2018
Care Provider Manual

MississippiCAN 2018

Physician, Health Care Professional, Facility and Ancillary

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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 the manual using the following steps:

1. Press CTRL+F.
2. Type in the keyword.
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.

Welcome to UnitedHealthcare Community Plan

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

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

If you have questions about the information or material in this manual or about any of our policies or procedures, please call Provider Services at 877-743-8734.

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 of information between your participation agreement and this manual, the terms of this manual will control unless the agreement dictates otherwise. UnitedHealthcare Community Plan reserves the right to supplement this manual to ensure that its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

In addition to this reference document, information is provided to members outlining their benefits, rights, and responsibilities at **UHCCommunityPlan.com**.

This manual will be amended as operational policies change.

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UnitedHealthcare Community Plan Corporate Overview

Medicaid contracts with UnitedHealthcare to provide services to its Mississippi Coordinated Access Network (MississippiCAN). As a result, we provide services to pregnant women, children and adults who meet income requirements.

UnitedHealthcare Community Plan understands 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

Innovative health care programs are the hallmark of UnitedHealthcare Community Plan. Our personalized programs encourage the utilization of services. These programs, some of them developed with the aid of researchers and clinicians from academic medical centers, are designed to help our chronically ill members avoid hospitalizations and hospital emergency room visits — in short, to live healthy, productive lives.

The unique UnitedHealthcare Community Plan Personal Care Model™ features direct member contact by our clinicians trained to foster an ongoing relationship between the health plan and members suffering from serious and chronic conditions. The goal is to use high-quality health care and practical solutions to improve members' health and keep them in their communities — with the resources necessary to maintain the highest possible functional status.

UnitedHealthcare Community Plan does not require or request you to enter into an exclusive relationship with us or any of our business affiliates.

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 **UnitedHealthcare Administrative Guide**.

How to Contact Us

UnitedHealthcare Community Plan	UHCprovider.com	To review a patient's eligibility or benefits, check claims status, submit claims or review Directory of Physicians, Hospitals and other Health Care Professionals.
Provider Services	877-743-8734 Hours of Operations: Monday – Friday 8 a.m. to 5 p.m.	This is an automated system. Please have your National Provider Identifier number and your tax ID or the member ID ready, or you may hold to speak to a representative. The call center is available for you to: ▪ Answer general questions ▪ Verify member eligibility ▪ Check status of claims ▪ Ask questions about your participation or notify us of demographic and practice changes
Prior Authorization Notification	866-604-3267 Fax 888-310-6858 UHCprovider.com	To request prior authorization or to notify us in accordance with the prior authorization/ notification requirements section of this guide.
Pharmacy Services	877-305-8952	OptumRx Pharmacy Help Desk Available 24 hours a day, 7 days a week
Behavioral Health Services	UBH Customer Service: 866-673-6315 Prior Authorization: 877-743-8731	
Dental	800-508-4862	
Vision	844-606-2724	
Hospital Inpatient Services and Concurrent Reviews	866-604-3267 Fax 888-310-6858	
Transportation	844-525-2331	

MississippiCAN Care Provider
Frequently Used Information

Our Claims Process

To help ensure prompt payment:

1. Review and copy both sides of the member's ID card. UnitedHealthcare Community Plan members receive an ID card containing information that helps you process claims accurately. These ID cards display information such as claims address, copayment information (if applicable), and telephone numbers such as those for member and care provider services.
2. Notify UnitedHealthcare Community Plan's Health Services of planned procedures and services on the Prior Authorization list.
3. Prepare a complete and accurate electronic or paper claim form (see "Complete claims" at right). Complete a CMS 1500 or UB-04 form.
4. Submit claims electronically to reduce costs, help ensure faster processing and reduce claim entry errors. 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. If you do not have access to internet services, you can mail the completed claim to:

UnitedHealthcare Community Plan
PO Box 5032
Kingston, NY 12402-5032

Complete Claims

A complete claim includes the following:

- Member's name, date of birth, address and ID number.
- Name, signature, address and phone number of physician or care provider performing the service, as in your contract document.
- National Provider Identifier (NPI) number.
- Physician's or care provider's tax ID number.
- CPT-4 and HCPCS procedure codes with modifiers where appropriate.
- ICD-10 diagnostic codes.
- Revenue codes (UB-04 only).
- Date of service(s), place of service(s) and number of services (units) rendered.
- Referring physician's name (if applicable).
- Information about other insurance coverage, including job-related, auto or accident information, if available.
- Attach operative notes for claims submitted with modifiers 22, 62, or any other team surgery modifiers.
- Attach a description of the procedure/service provided for claims submitted with unlisted medical or surgical CPT codes or experimental or reconstructive services (if applicable).

Injectable drugs provided in an office/clinic setting:

The health plan will be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to care providers providing both home infusion services and the drugs and biologics. The health plan will require that all professional claims contain NDC (National Drug Code) 11-digit number and unit information to be paid for home infusion and J codes. The NDC number must be entered in 24D field of the CMS-1500 Form or the LIN segment of the HIPAA 837 electronic form. Services reimbursed by the health plan will not be included in any pharmacy benefit limits established for pharmacy services.

How to Contact Us

UHCprovider.com
Verify member eligibility, check status of claims, submit claim adjustment requests.

Provider Services: 877-743-8734
This is an automated system. Please have your National Provider Identifier number and your Tax ID or the member ID ready, or you may hold to speak to a representative. The call center is available for you to:

- Ask questions about benefits.
- Verify member eligibility.
- Check claim status.
- Ask questions about your participation or notify us of demographic and practice changes.
- Request information regarding credentialing.

Prior Authorization: 866-604-3267
Available Monday – Friday 8 a.m. – 5 p.m. (CT), 24 hours for emergency. For a complete and current list of prior authorizations, go to **UHCprovider.com/priorauth**.
Fax prior authorizations to 888-310-6858

Utilization Management: 877-743-8731
Staff is available Monday through Friday, 8 a.m. to 5 p.m. (ET), to assist with routine prior authorizations, admissions, discharges and coordination of members' care. On-call staff is available 24/7 for emergency prior authorization purposes.

