population and individual based care, emphasizing the whole individual, including environment, background and culture. Program components are culturally relevant and provide health education, member engagement, preventive interventions, improving the patient/provider relationship and care transition management.

WPC Model focuses outreach on the most at-risk and vulnerable members exhibiting high or costly system use. While the number varies over time, WPC Model eligible members generally represent 1.0-2.0% of a health plan's Medicaid membership.

Members are identified for the WPC Model program participation in a number of ways:

1. Persistent Super Utilizer algorithm. A Persistent Super Utilizer (PSU) is a member identified through numerous claims analyses and predictive modeling at the highest risk for future health care cost and use, and most likely to benefit from WPC Model interventions. Certain events, such as inpatient admission or ER visits, will trigger outreach to this member.

    a. Critical Risk Persistent Super Utilizers. This subset of PSU members indicates a history of 12 or more inpatient admissions or ER visits within the last 12 months. Outreach begins immediately upon identification.

2. High Risk Admission Inpatient Notification through transitions in care
3. Healthy First Steps (HFS) high risk maternity case management program (usually through 834/OBRAF)
4. Referrals from providers, state or government agencies, the health plan or member self-referral

If you have a UnitedHealthcare Community Plan KanCare patient who may benefit from the WPC Model, please contact Member Services at 877-542-9238.

Once identified, UnitedHealthcare Community Plan assigns the member to a Community Health Worker (CHW), Case Manager (RN), and Behavioral Health Advocate (BHA). While all team members may participate in the member's case, there is one team lead, depending on the member's unique circumstances and clinical needs.

Community Health Workers are a critical component in this program. They are the "feet on the street" and have first-hand knowledge of the local community and culture, which allows them to build trust, increase engagement, and facilitate access to community resources.

A key intervention for the CHW is to remove barriers to care access. CHWs help members become established patients with a PCP. You and your office or facility may meet CHWs as they facilitate appointment scheduling and transportation for members enrolled in WPC Model.

Clinical interventions are managed by the RN case manager, and/or the Behavioral Health Advocate. Case managers perform assessments, develop care plans, and coach and monitor a member's progression according to stated goals.

Interventions may include:

- Disease specific education and interventions
- Medication and treatment adherence
- Symptom monitoring and self-care
- Nutrition and weight management
- Lifestyle changes such as physical activity or smoking cessation
- Education and assistance with advance directives and caregiver support
- Referrals to internal and community programs

Clinical case managers communicate with providers regarding changes in a member's condition and/or need for assistance (e.g., durable medical equipment needs, care issues).

4.9.2 Disease Management Mailings

Disease Management mailings are an additional component of our care coordination program. The Disease Management mailings focus on conditions prevalent in our KanCare population, such as members' self-care efforts that positively affect health outcomes. Our programs help people better manage conditions like heart failure, chronic obstructive pulmonary disease (COPD), asthma, coronary artery disease and diabetes.

The primary objectives of Disease Management mailings are to support members in establishing and maintaining a stabilized, improved state of health. This is achieved by providing education on reducing risk factors, encouraging appropriate self-care, and reinforcing the importance of the physician–member relationship. reducing risk factors, encouraging appropriate self-care, and reinforcing the importance of the physician–member relationship.

Members identified for Disease Management mailing receive:

- A welcome letter and condition-specific booklet. Booklets include tips on working with a doctor, medicines for treating the condition, lifestyle changes and a health log or action plan. Materials are written at a 4th grade reading level and are available in English and Spanish.
- An annual newsletter. This newsletter contains articles addressing condition management, as well as healthy living topics, such as tips on general wellness, smoking cessation and managing stress. The newsletter is written at a 4th grade reading level and is mailed in English; a Spanish version is mailed where required.
- If a member is also actively engaged with a nurse care manager, the care manager may also mail information that supports both adult and pediatric members, as well as advance-directive planning.

4.10 Clinical Practice Guidelines

UnitedHealthcare Community Plan adopts clinical practice guidelines as the clinical basis for our Care Management program. Clinical guidelines are systematically developed, evidence-based statements that help providers make decisions about appropriate health care for specific clinical circumstances. We adopt clinical guidelines that are evidence-based and published by a variety of clinical experts and organizations, including specialty medical societies, as well as respected peer-reviewed medical journals.

UnitedHealthcare Community Plan uses nationally recognized, evidence-based clinical criteria to guide our medical necessity decisions, including MCG Care, Behavioral Health Level of Care Guidelines, and CMS policy guidelines. MCG Care Guidelines is widely regarded for its scientific approach, using comprehensive medical research to develop recommendations on optimal length of stay goals, best-practice care templates, and key milestones for the best possible treatment and recovery. Our Behavioral Health Level of Care Guidelines provide objective and evidence-based admission and continuing stay criteria for mental health and substance abuse services. These guidelines are integrated into our clinical system.

For specific state benefits or services not covered under national guidelines, we develop criteria through the review of current medical literature and peer reviewed publications, Medical Technology Assessment Reviews and consultation with specialists.

The clinical practice guidelines are reviewed and revised annually. The UnitedHealthcare Executive Medical Policy Committee (EMPC) reviews and approves nationally recognized clinical practice guidelines. The guidelines are then distributed to the National Quality Management Oversight Committee (NQMOC) and the Health Plan Quality Management Committee.

Medical guidelines are available and shared with providers upon request and are available on the provider website, **UHCCommunityPlan.com**. Policies and guideline updates are communicated through provider notices prior to implementation.