Case Management: 877-743-8731

Disease Management: 877-743-8731

Pharmacy Prior Authorization:
Go to **UHCprovider.com/priorauth** for a copy of the pharmacy provider authorization form. Call 800-310-6826 or fax pharmacy prior authorization to 866-940-7328

Vision: 800-877-7195

Transportation: 844-525-2331

Behavioral Health
BH Claims: **866-673-6315**
BH Prior Authorization: **877-743-8731**

Member Services Helpline: 877-743-8731
Available to answer member calls Monday through Friday, 8 a.m. to 6 p.m. (CT). In addition, our interactive voice response (IVR) telephone system is available 24 hours a day, 7 days a week, and our nurse triage hotline is available through our IVR for health-related issues.

UnitedHealthcare®
Community Plan

MississippiCAN Care Provider
Frequently Used Information

Other Important Information

Claim Reconsideration Request
UHCprovider.com/claims > Claims Reconsiderations

Claim mailing address
P.O. Box 5032
Kingston, NY 12402-5032

Fraud and Abuse Division for Anonymous Reporting: 866-242-7727
(Mon-Fri 8:00 a.m. – 4:30 p.m. Central)

UnitedHealthcare Online Support Services:
UHCprovider.com
HelpDesk: 866-842-3278

Pharmacy

- Preferred Drug List (PDL)
  877-743-8734
  UHCCommunityPlan.com
- Pharmacy Prior Authorization
  800-310-6826
  UHCCommunityPlan.com
- Pharmacy (OptumRx) Technical Help Desk
  877-305-8952
- Network Pharmacy Locator
  UHCCommunityPlan.com

Notify UnitedHealthcare Community Plan's Health Services Within the Following Time Frames:

Non-Emergency Care (except maternity)
At least five business days prior to non-emergent, non-urgent hospital admissions and/or outpatient services.

Emergency Care:
Urgent or emergent admissions do not require a prior authorization. HOWEVER, Urgent/Emergent inpatient admissions do require notification within 24 hours of admission.

Return calls from health service coordinators and medical directors and provide complete health information within one business day.

NPI Compliance

National Provider Identification (NPI)

Federal regulations and many state Medicaid agencies require the use of your NPI on all electronic and paper claim submissions. Therefore, you must include a valid NPI on all claims submitted to us for payment. To assist us in expediting this process, please also include your name, address, and TIN.

If you have not yet applied for and received your NPI, please do so immediately by visiting nppes.cms.hhs.gov. If you have not yet provided your NPI to us, please do so immediately by going to UHCprovider.com and choose National Provider Identifier from the Most Visited section. Downloadable forms are on the website for you. NPI information can also be faxed to 866-455-4068 or 414-721-9006.

You must provide to UnitedHealthcare Community Plan the NPI that aligns with your MS Medicaid ID. Failure to do so may impact claims payment.

Medicaid ID Requirement

You must be enrolled in Mississippi Medicaid and have a state provider Medicaid ID to be reimbursed for services provided to a MississippiCAN member.

An enhanced claim denial edit helps ensure that no payments are made to care providers without a Mississippi Medicaid ID, on file. If your claims have denied due to missing Medicaid ID, and you have a current Mississippi Medicaid ID, contact Provider Services at 877-743-8734. We will update your records and adjust applicable claims.

If you do not have a current Mississippi Medicaid ID, a care provider enrollment application can be found at ms-medicaid.com/msenvision.

MississippiCAN Benefits

The Services Listed are Covered by Mississippi Medicaid

Federally Mandated Covered Services:

- EPSDT and Expanded EPSDT Services
- Family Planning Services
- Federally Qualified Health Centers Services
- Home Health Services
- Inpatient Hospital Services
- Laboratory and X-Ray Services
- Nurse Midwife Services
- Nurse Practitioner Services (Pediatric and Family)
- *Nursing Facility Services
- Outpatient Hospital Services
- Physicians Services
- Rural Health Clinic Services
- Transportation Services

State-Covered Optional Services:

- Ambulatory Surgical Center Services
- Behavioral Health Services
- Chiropractic Services
- Christian Science Sanatoria Services
- Dental Services
- Disease Management Services
- Durable Medical Equipment
- Eyeglasses
- Freestanding Dialysis Center Services
- Hospice Services
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Services
- Inpatient Psychiatric Services
- Physical Therapy
- Occupational Therapy
- Pediatric Skilled Nursing Services
- Podiatrist Services
- Prescription Drugs
- *Psychiatric Residential Treatment Facilities Services
- Speech Therapy
- State Department of Health Clinic Services
- Targeted Case Management Services for Children With Special Needs
- Long-Term Acute Care (LTAC) for Children

* These services are provided through the Mississippi Division of Medicaid Fee-For-Service program.

All benefits are subject to change at the discretion of Mississippi Medicaid.

For more comprehensive information on benefits, please visit the website at **medicaid.ms.gov**.

MississippiCAN Benefit Summary

Benefit	Limitation	Prior Authorization*	Notes
Ambulatory Surgical Center Services		Not required	
Ambulance Services		Emergency: not required Non-emergency and fixed-wing requires prior auth: ph: 866-604-3267 fax: 888-310-6858	
Non-Emergency Transportation Services	Limited to Medicaid-covered services only. Excluded if service limits have been met. Excluded if beneficiary has transportation resources	Three days' notice required by calling Member Services at: 877-743-8731	Requests must be made at least three business days in advance.
Chiropractic Services	$700 maximum per calendar year	Not required	
Christian Science Sanitoria Services		Not required	
Cosmetic and Reconstructive Surgery- Outpatient		Yes ph: 866-604-3267 fax: 888-310-6858	
Dialysis Outpatient Center Services		Not required	
Durable Medical Equipment (DME)	Medicaid policy restrictions apply	Yes ph: 866-604-3267 fax: 888-310-6858	Additional DME information can be found at: medicaid.ms.gov
Medical Supplies	Maximum of six diapers/ underpads per day for ages three and up with medical condition causing incontinence of bowel and/or bladder	Yes for more than six diapers/ underpads per day for ages three and up ph: 866-604-3267 fax: 888-310-6858	Medicaid provides one month supply at a time
EPSDT†	Limited to beneficiaries younger than 21	Not required	
Expanded EPSDT Services‡	Limited to beneficiaries younger than 21	Not always required	Prior authorization may be required to determine medical necessity
Family Planning Services		Not required	
Federally Qualified Health Center Services		Not required	
Genetic Testing		Yes ph: 866-604-3267 fax: 888-310-6858	