4.11 Lock-In Program

The Lock-In Program is designed to improve medical management for members who may not be utilizing medical services appropriately. This is done through educational interventions, service coordination and reinforcement of the physician-member relationship. Members participating in the Lock-In Program are limited to one pharmacy, one hospital and one primary care physician for all non-emergent medical care.

A member can be selected for Lock-in Program review when any one or more of the following occur:

1. A utilization review report indicates the member has not utilized healthcare services appropriately; including, but not limited to: over-utilization, persistent non-compliance, or abusive/threatening conduct;

2. Medical providers, social service agencies, or other concerned parties have provided direct referrals to the State or to UnitedHealthcare Community Plan.

3. Member identified as committing fraud (reported and/or data analytics) or abuse of medical benefits.

When a member is selected for Lock-In Program review, MCO staff (with clinical oversight) evaluates the member's medical and/or billing history to determine if the member has utilized health care services and/or medications at a frequency or amount that is not medically necessary/abusive/excessive.

As a result of the Lock-In Program review, UnitedHealthcare Community Plan may take any of the following steps:

1. Determine that no action is needed and close the member's file;

2. Send the member and, if applicable, the member's authorized representative, a letter of concern with information on specific findings and notice of potential placement in the Lock-In Program;

3. Refer the member for education on appropriate use of health care services;

4. Refer the member to substance abuse or behavioral health treatment, or to other support services or agencies; or

5. Enroll the member in the Lock-in Program if education and referrals are not successful in changing the member's service utilization.

The initial Lock-In period is 24 months. Prior to enrollment, United Healthcare Community Plan will assist the member in selecting Lock-In providers:

a. Primary care physician (PCP)

b. Pharmacy

c. Hospital

2. The MCO will send the member and, if applicable, the member's authorized representative, a written notice containing at least the following components:

   a. Action MCO intends to take related to Lock-In.

   b. Reason for this action

   c. Instructions related to choosing a primary care physician, pharmacy and hospital.

   d. Effective date of the Lock-In

   e. The duration of the enrollment and re-evaluation period

   f. Member's right to file an appeal

   g. Any other requirements under federal, state laws and regulations

3. The member will remain assigned to the same providers throughout the Lock-In enrollment period unless:

   a. The member moves to a residence outside the provider's service area; or

   b. The provider moves outside the member's local geographic area and is no longer reasonably accessible to the member.

   c. The provider refuses to continue to serve the member.

   d. The provider was assigned to the member by the health plan, because the member failed to select a provider. In this case, the member may request a change once within 30 calendar days of the initial assignment.

   e. The member's current provider no longer participates with the health plan.

4. A member placed in the Lock-in Program remains enrolled in the Lock-In Program for the initial 24-month period regardless of whether the member changes MCOs or becomes a Fee-for-Service member.

5. Prior to the end of the 24 month Lock-In period, the member will be re-reviewed by the United Healthcare Community Plan Lock-In Committee. If service utilization and medical compliance has improved, the member will be removed from the program and notified in writing. If a member continues to meet Lock-In Program criteria, the member will remain enrolled in the Lock-In program for an additional 24 month period and will be notified in writing regarding continued Lock-In enrollment.

Provider Participation

The Kansas Medical Assistance Program (KMAP) website provides Medicaid eligibility and Lock-In information to all providers participating in United Healthcare Community Plan. Providers should verify eligibility and Lock-In status prior to rendering services. Non-emergency services provided to a Lock-In member without a PCP referral will result in a denied claim.

When a Primary Care Physician (PCP) is selected for a Lock-In Program member, the PCP's office is contacted to confirm that the PCP is willing to accept a Lock-In patient. The provider's practice location and billing NPI number is verified. Providers may opt out of participation in the Lock-In Program by notifying the health plan.

Providers who participate in the Lock-In Program are expected to meet the following requirements:

1. Providers must be located in the member's local geographic area, and/or be reasonably accessible to the member.
2. The Lock-In PCP supervises and coordinates all Lock-In member's health care services, including continuity of care and referrals to specialists when necessary.
    a. The Lock-In PCP is expected to perform a thorough history and physical examination of the member prior to making referrals to other physicians or providers.
    b. The Lock-In PCP should document the rationale and medical necessity for all referrals in the member's medical record.
    c. A written referral is required for all non-emergent professional provider services and non-emergent outpatient physician services performed at a hospital using the UnitedHealthcare Lock-In Referral Form (see form instructions)
    d. Following inpatient hospitalization, the Lock-In PCP must authorize professional services and a referral is required.
    e. The Lock-In PCP is responsible for identifying the need for a referral and to which provider the member will be referred. Referrals to providers with the same specialty as the Lock-In PCP should be avoided.
    f. The Lock-In PCP should retain prescribing privileges when appropriate, based on the medications prescribed and provider's scope of practice.
    g. After the referral has been made, the Lock-In PCP is expected to provide ongoing management of the member's healthcare.
    h. The referred-to provider must receive the UnitedHealthcare Lock-In Referral Form prior to rendering services and agree to provide only the services requested by the Lock-In PCP. The referred-to provider must submit a copy of the Lock-In Referral Form with their initial claim for payment. Claims will be denied in the absence of a referral, and member will be responsible for payment.
    g. After the requested services are provided by the referred-to provider, a consultation report, including results of any diagnostic test, lab or x-ray, and follow-up or prescribing recommendations should be provided to the Lock-In PCP.
    h. A referral is NOT required for the following services:
        - Non-ambulance medical transportation
        - Home and community based services (HCBS)
        - Community mental health (services only)
        - Durable medical equipment
        - Vision services (Routine eye exams only)
        - Radiology and laboratory services
3. The pharmacy fills all Lock-In members' prescriptions.
4. The hospital provides all Lock-In members non-emergent hospital services.