Benefit	Limitation	Prior Authorization*	Notes
Health Department Services		Not required	Includes certain pharmacy services through MS State Dept. of Health (MSDH), Early Intervention Program (EIP), Perinatal High Risk Management/ Infant Services (PHRM/ISS)
Hearing Services	Hearing tests are covered. Hearing services are limited to beneficiaries under 21 years of age	Required for any services beyond EPSDT-covered services and all hearing aides ph: 866-604-3267 fax: 888-310-6858	
Home Health Services	Children - unlimited Adults - 25 visits per calendar year	Children visits over 25 per calendar year require prior auth; Adults no prior auth required ph: 866-604-3267 fax: 888-310-6858	This does not apply to physical, occupational, speech therapies, DME, orthotics, or prosthetics. See those sections for additional information
Home Infusion		Certain medications may require prior auth. depending on Medicaid preferred drug list	Medicaid preferred drug list can be accessed: **medicaid.ms.gov**
Hospice **-Inpatient** **-Outpatient**	Limited to diagnoses that include six months or less life expectancy as certified by physician	Not required	Provides benefits for Hospice Services unless concurrent of an inpatient stay
Hospital Services **-Inpatient Days** **-Long-Term Acute Care (LTAC) for Pediatrics** **-Emergency Dept**		Required for admissions ph: 866-604-3267 fax: 888-310-6858 Not required for emergency services	To request authorization online: **UHCprovider.com**
Hysterectomy	For age 21 years and older	Yes ph: 866-604-3267 fax: 888-310-6858	Medicaid consent required and can be accessed: **medicaid.ms.gov/resources/forms/**
Imaging **-Nuclear Studies** **-Computed Tomography (CT, SPECT Scans)** **-Magnetic Resonance (MRI, MRA)** **-PET Scans**		Yes ph: 866-604-3267 fax: 888-310-6858 Online authorization: **carriers.carecorenational.com/PreAuthorization/screens/login.aspx**	Additional information: **UHCCommunityPlan.com/health-professionals/ms/radiology.html**
Laboratory		Not required	
Non-Contracted Provider Services (Outpatient Facility & Professional)		Yes ph: 866-604-3267 fax: 888-310-6858	Care provider and/or outpatient facility services are payable only with prior authorization
Nurse Practitioner Services		Not required	

Benefit	Limitation	Prior Authorization*	Notes
Nursing Facility Services		Yes Benefits provided through Division of Medicaid.	Services are not administered by UnitedHealthcare Community Plan although member is entitled to all Medicaid benefits
Orthotics and Prosthetics	Limited to beneficiaries under 21 years of age. Coverage does not include arch supports	Yes ph: 866-604-3267 fax: 888-310-6858	Medicaid does not cover treatment for flat feet (including arch supports) for adults 21 and older so it is not covered service
Outpatient Physical, Occupational, and Speech Therapies (PT, OT, SLP)		Not required except for services provided by home health agencies (see Home Health Services) ph: 866-604-3267 fax: 888-310-6858	These benefits are not covered through the home health program for beneficiaries 21 and older
Skilled Nursing and Private Duty Nursing Services	Limited to beneficiaries younger than 21	Yes ph: 866-604-3267 fax: 888-310-6858	
Perinatal High Risk Management Services		Not required	
Physician Assistant Services		Not required	
Physician Services for Long-Term Care Visits	36 visits per year	Yes Benefits provided through Division of Medicaid.	Services are not administered by UnitedHealthcare Community Plan, although member is entitled to all Medicaid benefits
Physician Services in Medical Offices (Primary and Specialty Care)		Not required	
Podiatrist Services		Not required	
Prescribed Pediatric Extended Care (PPEC)	Limited to beneficiaries younger than 21	Yes ph: 866-604-3267 fax: 888-310-6858	
Prescription Drugs	Five per month with no more than two of them being brand name drugs. Beneficiaries younger than 21 can receive more than the monthly limit with a medical necessity prior authorization	Yes for beneficiaries younger than 21 if therapy exceeds limitations. ph: 800-310-6826 fax: 866-940-7328 Note that some drugs on the preferred drug list (PDL) may still require prior authorization	Medications can be dispensed as an emergency 72-hour supply when drug therapy must not be delayed and prior-authorization is not available. This applies to non-preferred drugs and any drug affected by a need for prior authorization. See: UHCCommunityPlan.com > For Health Care Professionals > Select Mississippi > Select the Pharmacy Program tab.

Benefit	Limitation	Prior Authorization*	Notes
Rural Health Clinic Services		Not required	
Sleep Studies		Yes ph: 866-604-3267 fax: 888-310-6858	
Sterilization	For members 21 and older	Yes ph: 866-604-3267 fax: 888-310-6858	Medicaid consent required and can be accessed: **medicaid.ms.gov/resources/forms/**
Surgery (Inpatient)		Yes ph: 866-604-3267 fax: 888-310-6858	
Transplant Services		Yes ph: 866-604-3267 fax: 888-310-6858	
Eye Care Benefit	**Limitation**	**Prior Authorization***	**Notes**
Children **-Examination** **-Glasses**	Two exams per year Two pairs of glasses per year	Required only for second pair of glasses within the year ph: 844-606-2724	
Adults **-Examination** **-Glasses**	One exam per year One pair of glasses every three years	Not required	
Dental Benefit	**Limitation**	**Prior Authorization***	**Notes**
Children	$2,500 maximum per calendar year for dental unless prior authorization is obtained $4,200 maximum per lifetime per child	Required for procedures such as crowns, root canals, dentures, orthodontics ph: 800-508-4862	Included: Preventive Diagnostic Restorative Orthodontia Emergency pain relief
Adults	$2,500 maximum per calendar year for dental unless prior authorization is secured	Required for procedures such as crowns, root canals, dentures, orthodontics ph: 800-508-4862	Included: Preventive Diagnostic Restorative Emergency pain relief Orthodontics is not covered for adults

Mental Health Benefit	Limitation	Prior Authorization*	Notes
Community Mental Health Center (CMHC) Services		Yes for some services. Refer to this manual. ph: 877-743-8731	
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Inpatient Services	Therapeutic leave days limited to 90 days per year	No ph: 877-743-8731	Beneficiaries must be deemed eligible by MS Division of Medicaid to receive these services
Inpatient Psychiatric Services	Limited to beneficiaries younger than 21	Yes ph: 877-743-8731	
Physician Psychiatry Services		Yes for some services. Refer to this manual. ph: 877-743-8731	
Psychiatric Residential Treatment Facilities (PRTF)		Yes Benefits provided through Division of Medicaid.	Services are not administered by UnitedHealthcare Community Plan, although member is entitled to all Medicaid benefits. Case management resources are provided through UnitedHealthcare Community Plan ph: 877-743-8731
Psychological Evaluation and Testing by Licensed Psychologist		Yes for some services. Refer to this manual. ph: 877-743-8731	
Therapeutic and Evaluative Mental Health Services for Children		Yes for some services. Refer to this manual. ph: 877-743-8731	

Prior Authorization is initiated by the care provider performing the requested services
† EPSDT Services can only be performed by a care provider certified by the MS Division of Medicaid.
Services include:

- a comprehensive unclothed physical exam
- comprehensive family/medical/developmental history
- immunization status, any shots that are needed
- lead assessment and testing
- necessary blood and urine screening
- tuberculosis (TB) skin test
- developmental assessment
- nutritional assessment/counseling
- adolescent counseling
- vision testing/screening
- hearing testing/screening
- dental referral services

Benefit Exclusions
• Items or services furnished gratuitously, without regard to the individual's ability to pay and without expectation of payment from any source, such as free X-rays provided by a health department.
• Any operative procedure, or any portion of a procedure, performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.
• Routine physical examinations, such as school, sports, or employment physicals that are not part of the well-child screening program for beneficiaries younger than 21 years or are not covered.
• Services of physical therapist or speech therapist are not covered for Medicaid beneficiaries 21 or older, except when provided as an outpatient hospital service, or as a nursing facility service. Therapy services are not covered in a nursing facility when performed by a home health agency.
• Prosthetic and orthotic devices, and orthopedic shoes for beneficiaries 21 or older, except for crossover claims allowed by Medicare.
• Vitamin injections, except for B-12 as specific therapy for conditions determined to be medically necessary and specifically covered by Medicaid.
• Prescription vitamins and mineral products are excluded except for prenatal vitamins and folic acid for obstetrical patients. (Medically necessary nutritional supplements may be covered and are subject to inclusion criteria. See prior authorization requirements to determine medical necessity.)
• Routine circumcisions for newborn infants.
• Interest on late pay claims.
• Physician assistants prior to July 1, 2001.
• Freestanding substance abuse rehabilitation centers and psychiatric facilities for beneficiaries 21 or older.
• Reimbursement for services provided to only Qualified Medicare Beneficiaries (QMB) except for Medicare/Medicaid crossover payments of Medicare deductibles and coinsurance.
• Medicare deductibles and coinsurance will not be paid for QMBs in non-Medicaid eligible facilities.
• Reimbursement for any Medicaid service for Specified Low-income Medicare Beneficiaries (SLMB) and Qualified Individuals (QI). These individuals are entitled only to payment or partial payment of their Medicare Part B premium.
• Ambulance transport to and from dialysis treatment.
• Reversal of sterilization, artificial or intrauterine insemination and in vitro fertilization.

Benefit Exclusions
• Services, procedures, supplies or drugs which are still in clinical trials and/or investigative or experimental in nature.
• Routine foot care in the absence of systemic conditions.
• Gastric surgery (any technique or procedure) for the treatment of obesity or weight control, regardless of medical necessity.
• Telephone contacts/consultations and missed or cancelled appointments.
• Wigs.
• Services ordered, prescribed, administered, supplied or provided by an individual or entity that has been excluded by DHHS.
• Services ordered, prescribed, administered, supplied or provided by an individual or entity that is no longer licensed by their governing board.
• Services outside the scope and/or authority of a practitioner's specialty and/or area of practice.
• Services not specifically listed or defined by Medicaid are not covered.
• Any exclusion listed elsewhere in the Mississippi Medicaid Provider Policy Manual, bulletins, or other Mississippi Medicaid publications. This includes: – Drugs that are investigational or approved for investigational purposes, – Drugs used for off-label indications not found in official CMS-approved compendia or generally accepted in peer-reviewed literature
Acronyms
MH - Mental Health
MS - Medical Services
NET - Non-Emergency Transportation

MississippiCAN Services

NurseLine℠ Services

Helping our members to make confident health care decisions.

Coping with health concerns can be time-consuming and complex. With so many choices, it can be hard to know where to look for trusted information and support.

That's why NurseLine services were developed — to give our members peace of mind with:

- Immediate answers to health questions any time, from anywhere — 24 hours a day at 877-370-4009 Health Information Library Pin Number: 466;
- Access to caring registered nurses who have an average of 15 years clinical experience; and
- Trusted, care provider-approved information to guide health care decisions.

When a member calls, a caring nurse can help our members to:

Choose appropriate medical care.

- Understand a wide range of symptoms;
- Determine if the emergency room, a doctor visit or self-care is right for their needs;

Find a doctor or hospital.

- Find doctors or hospitals that meet their needs and preferences;
- Locate an urgent care center and other health resources.

Understand treatment options.

- Learn more about a diagnosis;
- Explore the risks, benefits and possible outcomes of treatment options;

Achieve a healthful lifestyle.

- Get tips on how nutrition and exercise can help the member maintain a healthful weight.
- Learn about important health screenings and immunizations;

Ask medication questions.

- Learn how to take medication safely and avoid interactions.

Members can call a NurseLine nurse any time for health information and support — all at no cost — at 877-370-4009. Health Information Library Pin Number: 466.

Online Resources

Members also have access to a wealth of information online. Members can visit **UHCCommunityPlan.com** for health and well-being news, tools, resources and more. Members can even chat with a nurse any time about health questions or concerns.