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

10895 Grandview, Suite 200
Overland Park, KS 66210

Primary Care Physician Lock-In Referral

Date of referral _____

This authorizes _____
Provider to whom member is referred

to only provide _____
Description of service: office visit, consultation, surgery

to _____ ID # _____
Patient name *Medicaid 11-digit ID*

for symptoms and conditions of _____.

Authorized date(s) of service _____ to _____
Referral should not be for more than a 30-day period.
Mental health and on-going pain management should be for no more than six months.

Please contact my office at _____ - _____ - _____ to forward lab results, consultation information and to make prescribing recommendations.

Lock-in provider signature _____

Lock-in provider NPI number _____

Date of signature _____

Lock-In Physician: Retain this referral in the member's file and forward one copy to the provider that the member is being referred.

Lock-In Referral Guidelines

1. A written referral is required for non-emergency medical services to be performed by another physician or health care professional.
2. The Lock-In PCP must complete the Referral Form and forward it to the referred-to provider via mail, fax or email.
3. Referrals may be written for one day or subsequent days, but should not be written for more than 30 days per each Referral Form, unless a longer period of time is appropriate (i.e. mental health or on-going pain management). The maximum time allowed for any written referral is 6 months.
4. The Lock-In PCP should keep a copy of the Referral Form in the member's record. In addition, the PCP can provide a copy of the Referral Form to the member for purposes of communication and lock-In referral compliance.
5. The referred-to provider must receive the Lock-In Referral Form prior to rendering services and agree to provide only the services requested by the Lock-In PCP. Claims will be denied in the absence of a referral, and member will be responsible for payment.
6. After the requested services are provided by the referred-to provider, a consultation report, including results of any diagnostic test, lab or x-ray, and follow-up or prescribing recommendations should be forwarded to the Lock-In PCP.
7. The referred to provider must submit a copy of the Lock-In Referral Form with their claim for payment, and the Name and NPI number of the Lock-In PCP must be included on the provider claim.
8. A written referral is NOT required for the following services:
    a. Non-ambulance medical transportation
    b. Home and community based services (HCBS)
    c. Community mental health (services only)
    d. Durable medical equipment
    e. Vision services (Routine eye exams only)
    f. Radiology and laboratory services
9. Providers can find additional information regarding the Lock-In process, forms, claims and referrals at UnitedHealthcareOnline.com > Tools & Resources. You may also contact the Provider Services team for assistance regarding the Lock-In PCP referrals and verification of member enrollment by calling UnitedHealthcare Community Plan at 877-542-9235.
10. For suspected Medicaid Fraud or Abuse, providers should contact the Fraud and Abuse Hotline at 866-242-7727.

4.12 Member Dismissals

1. Provider notifies member in writing

2. Provider is responsible for continuing care to member for 30 days from the date the letter is dated to the member

3. Provider must specify in writing to the member specific reason for dismissal

4. This applies to all members including those currently participating in the "Lock-in Program".

5. Provider is responsible for notifying the health plan in writing of the member dismissal along with a copy of the letter that was sent to the member. Written notification should be mailed to "United Healthcare Community Plan, Member Advocate, 10895 Grandview Drive, Suite 200, Overland Park, KS 66210.

6. Health Plan is responsible for contacting the member and assisting them in finding a new PCP

4.13 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 also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available. Members have a choice to receive services from their UnitedHealthcare PCP/PCCM clinic or go directly to a local health department or family planning clinic. Members do not need a referral (permission) from the Health Plan for the services below:

- Family Planning services and birth control
- Immunizations
- HIV and AIDS testing
- TB screening and follow-up care
- Sexually transmitted disease treatment and follow-up care

4.14 Maternity Care

Pregnant UnitedHealthcare Community Plan members are encouraged to receive care from participating providers.

Providers should notify UnitedHealthcare Community Plan promptly of a member's confirmed pregnancy to ensure appropriate follow-up and coordination by the UnitedHealthcare Healthy First Steps coordinator.

Providers need to contact Healthy First Steps by submitting an American College of Gynecology or any initial prenatal visit form to Healthy First Steps via fax 877-353-6913. Providers with questions regarding Healthy First Steps should call 800-599-5985. (See more information about Healthy First Steps below.)

The following information must be provided to UnitedHealthcare Community Plan within one business day of the visit when the pregnancy is confirmed:

- Member's name and member ID number
- Obstetrician's name, phone number, and member ID number
- Facility name
- Expected date of confinement (EDC)
- Planned vaginal or Cesarean delivery
- Any concomitant diagnoses that could affect pregnancy or delivery
- Obstetrical risk factors
- Gravida
- Parity
- Number of living children
- Previous care for this pregnancy

An obstetrician does not need approval from the member's primary care physician for prenatal care, testing or obstetrical procedures.

4.15 Healthy First Steps (Maternity Case Management)

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;
- Ensure appropriate postpartum and newborn care;
- Develop the physician/member partnership and relationship before and after delivery.