Pharmacy Services

The following drugs and medical supplies are covered:

(a) Legend drugs (federal law requires these drugs be dispensed by prescription only). These drugs are manufactured by companies who have a signed drug rebate agreement. The Division of Medicaid and its contractors are not required to cover prescription drugs from manufacturers that do not participate in the federal drug rebate program;

(b) Compounded medication of which at least one ingredient is a legend drug;

(c) Disposable blood glucose testing agents;

(d) Disposable insulin needles/syringes;

(e) Growth hormones;

(f) Insulin;

(g) Lancets;

(h) Legend contraceptives;

(i) Retin-A (tretinoin topical);

(j) Smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms (e.g., Nicorette, NicoDerm).

The following are excluded:

(a) Anabolic steroids (e.g., Winstrol, Durabolin);

(b) Anorectics (any drug used for the purpose of weight loss) with the exception of Dexadrine and Adderall for Attention Deficit Disorder;

(c) Anti-wrinkle agents (e.g., Renova);

(d) Charges for the administration or injection of any drug;

(e) Dietary supplements;

(f) Infertility medications (e.g., Clomid, Metrodin, Pergonal, Profasi);

(g) Minerals (e.g., Potaba);

(h) Medications for the treatment of alopecia, e.g. (Rogaine);

(i) Non-legend drugs other than those listed as covered;

(j) Pigmenting/de-pigmenting agents;

(k) Drugs used for cosmetic purposes;

(l) Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed as covered, such as insulin needles and syringes;

(m) Any medication not proven effective in general medical practice;

(n) Investigative drugs and drugs used other than for the FDA-approved diagnosis;

(o) Drugs that do not require a written prescription;

(p) Certain prescription drugs if an equivalent product is available over the counter. This exclusion does not apply to drugs on the Medicaid preferred drug list; and

(q) Refills in excess of the number specified by the practitioner or any refills dispensed more than one year after the date of practitioner's original prescription.

Pharmacy Prior Authorization

Medications can be dispensed as an emergency 72-hour supply when drug therapy must start without delay and prior authorization is not available. The rules apply to non-preferred drugs on the PDL and to any drug that is affected by a clinical prior authorization edit.

To request pharmacy prior authorization, please call the OptumRx Pharmacy HelpDesk at 800-310-6826 or fax your authorization request to 866-940-7328.

Prior authorization requests are reviewed and notification is sent back within 24 hours.

Prescription Limitations

All Medicaid beneficiaries are limited to five prescriptions per month with no more than two being brand-name drugs, including refills.

Children younger than 21 can receive more than the monthly prescription limits with a medical necessity prior authorization. Requests for these exceptions should be made either in writing by the prescriber and faxed to 866-940-7328, or called into UnitedHealthcare Community Plan's Pharmacy Prior Authorization Services at 800-310-6826. A prior authorization request form is available at **UHCCommunityPlan.com** and should be used for all prior authorization requests if possible.

Pharmacy - Preferred Drug List (PDL)

The Division of Medicaid (DOM) determines and maintains its Universal Preferred Drug List (PDL). This list applies to all MississippiCAN beneficiaries.

For Medicaid beneficiaries, you are required to prescribe preferred drugs listed on the Universal PDL. For drugs not listed on the Universal PDL, Mississippi law requires the DOM not reimburse for a brand-name drug if an

equally effective generic equivalent is available and is the least costly. The same applies to UnitedHealthcare MississippiCAN members. If a non-preferred medication is required for a member's treatment, call the Pharmacy Prior Authorization Service at 800-310-6826, or fax a Pharmacy Prior Notification Request form to 866-940-7328 to make the request. The request will be promptly reviewed. You will be notified of the decision.

PDL information, including updates of when changes occur, will be provided to you in advance, and a summary of changes posted to the plan's website. The PDL and Pharmacy Prior Notification Request form can be found on the plan's website at **UHCCommunityPlan.com**. To obtain a print copy of the PDL, contact the Provider Service Center.

Dental

1. Benefits are provided for preventive and diagnostic dental care as recommended by the American Academy of Pediatric Dentistry (AAPD). The following Covered Dental Services are limited to $2,500 per fiscal year maximum (July 1-June 30):

   a. Bitewing X-rays as needed but no more frequently than one per fiscal year (July 1-June 30);

   (b. Complete mouth X-ray and panoramic X-ray – as needed, but no more frequently than once every 24 months;

   c. Prophylaxis- two times every fiscal year (July 1-June 30) and must be at least five months apart;

   d. Fluoride Treatment – two times every fiscal year (July 1-June 30) and must be at least five months apart;

   e. Space Maintainers – limited to permanent teeth through age 20;

   f. Sealants – covered through age 20 for permanent first and second and pre-molars, one per every five years. Sealants on primary teeth with prior authorization.

2. Benefits are also provided for restorative, endodontic, periodontic and surgical dental services as indicated:

   a. Amalgam, composite, sedative, and composite resin fillings including the replacement of an existing restoration;

   b. Stainless steel crowns on posterior and anterior primary teeth when amalgam and composite restoration are insufficient;

   c. Porcelain crowns to anterior teeth only;

   d. Simple and surgical extraction;

   e. Extraction of symptomatic impacted teeth;

   f. Pulpotomy, pulpectomy and root canal;

   g. Gingivectomy, gingivoplasty and gingival curettage, periodontal scaling and root planing once per quadrant per fiscal year.

3. Orthodontic Treatment - Orthodontic services are restricted to Medicaid-eligible beneficiaries younger than 21.

   UnitedHealthcare Community Plan will consider orthodontic authorization requests for beneficiaries through age 20 who meet at least one of the following pre- qualifying criteria:

   - Cleft lip, cleft palate and other craniofacial anomalies;
   - Overjet of 9 millimeters or more;
   - Reverse overjet of 2 millimeters or more;
   - Extensive hypodontia with restorative implications (more than one tooth per quadrant) requiring pre-prosthetic orthodontics;
   - Anterior openbites greater than 4 millimeters;
   - Upper anterior contact point displacement with greater than four millimeters;

- Individual anterior tooth cross bites with greater than a 2-millimeter discrepancy between retruded contact position and intercuspal position. For all orthodontic services, the member must complete the course of treatment by their 21st birthday. Approved cases subject to a lifetime maximum for orthodontic services of $4,200.

Adults age 21 and older have emergency dental benefits, some limitations and prior authorizations apply.

Prior Authorization

Prior authorization or other limitations may apply for some dental services such as crowns, periodontal or specific oral surgery procedures, and orthodontic treatment. Please contact Dental Provider Services for specific information at 800-508-4862.

Vision

Routine vision, which includes a comprehensive eye exam and glasses or contacts, is provided through our third-party vendor, MARCH® Vision Care. Additionally, the March® Vision network of ODs and MDs provide primary eyecare services. The vision plan provides supplemental coverage for non-surgical medical eyecare through a March® Vision doctor. Examples of services covered include diagnosis and tests for loss of vision, treatment for conditions such as conjunctivitis (pink eye), and management of glaucoma and diabetic retinopathy. March® Vision doctors may provide services, if covered, up to the optometry scope of licensure in the state of Mississippi in accordance with the covered benefits.

Patients do not need a referral before the initial visit with their selected March® Vision doctor. Patients may call for an appointment or be seen immediately if you determine urgent care is necessary.

Call March® Vision at 844-606-2724 or visit MarchVisionCare.com.

Medical eyecare beyond the scope of primary eyecare services, to include surgical care, is provided through UnitedHealthcare Community Plan's contracted ophthalmologists as listed in the UnitedHealthcare Community Plan Provider Directory. If medical eyecare is needed, please refer patients to a participating ophthalmologist.

Benefit	Limitation	Prior Auth	Contact for Prior Auth
Eyecare (Eye exams and glasses)	Children – two eye exams per fiscal year, one pair eyeglasses per fiscal year, plus one additional pair eyeglasses covered under repair/ replacement coverage per fiscal year Adults – one eye exam per fiscal year, one pair eyeglasses every three fiscal years	Yes, for children after first pair per fiscal year	Member's selected March® Vision Provider or March® Vision directly by calling 844-606-2724

Behavioral Health

Members have statewide access for outpatient behavioral health services. Out-of-state behavioral health services are limited to specific emergency services. For information on referring patients for behavioral health services, call 866-673-6315. Members should also be referred to this number for assistance in finding a behavioral health care provider.

1. Inpatient behavioral health services, other than services described under substance abuse services, but including services furnished in a state-operated behavioral health hospital and including residential or other 24-hour therapeutically planned structural services.

   a. Benefits for covered medical expenses are paid for medically necessary inpatient psychiatric treatment of an enrolled child.

b. Benefits for covered medical expenses are provided for partial hospitalization.

c. Certification of medical necessity by the Utilization Management (UM) program is required for admissions to a hospital.

d. Benefits for behavioral health/nervous conditions do not include services where the primary diagnosis is substance abuse.

Substance Abuse

Inpatient substance abuse treatment services and residential substance abuse treatment services:

a. Benefits for covered medical expenses are provided for the treatment of substance abuse, whether for alcohol abuse, drug abuse or a combination of alcohol and drug abuse.

b. Benefits for covered medical expenses are provided for medically necessary inpatient stabilization and residential substance abuse treatment.

c. Certification of medically necessity by the health plan's UM program is required for admissions to a hospital or residential treatment center.

Medical Management

Referral Guidelines

You are generally responsible for initiating and coordinating referrals of members for medically necessary services beyond the scope of your practice. You are expected to monitor the progress of referred members' care and help ensure that members are returned to their care as soon as medically appropriate. We require prior authorization of all out-of-network referrals. The request is generally processed like any other authorization request. The nurse reviews the request for medical necessity and/or service. If the case does not meet criteria, the nurse routes the case to the medical director for review and determination. Out-of-network referrals are generally approved for, but not limited, to the following circumstances:

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

Only in-network care providers may initiate prior authorizations. Authorization for out-of-network services should be initiated by the in-network PCP or specialist. Through the provider portal, the in-network provider should appropriately indicate the care provider who is performing the service.

Out-of-network referrals are monitored on an individual basis and trends related to individual care provider or geographical locations are reported to Network Provider Services to assess root causes or action planning.

Emergency Care

Prior authorization is not required for emergency services. Emergency care should be rendered at once, with notification of any admission to:

866-604-3267 (Phone)
888-310-6858 (Fax)

Admission to inpatient starts at the time the order is written by a care provider that a member's condition has been determined to meet an acute inpatient level of stay.

Inpatient admissions resulting from emergency services require notification to UnitedHealthcare Community Plan within 24 hours from admission.

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 us. Emergency services (i.e., physician and outpatient services furnished by a qualified care provider necessary to treat an emergency medical condition) are covered both within and outside UnitedHealthcare Community Plan's service area.

An emergency medical condition is defined as a medical condition, that 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);
- Serious impairment to such person's bodily functions; or

Additionally, in accordance with the provisions of 42 C.F.R. § 422.133-c, post-stabilization services are covered and provided without the need of prior authorization if the services are medically necessary and resulting from the emergency medical condition.

Medicaid ID Requirement

You must be enrolled in Mississippi Medicaid and have a state provider Medicaid ID to be reimbursed for services provided to a MississippiCAN member.

An enhanced claim denial edit helps ensure that no payments are made to care providers without a

Mississippi Medicaid ID on file. If your claims have denied due to missing Medicaid ID, and you have a current Mississippi Medicaid ID, please contact Provider Services hotline at 877-743-8734. We can update your records and adjust affected claims.

If you do not have a current Mississippi Medicaid ID, a provider enrollment application can be found at: **ms-medicaid.com/msenvision**.

Prior Authorization

Determination of Medical Necessity

UnitedHealthcare Community Plan uses nationally recognized, evidence-based criteria to guide our medical necessity decisions. These criteria are taken from comprehensive medical research and serve as the basis of policies that guide length-of-stay goals, best practices, clinical indications, and key milestones, all aimed at the best best possible treatment and recovery goals.

UnitedHealthcare Community Plan evaluates medical necessity according to the following standards:

Medically necessary services are services, supplies or equipment provided by a licensed health care professional that are:

- Appropriate and consistent with the diagnosis or treatment of the member's condition, illness, or injury;
- In accordance with the standards of good medical practice consistent with the individual member's condition(s);
- Not primarily for the personal comfort or convenience of the member, family or care provider;
- The most appropriate services, supplies, equipment or levels of care that can be safely and efficiently provided to the member;
- Furnished in a setting appropriate to the member's medical need and condition and, when applied to the care of an inpatient, further mean that the member's medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient;
- Not experimental or investigational or for research or education;
- Provided by an appropriately licensed practitioner; and
- Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

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. In the case of pediatric members, the only limitation on services is that they are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an EPSDT screen, periodic or interperiodic, whether or not such services are covered or exceed the benefit limits under Mississippi Medicaid. All services determined to be medically necessary must be covered.