4.16 Neonatal Resource Services (NICU Case Management)

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

Neonatal Resource Services (NRS)

Neonatal Resource Services (NRS) Program helps to ensure quality of care and efficiency in treatment of NICU babies. The NRS Program Eligible member is defined as a newborn who has been admitted to the NICU upon birth (including babies that get transferred from PICU to NICU) and/or any infants readmitted within the first 30 days of life. All babies admitted to the NICU will be followed by NRS. (Detained babies will also be eligible for the program for the initial inpatient hospitalization only).

NRS Neonatologists and NICU nurses proactively manage NICU patients through evidence based medicine and the use of care plans. The NRS nurse case manager will:

- Collaborate with the family, physician, and Discharge Planner on a coordinated discharge to ensure timely provision of care and delivery of services
- Develop alternate strategies for care management interventions (as needed)
- Facilitate the discharge
- Coordinate services post-discharge as required if member is under NRS case management
  The NRS Program also provides onsite nurses in many markets.

The NRS program includes a multidisciplinary approach to case management in the 30 day post discharge period. The NRS nurse case manager's role is comprehensive and includes:

- Discharge planning and facilitation of timely release
- Coordination of alternative care options, including home care, equipment and skilled nursing
- Post-discharge Support for 30 days, except detained babies
- Educating parents and families on local community resources and support services available
- Case managers provide benefit solutions to families in order to ensure appropriate services for the neonate

Home Health Services

Home Health Services should be pre-certified by the home health provider or the hospital Discharge Planner ordering the home care by calling the Prior Authorization Department at 866-604-3267 or sending a fax to 866-943-6474

4.17 Delivery Admissions

Authorization for delivery is not required, but delivery notification is requested. Please call 866-604-3267 or fax the following information for the newborn to UnitedHealthcare Intake at 866-943-6474:

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

4.18 Newborn Admissions

The hospital must notify UnitedHealthcare Community Plan prior to or upon the 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

4.19 Abortion

Indications and Limitations of Coverage

Abortions are covered only under the following conditions:

1. If the pregnancy is the result of an act of rape or incest (use the G7 modifier); or
2. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself.

The Abortion Necessity form must be completed in order for the claim to be processed. The Abortion Necessity Consent Form can be found at the following web address: **www.kmap-state.us**.

Prior Authorization is not required for abortions. The Abortion Necessity Consent Form must be completed in its entirety and submitted with the claim.

4.20 Sterilization Procedure Billing

The surgeon performing the sterilization procedure, including hysterectomies, is responsible for obtaining a complete and accurate Sterilization Consent Form/Hysterectomy Necessity Form. However, we recommend providers, hospitals and/or or your billing service obtain a copy of the Sterilization Consent Form/Hysterectomy Necessity Form from the surgeon prior to the service to validate a completed and correct form.

If a hospital or provider (other than the surgeon performing the sterilization) files a claim prior to the surgeon, we will not have a valid sterilization consent form on file. As a result, the claim will deny and you or the hospital will be responsible for submitting a corrected claim once the surgeon's claim is on file with valid sterilization consent form. If you obtained a copy of the complete and accurate Sterilization Consent Form/Hysterectomy Necessity Form from the surgeon, you may submit the form with their claim to facilitate payment.

If the surgeon does not complete the Sterilization Consent Form/Hysterectomy Necessity Form correctly, which makes it invalid per federal regulation, we cannot accept it. All sterilization-related services will be denied. If the surgeon performs a sterilization procedure without obtaining the necessary Sterilization Consent Form/Hysterectomy Necessity Form, UnitedHealthcare Community Plan will not pay for any services related to the sterilization.

Effective immediately, please complete and submit a Sterilization Consent Form/Hysterectomy Necessity Form, which is available at **kmap-state-ks.us**, with your initial claim for any sterilization procedures, including hysterectomies for KanCare members, even if KanCare is not the primary payer.

If you have questions, please call Provider Services at 877-542-9235, Monday through Friday from 8 a.m. to 5 p.m. Central Time, or your provider advocate.

4.21 Concurrent Review

UnitedHealthcare Community Plan performs concurrent review on all hospitalizations for the duration of the stay based on contractual arrangements with the hospital. UnitedHealthcare Community Plan performs fax, telephonic or onsite utilization reviews at the facility.

UnitedHealthcare Community Plan uses evidence based, nationally accepted, clinical criteria guidelines for determinations of appropriateness of care.

The Inpatient Care Manager may certify extension of the length of stay, but may not deny any portion of the stay. Only a medical director or physician advisor can deny an extension of the length of stay.

UnitedHealthcare Community Plan notifies the facility when the Inpatient Care Manager refers a hospital stay for review by a medical director or physician advisor. If a medical director or physician advisor determines that the extended stay is not justified, UnitedHealthcare Community Plan notifies the facility by phone and fax within one working day.

The attending physician, facility, or provider caring for the member may appeal any adverse decision, according to the procedures in the Complaints and Grievances section.

Inpatient Concurrent Review: Clinical Information

Your cooperation is required with all of our 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.

4.22 Discharge Planning and Continuing Care

The Inpatient Care Manager contacts the provider caring for the member, the attending physician, the member, and member's family to assess needs and develop a plan for continuing care beyond discharge, if medically necessary.

UnitedHealthcare Inpatient Care Managers facilitate of care across multiple sites of care. The Inpatient Care Managers work with the member, family members, physicians, hospital discharge planners, rehabilitation facilities, and home care agencies. They evaluate the appropriate use of benefits, oversee the transition of patients between various settings, and refer to community-based services as needed.