Our UM team is available Monday through Friday, 8 a.m. to 5 p.m. to answer any UM or prior authorization questions. The team can be reached by calling 877-743-8731. Assistance is also available after hours.

Find medical policies and coverage determination guidelines at **UHCCommunityPlan.com** > For Health Care Professionals > Select Your State > Provider Information > UnitedHealthcare Community Plan Medical Policies and Coverage Determination Guidelines.

To provide a streamlined, simplified experience for you, UnitedHealthcare Community Plan medical policies have been aligned with the rest of UnitedHealthcare's medical policies and procedures.

Services not covered under the plan as described in the medical policies will be denied as unproven, experimental in nature, cosmetic or not medically necessary. The member must be held harmless in accordance with the terms of your provider agreement.

Clinical criteria are available in writing upon request to:

UnitedHealthcare of Mississippi Medical Director
795 Woodlands Parkway Suite 301
Ridgeland, MS 39157

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

UnitedHealthcare Community Plan will make routine prior approval decisions and give notice within three calendar days and/or two business days. Emergency prior approval decisions will be given within 24 hours after receiving the emergency prior approval request.

Disease Management

UnitedHealthcare Community Plan Disease Management (DM) programs are part of our innovative Care Management Program. Our DM program is guided by the principles of the UnitedHealthcare Community Plan 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.

Member Identification

The Health Risk Assessment (HRA) and our predictive modeling and stratification system are the primary tools for identifying members for DM programs.

Health Risk Assessment

The HRA 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 questions, the tool will assign a score that corresponds to a level. These levels are as follows:

- Level 1: Low-risk members who are typically healthy, stable or only have one medical condition that is well managed.
- Level 2: Moderate-risk members who may have a severe single condition, multiple conditions issues across multiple domains of care of DM.
- Level 3: High-risk members who are medically fragile, have multiple co-morbidities and need complex care management.

Outreach and Other Identification Processes

While HRAs and retrospective data are the first line of identification of new members in our DM programs, we have developed an extensive outreach program that supports real-time identification and referral for our DM services. Through community partnerships and relationships, our staff encourages and educates you, ER staff, and hospital discharge planners to refer program members for a greater intensity and frequency of DM interventions when the situation requires it.

DM Interventions

After a member has been identified, the care manager contacts the member or the member's parent or caregiver by phone and sends program and health education materials targeted to the member's specific care opportunities. The accompanying letter informs the member or member's parent or caregiver on how to use the DM services, how the member became eligible to participate in the program and how to opt out if they do not wish to participate.

Because our DM program provides 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 DM program. We employ a number of strategies to locate and contact the member or member's parents or caregivers, including after-hours calls, searching for updated member information by

contacting the primary care provider (PCP)/specialist office and reviewing prior authorization information, and sending written correspondence. We document and track contacts to help ensure that all options have been exhausted prior to reporting failure to contact.

Once a member agrees to enroll in the DM program, the care manager performs a comprehensive health risk and needs assessment that identifies additional risk factors, current and past medical history, personal behaviors, family history, social history and environmental risk factors. This information uses, augments, and validates members' risk stratification. We also institute disease-specific assessments to augment the HRA when the member is contacted.

We have developed evidence-based interventions for our DM program. The following general interventions have been structured to improve members' health status.

- Health risk assessment;
- Health review phone calls;
- Provide assigned care manager's phone number to the member/family;
- Ongoing monitoring of claims and other tools to re-assess risk and needs;
- Access to program website;
- Episodic educational interventions, as needed;
- Post-hospitalization and emergency room assessment;
- Educational materials are sent to member;
- Letter is sent to you identifying the member's involvement, intervention and point of contact for the DM program; and
- Additional and/or specific interventions are also conducted to individualize the plan of care.

Plan of Care

All of our DM programs are part of the Personal Care Model™, our overall care management program, in which we pioneered a member-centric approach to the development of the plan of care for program participants. Our unique Personal Care Model™ features direct member, parent and caregiver contact by clinical staff who work to build a support network for high-risk chronically and acutely ill members involving family, you, and community-based organizations. The goal is to employ practical solutions to improve members' health and keep them in their communities with the resources they need to maintain the highest possible functional status.

The plan's implementation goals are two-fold: 1) Care manager interventions support self-management/self-efficacy and patient education; and 2) Care manager interventions are defined to help ensure appropriate medical care referrals and assure appointments are kept, immunizations are received, and the member is connected with available and appropriate community support groups (e.g., nutrition programs or caregiver support services). When the plan of care is implemented, our goals are:

- To assure the member is leveraging personal, family, and community strengths when able;
- To help ensure that we are using evidence-based guidelines and best practices for education and self-management information while integrating interventions to address co-morbidities;
- To modify our approach or services based on the feedback from the member, family, and other health care team members;

- To document services and outcomes in a way that can be captured and modified to continually improve;
- To communicate effectively with the PCP/specialist and other care providers involved in the member's care; and
- To monitor member satisfaction with services, adjusting as needed.

The care manager develops and implements an individualized plan of care for members requiring services, reviews the member's progress and adjusts the plan of care as necessary. This helps ensure the member continues to receive an appropriate level of care. The care manager will involve you in the plan of care development process and assist you in directing the course of treatment in accordance with the evidence-based clinical guidelines that support our DM program. The plan of care addresses the following areas of care:

- Psychosocial adjustment;
- Nutrition;
- Complications;
- Pulmonary/cardiac rehab;
- Medication;
- Prevention;
- Self-monitoring, symptoms and vital signs;
- Emergency management/co-morbid condition action plan; and
- Appropriate health care utilization.

Pharmacy

Our pharmacy disease management is integrated with our other DM programs into our Care Management Program. Like the other DM program, it is based on our Personal Care Model (PCM), which emphasizes the whole individual, including environment, background and culture.