Care Coordinators supporting members with Long-term Services & Supports (LTSS) are actively engaged in discharge planning to assist with needed in-home assessments where post-discharge functional changes may require revision to Care Plans.

4.23 Preventive Health Care Standards

UnitedHealthcare Community Plan's goal is to partner with providers to ensure that members receive preventive care. UnitedHealthcare Community Plan endorses and monitors the practice of preventive health standards recommended by recognized medical and professional organizations. Preventive health care standards and guidelines are available at **UHCCommunityPlan.com**. Standards such as well child, adolescent and adult visits, childhood and adolescent immunizations, lead screening, and cervical and breast cancer screening are included in the website. Education is provided to both members and providers related to preventive health services and members are offered assistance with gaining access to these services if needed. Members may self-refer to all public health agency facilities for medical conditions treated by those agencies.

Following are charts that outline preventive care recommendations for both children and adults.

Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The PATH program focuses on collaborating with physicians to engage with our members to improve HEDIS and CAHPS results by encouraging our members to complete their annual wellness visit and get the recommended preventive care services they need.
The goals of PATH are:

- **To get more members to engage with their physicians,** so they get the preventive care services they need
- **To share valuable data, tools and resources** with physician practices
- **To deliver administrative tools and clinical support** to maximize performance

Path can be accessed at: **uhcprovider.com/PATH**

4.24 Recommended Childhood Immunization Schedules

The childhood and adolescent immunization schedule and the catch-up immunization schedule have been approved by Advisory Committee on Immunization Practices (ACIP), American Academy of Family Physicians (AAFP), and the American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG).

Visit **cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html** for the CDC recommended immunization schedules for persons aged 0 through 18 years.

4.25 Kan Be Healthy Periodicity Schedule

Screening frequencies are based on the 2007 American Academy of Pediatrics (AAP) "Recommendations for Preventive Pediatric Health Care" as published on the AAP website, as of November 5, 2007. The first screen may be performed at any age under 21 and repeated according to ideal timeframes listed in the Kan Be Healthy (KBH) Screening Frequencies table below. When the ideal schedule is not possible to follow, please note that KBH medical screens may be completed at any time.

Note: Every KBH visit must have all components completed and documented. For update information on KBH visit: **kmap-state-ks.us**.

Medical Screenings

(M) Medical screens follow the KBH minimum documentation requirements which include the hearing, vision, and dental screening.

Dental Screenings

(D) Dental screens are a required component of each KBH visit based on both the Kansas State and AAPD/ADA/AAP Periodicity Schedule.

Vision Screenings

(V) Vision screens are a required component of each KBH visit based on both the Kansas State and AAP Periodicity Schedule. School vision screenings are a separate and distinct process and follow their own periodicity schedule as outlined in the KDHE Vision Screening Guidelines.

Hearing Screenings

(H) Hearing screens are a required component of each KBH visit based on both the Kansas State and AAP Periodicity Schedule. School hearing screenings are a separate and distinct process and follow their own periodicity schedule as outlined in the KDHE Hearing Screening Guidelines and Resource Manual.

Delegation Oversight

UnitedHealthcare Community Plan may delegate Medical Management to a medical group/Independent Practice Association (IPA) that demonstrates compliance with UnitedHealthcare Community Plan and has established standards for the medical management function. This function is utilization management. Care providers associated with these delegated IPA/medical groups may use the medical group/ IPA's medical management office and protocols for all delegated authorizations. The medical group/IPA medical management protocols and UnitedHealthcare Community Plan must be aligned. The delegated medical group/IPA's medical management protocols and procedures must comply with all applicable state and federal regulatory requirements.

A delegated medical group/IPA may have processes and forms that differ somewhat from those outlined in this section. If you have questions about medical management delegation, please contact your provider advocate.

UnitedHealthcare Community Plan will perform a precontractual assessment before delegating medical management functions. UnitedHealthcare Community Plan will also perform an initial assessment within 90 calendar days after the contract effective date to measure the medical group/IPA's medical management compliance with UnitedHealthcare Community Plan's standards. At least annually thereafter, UnitedHealthcare Community Plan will assess the delegated medical group/IPA to help ensure continued compliance. We may initiate a focused or off-cycle assessment of the medical group based on specific activity that warrants such an assessment. The medical group/IPA is required to provide specific documents/evidence to the assessment, or as applicable.

Based on the compliance assessment findings, UnitedHealthcare Community Plan may require the delegate to develop and implement a corrective action plan designed to bring the medical group/IPA back into compliance. Delegates who do not achieve compliance within the established timeframes may undergo intensive corrective action until such time as they achieve compliance. Medical management is a delegated function subject to revocation. Delegation sanctions may be a corrective action plan or revocation.

There are monetary costs to the delegate if the function is revoked.

When UnitedHealthcare Community Plan reviews an adverse determination member or care provider appeal from a delegated medical group/IPA, the plan will use MCG (formerly Milliman Care Guidelines) as the externally licensed medical management guidelines, even if the delegated medical group/IPA used different externally licensed medical management guidelines to make the initial adverse determination. We will use Medicare Coverage Guidelines as appropriate for Medicaid appeals.

Semi-Annual Reporting

The delegate will provide UnitedHealthcare Community Plan of Kansas with semi-annual reports as outlined in the delegation agreement. Also, reports must meet applicable regulatory requirements and accreditation standards.

Purpose of Medical Management Program

Delegated medical groups/IPAs should use the following information-

The purpose of the Medical Management Program is to determine if the medical services proposed or rendered are:

- Medically necessary;
- Covered under the member's UnitedHealthcare Community Plan of Kansas benefit plan; and/or
- Performed at both the appropriate place and level of care.

Criteria for Determining Medical Necessity

Delegated medical management groups/IPAs review nationally recognized criteria to determine medical necessity and appropriate level of care for services whenever possible.

Delegated medical group/IPAs will use multiple resources and guidelines to determine medical necessity and appropriate care level. This includes Medicaid coverage guidelines. For services not addressed in Medicaid coverage guidelines, the delegates will use UnitedHealthcare Community Plan's medical policies. If other nationally-recognized criteria contradict Medicaid coverage guidelines, the delegated medical group/IPAs will follow Medicaid coverage guidelines for Medicaid members.

Members may request individual eligibility and benefit criteria. Members may call the medical group / IPA's general number (or the number listed in the denial letters). The may also call our Member Services department.

NCQA Accreditation standards require all health care organizations, health plans and medical group/IPAs, delegated for utilization/ medical management distribute a statement to all members, care providers and employees who make utilization management (UM) decisions for the following:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- You or other individuals are not specifically rewarded for issuing denials of coverage or service.
- Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

Care Provider Requirements

You must render covered services at the most appropriate level of care, based on nationally recognized criteria.

With limited exceptions, you will not be reimbursed for services not covered, not medically necessary, or for incorrect procedures (e.g., notification requirements, preauthorization, or verification guarantee process).

The delegated medical group/IPA sets its own policies regarding your responsibilities. Neither UnitedHealthcare Community Plan of Kansas nor the member should be responsible to reimburse you for medical services, admissions, inappropriate facility days, and/or not medically necessary services if you did not obtain required prior authorization. Authorization receipt does not affect the application of any applicable payment policies in determining reimbursement.

Regardless of the Medical Management Program determination, the decision to render medical services lies with the member and you, as the attending care provider. If you and the member decide to go forward with the medical services once UnitedHealthcare Community Plan of Kansas or the delegated medical group/IPA has denied preauthorization, no care provider, facility, or ancillary services will be reimbursed by UnitedHealthcare Community Plan of Kansas or the delegated medical group/IPA. The delegates' medical directors are available to discuss their decisions and criteria with the member. The delegate will also make the medical policy decisions available upon request.

Medical Management Denials/Adverse Determinations

UnitedHealthcare Community Plan or a delegated medical group/IPA may issue a denial/adverse determination when there is no apparent medical necessity for a health care service, a non-covered benefit is requested, or when no information or insufficient information is provided.

Denials, Delays or Modifications

UnitedHealthcare Community Plan or the delegated medical group/IPA must make and communicate decisions in a timely manner to approve, modify, or deny health care service authorization requests. They must also communicate if the decision delays service delivery based on medical necessity or benefit coverage appropriate to the member's medical condition, and in accordance with the applicable state and federal law.

All authorization decisions must be based on sound clinical evidence including, but not limited to, medical record review, consultation with the treating care providers, and review of nationally recognized criteria. Clearly document the criteria for determining medical appropriateness and include procedures for applying criteria based on the needs of individual members and characteristics of the local delivery system.

Consistently gather and document all information to support decision-making. State and federal law applies to criteria disclosure.

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

- You will not review your own referral requests,
- Referral requests considered for denial will be reviewed by care providers qualified to make an appropriate determination, and
- Any referral request where the medical necessity or the proposed treatment plan is not clear will be clarified and discussed with you. Complex cases may be brought to the UMC/Medical Director for further discussion and decision.
- Individual(s) who meet the qualifications of holding financial ownership interest in the organization may not influence the clinical decision making regarding payment or denial of a service.
- Possible request for authorization determinations include:
  - Approved as requested – No changes;
  - Approved as modified – Referral approved, but the requested care provider or treatment plan was modified. Must send denial letter if requested care provider is changed or specific treatment modality is changed (e.g., requested chiropractic, approved physical therapy);
  - Extension – Delay of decision regarding a specific service. (e.g., need additional documentation, information, or require consultation by an expert reviewer).
  - When a Medicare member requests an extension, CMS allows it. The extension is justified and in the member's interest due to the need for medical evidence from a care provider that may change the decision to deny an item or service; or the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the member's interest.
  - Delay in Delivery – postpone access to an approved service for a specified period of time or until a specified date. This is not the same as a modification. A written notification in the denial letter format is required;
  - Denied – Non-authorization request for health care services. Reasons for denials of requests for services include, but are not limited to, the following:

- Not a covered benefit – the requested service(s) is a direct exclusion of benefits under the member's benefit plan – specific benefit exclusion must be noted;
- Not medically necessary or benefit coverage limitation – specify criteria or guidelines used in making the determination as it relates to the member's health condition;
- Member not eligible at the time of service;
- Benefit exhausted - include specific information as to what benefit was exhausted and when
- Not a participating care provider – a participating care provider/service is available within the medical group/ IPA in-network;
- Experimental or investigational procedure/treatment;
- Self-referred/no prior authorization (for non-emergent post-service);
- PCP can provide services

Written Denial Notice

The written denial notice serves many purposes and is an important component in the member's chart and the medical group/ IPA records. Regardless of the form used, the denial letter serves to document member and care provider notification of:

- The denial, delay, partial approval or modification of requested services;
- The basis of denial, delay, partial approval or modification, including medical necessity, benefits limitation or benefit exclusion;
- Member-specific information relating to how the member did not meet criteria for approval in easily understandable language;
- The appeal rights;
- An alternative treatment plan, if applicable;
- Benefit exhaustion or planned discharge date.

CMS requires the use of the CMS Integrated Denial Notice/Notice of Denial of Medical Coverage (IDN/NDMC) for Medicaid plan members. This template may not be altered in any way, except to add text to the areas indicated on the template.

Most states require approved standardized templates for member notices, such as denial of services. UnitedHealthcare Community Plan of Kansas will provide appropriate and approved templates to the delegated medical group/IPAs.

Minimum Content of Written or Electronic Notification

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

- The specific service(s) denied, delayed in delivery, modified or partially approved;
- The specific reference to the benefit plan provisions to support the decision;

- The reason the service is denied, delayed in delivery, modified, or partially approved including:
  - Clear and concise explanation of the reasons for the decision, in sufficient detail, using an easily understandable summary of the criteria, so that all parties can understand the rationale behind the decision, and;
  - Description of the criteria or guidelines used, reference to the benefit provision, protocol or other similar criterion on which the denial decision is based, and;
  - How those criteria were applied to the member's condition (member-specific information);
  - Specific name of the referenced criteria
- Notification that the member can obtain a free of charge copy of the actual benefit provision, guideline, protocol, or other similar criterion which the denial decision was based, upon request.
- Notification you may request a peer to peer review;
- Contractual rationale for benefit denials;
- Alternative treatment options offered, if applicable (not applicable for retrospective review or non-covered benefit denials);
- A description of any additional material or information necessary for the member to "perfect" the request, and why that information is necessary;
- If the request is for an experimental or investigational treatment, an explanation of the scientific or clinical judgment for making the determination and;
- Appeal and grievance processes, including:
  - Information about when, how and where to submit an appeal;
  - Information regarding the member's right to appoint a representative to file an appeal on the member's behalf;
  - Member's right to submit written comments, documents or other additional relevant information;
  - Information notifying the member and their treating care provider of the right to an expedited appeal for the time-sensitive situations (not applicable for retrospective review);
  - Information regarding the member's right to file a grievance or appeal with the applicable state agency, including information regarding the independent medical review process (IMR), as applicable;
- The name and direct phone number of the health care professional responsible for the decision.

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

Occasionally, a member may contact the delegated medical group/IPA instead of the plan. In such cases, the UM delegates are required to:

- Immediately, within one hour of receipt, forward all member grievances and appeals (complaints, appeal, quality of care/service concern, whether oral or written) to UnitedHealthcare Community Plan of Kansas for processing at:

  - Written grievance/appeal – contact information included in the Integrated Denial Notice/ Notification of Denial of Medicaid Coverage.
  - Oral grievance/appeal – contact information included in the Integrated Denial Notice/ Notification of Denial of Medicaid Coverage.

- Respond to UnitedHealthcare Community Plan of Kansas requests for information relevant to the member's appeal or grievance within the designated timeframe. You must submit the requested information to UnitedHealthcare Community Plan's request expedited appeals, within two hours, standard appeals, within 24 hours (no exceptions or delays due to weekend or holidays). Timeframes apply to every calendar day of the year.
- Comply with all final determinations made by UnitedHealthcare Community Plan of Kansas regarding member appeals and grievances.
- Cooperate with UnitedHealthcare Community Plan of Kansas and the external independent medical review organization or State Fair Hearing, including but not limited to, promptly forwarding to the external review organization copies of all medical records, and information relevant to the disputed health care service in the medical group/IPA's possession as well as any newly discovered relevant medical records or any information in the participating medical group/IPA's possession, requested by external review organization.
- Provide UnitedHealthcare Community Plan of Kansas with a copy of the authorization (preservice) within the stipulated timeframes on adverse determinations reversals. You must respond to UnitedHealthcare Community Plan's requests for proof of overturned appeals: expedited appeals, within two hours or for standard appeals, within 24 hours (no exceptions or delays due to weekend or holidays). Timeframes apply to every calendar day of the year.

Referrals

Provide or Arrange Covered Services

Each member is assigned a PCP at the time of enrollment. The PCP has primary responsibility for coordinating the member's overall health care, including behavioral health care, and the appropriate use of pharmaceutical medications.

Referral authorization procedure

The delegated medical group/IPA may be responsible to initiate the referral authorization process when a request is made to refer a member for services. (Please refer to the delegated group's pre-authorization list, as applicable). The following capitated medical services are examples where a referral authorization may be necessary:

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

The medical group/IPA, PCP and/or other referring care provider is responsible for verifying eligibility and participating care provider listings on all referral authorization requests, so the referral is the appropriate in-network care provider.

The medical group/IPA, PCP, or treating care provider must comply with the following procedures:

- When a member requests specific services, treatment or referral to a specific care provider, review the request for medical necessity.

- If there is no medical indication for the requested treatment, discuss an alternative treatment plan with the member.
- If the treatment option selected by the member requires referral or prior authorization, the PCP or treating care provider must submit the member's request to the medical group/IPA Utilization Management Committee or its designee for determination.

Include appropriate medical information and commentary on the referral regarding why you believe the requested treatment is or is not indicated and alternative treatments as appropriate.

- If the request is not approved in whole, the delegated medical group/IPA must issue a denial letter to the member, specific to the requested services, treatment or referral, and which complies with the applicable state and federal requirements.

Referral Authorization Form

The delegated medical group/IPA may design its own request for an authorization form, without approval by UnitedHealthcare Community Plan of Kansas. The form shall, at a minimum, include all of the following:

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

The delegated medical group/IPA provides copies of the referral authorization form to the following:

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

The delegate provides the referral form to all parties within 36 hours of receipt of information necessary to make a decision, to include one working day, and not to exceed 14 calendar days from date of receipt for services for standard requests.

If UnitedHealthcare Community Plan of Kansas is financially responsible for the services, the delegated medical group/IPA submits the authorization information to the plan.

Continuity of Care

Continuity of care is intended to be a short term transition period, which allows members to temporarily continue to receive services from a non-participating care provider.

The delegate is responsible to facilitate continuity of care for medically necessary covered services. If a member entering the health plan is receiving medically necessary covered services, in addition to, or other than prenatal services, the day before enrollment into the health plan, the health plan is responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services provided by in-network or out-of-network care providers.

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

Any member entering the health plan is held harmless by the care provider for the costs of medically necessary covered services.

Non-pregnant members receiving a physician authorized treatment course are allowed to continue to receive such treatment, without any form of prior authorization and without regard to whether such services are provided by in-network or out-of-network providers, for the lesser of 60 calendar days or until the member has seen the assigned primary care provider who has authorized a course of treatment.

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

It is not enough to simply prefer receiving treatment from a former care provider or other non-participating care provider, even for a chronic condition. A member should not continue care with a non-participating care provider without formal approval by UnitedHealthcare Community Plan of Kansas or the delegated medical group/IPA. Except for emergent or urgent out-of-area (OOA) care, if the member does not receive preauthorization from UnitedHealthcare Community Plan of Kansas and the member's participating medical group, payment for services performed by a non-participating medical group/IPA and/or payment for services performed by a nonparticipating care provider will be the member's responsibility.

UnitedHealthcare Community Plan of Kansas (or the medical group/IPA delegated for continuity of care) reviews all requests for continuity of care on a case-by-case basis. We must give reasonable consideration to the severity of the member's condition and the potential clinical effect on the member's treatment and outcome of the condition under treatment, which may result from a change of care provider.

A member may request to continue covered services with a care provider for continuity of care under the following circumstances:

- Care provider terminating from UnitedHealthcare Community Plan, other than for cause or disciplinary action. As the care provider, you must agree in writing:
  - To be subject to the same contractual terms and conditions imposed upon participating care providers, including, but not limited to credentialing, facility privileging, utilization review, peer review and quality assurance requirements; and
  - To be compensated at rates and methods of payment similar to those used by UnitedHealthcare Community Plan of Kansas and current participating care providers providing similar services, who are not capitated and who are practicing in the same or a similar geographic area.

To consider a member's request for continuity of care, a member must be undergoing an active course of treatment.

Second Opinion

Members have the right to second opinions. The delegate will provide a second opinion when a qualified health care professional requests it within the network. Delegate also provides second opinion when the member requests it, or the delegate must arrange for the member to obtain one outside the network. Qualified health care professionals must provide second opinions at no cost to the member. A third surgical opinion, provided by a third provider, is allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation, and if the member desires the third opinion.

Notification Requirements for Facility Admissions when UnitedHealthcare pays claims

Contracted facilities are ultimately accountable to provide timely notification to both the medical group/IPA and UnitedHealthcare Community Plan within 24 hours of admission for all inpatient and observation status cases, including changes in level of care impact billing category.

Maternity – Notify normal vaginal deliver or C-section delivery on or before the end of the mandated period 48 hours or 96 hours respectively. Notification is always required if the baby stays longer than the mother. In all cases, separate notification is required immediately when a baby is admitted to the neonatal intensive care unit.

The medical group/IPA must have a clearly defined process with the contacted facility where the facility provides the medical group/IPA and UnitedHealthcare Community Plan of Kansas information on all facility admissions, updates in member status and discharge dates on a daily basis.

Timely admission notification is required by UnitedHealthcare Community Plan of Kansas and the medical group/IPA to verify eligibility, authorize care, including level of care, and initiate concurrent review and discharge planning.

For emergency admissions, notification occurs once the member has been stabilized in the emergency department. Proper notification is required by UnitedHealthcare Community Plan of Kansas on the day of admission for timely and accurate payment of facility claims.

Authorization Log and Denial Log Submission

Authorization logs for all inpatient acute, observation status and skilled nursing facility cases must be accurately submitted according to the current process. When there are no inpatient acute, observation statuses or skilled nursing facility cases to report, the medical group/IPA is required to submit its weekly authorization log indicating either "no activity" or "no admissions" for each of the designated admission service type specified in this section and for the applicable reporting time.

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

- Member ID
- Member Name
- Member Date of birth
- Member Name
- Attending care provider: (Name and Address, with TIN if available)
- Facility care provider: (Name and Address, with TIN if available)
- Admitting diagnosis (ICD-10-CM or its successor code)
- Actual Admission Date
- Actual Discharge Date
- Level of care (i.e., bed type, observation status, outpatient procedures at acute facilities)
- Length of stay (LOS) (i.e., number of days approved, as well as the number of days denied)

- Procedure/surgery (CPT Code)
- Discharge Disposition
- Planned Admission Date
- Planned Discharge Date
- Service Type
- Authorization number (if available)

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

For more information or if you have questions, please contact your provider advocate.