With the exceptions of the asthma component pharmacy disease management services, UnitedHealthcare Community Plan provides pharmacy disease management through OptumRx, our pharmacy benefit manager, and a UnitedHealth 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.

We also integrate pharmacy disease management for asthma into our regular asthma disease management program.

Our DM program is supported by our integrated clinical system. It includes basic and comprehensive supplemental assessments, facilitates the development of integrated care plans, and includes ongoing monitoring and evaluation tools.

Drug Utilization Review Programs

UnitedHealthcare Community Plan offers the following Drug Utilization Review (DUR) programs, including:

- Narcotic Drug Utilization Review
- Drug Interaction Alert
- Polypharmacy
- Geriatric RxMonitor
- Dose-Duration
- Drug-Age
- Asthma
- Poly Drug-Disease

In addition, we follow recommendations or actions approved by Medicaid's Drug Utilization Review Board.

Coordination of Care

Each member must select a PCP medical home for community-based health and preventive services. You will receive reports regarding the health status of members participating in specific DM programs. As this link is established, we involve you 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 you on an ongoing basis to help ensure integration of physical and behavioral health issues. In addition, the care manager will help ensure the plan of care supports the member's/caregiver's preferences for psychosocial, educational, therapeutic and other non- medical services. The care manager helps ensure the plan of care supports your 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:

- Works to identify and understand the member's barriers to success.
- Problem solves for alternative solutions with the member.
- Reports non-compliance to the treating care provider/specialist, offer potential solutions and integrate your feedback.
- Facilitates agreement for change between all parties and monitor progress of the change.

As the member's medical home, you are continuously updated on the member's participation in the DM program(s), the member's compliance with the plan of care, and any unscheduled hospital admissions and emergency room visits. You receive notifications of when members are enrolled and disenrolled from the DM programs, the assigned care manager for the DM program, and how to contact the care manager. In addition, you receive notification of members who have generated care opportunities related to specific DM programs. These evidence-based medical guidelines are generated from our multi-dimensional, episode-based predictive modeling tool.

We also distribute clinical practice guidelines upon your request and provide training for you and your staff on how best to integrate practice guidelines into everyday practice. When you demonstrate a pattern of non-compliance with clinical practice guidelines, the medical director may contact you by phone or in person to review the guideline and identify any barriers that can be resolved.

Case Management

We use retrospective and prospective methods to help ensure potential high-risk members are identified as early as possible. To identify members who meet criteria for disease and care management, we continuously forecast risk through predictive modeling of our claims data. To supplement our retrospective, claims-based approach, we perform an automated, mini health risk assessment. In addition, we also review authorization requests, hospital and ER use, pharmacy data and referrals from you, members and their family/caregivers as well as our clinical staff. Individuals identified for possible care management go through a more in-depth, scored comprehensive assessment and are routed to the appropriate DM or CM program based on the outcome of that scoring.

Prospective Identification—UnitedHealthcare Community Plan uses numerous data sources to identify members with a diagnosis for which we have a DM program as well as those whose utilization reflects high-risk and/or complex conditions (level 3). These data sources include but are not limited to:

- Short health risk assessments conducted during new member welcome calls.
- Member reported health needs in calls made to our Member Services Department.
- Pharmacy and lab data indicating the incidence of a specific condition (e.g., insulin or inhalers).
- Emergency room utilization reports, authorization requests and transitional care coordination requests.
- Physician referrals.
- Referrals from health departments, rural health clinics and FQHCs.

- UnitedHealthcare Community Plan clinical staff referrals.

Risk Stratification — All identified members complete a health risk assessment that scores them into risk categories. Based on the actionable population and aid categories of each health plan and state program, we determine the specific threshold for each case and disease management level. As previously mentioned, members are stratified into one of three levels and are assigned to the appropriately qualified staff.

Transition of Care

Newly enrolled members may continue to see the same care providers for ongoing treatment for up to 90 calendars day, or until the member is transferred to a network care provider, whichever comes first.

During the first 30 days of enrollment, a new prior authorization is not required for medically necessary covered services. This includes such services rendered by out-of-network care providers. To help ensure timely processing of claims, out-of-network care providers should contact us for administrative approval for those dates of service. To expedite administrative approval, please identify yourself as an out-of-network care provider.

If a claim denial for services is provided within the first 30 days of member eligibility, you will need to submit a Claim Reconsideration Request. To expedite approval for this request, include any treatment authorizations received prior to the member transitioning to UnitedHealthcare Community Plan.

After the initial 30 days with us, medical necessity review may be required. Review our prior authorization requirements and seek prior approval through our standard procedures as needed.

Clinical Practice Guidelines

Nationally recognized, evidence-based clinical criteria and guidelines are integrated into UnitedHealthcare Community Plan's 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.

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

For pharmacy DM, use of guidelines helps to help ensure appropriate use at the initiation of therapy. OptumRx implements and manages a preferred product listing, which lends itself to standardization, consistency and cost savings. In addition, they offer a case review process, which includes clinical pharmacist review of the clinical progress of the patient, any pertinent labs, and patient compliance to evaluate continuation of a medication.

UnitedHealthcare Community Plan adopts clinical practice guidelines as the clinical basis for the DM programs. Clinical guidelines are systematically developed, evidence-based statements that help you make decisions about appropriate health care for specific clinical circumstances. We adopt clinical guidelines from recognized sources. These guidelines can be found at **UHCCommunityPlan.com**.

Concurrent Review

Your cooperation is required with all 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 our 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 24 hours of receipt of our request and provide requested information within the same business day. We will provide a concurrent review decision within 24 hours of receipt on requested documentation.

UnitedHealthcare Community Plan uses CMS recommendations, and 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. UnitedHealthcare Community Plan maintains a timely and organized process using established policies and procedures to help ensure prompt resolution of informal and formal complaints/grievances filed by members and you. Our system includes member and care provider appeals processes and a care provider payment dispute process. UnitedHealthcare Community Plan has a specialized grievance and appeal department. We allocate qualified and trained personnel to establish, implement and maintain this process. Our grievance and appeals system is HIPAA compliant and conforms to applicable federal and state laws, regulations and policies.

Retrospective Review

A retrospective review is conducted after services are provided to a member. We perform these reviews for retroeligibility or for extenuating circumstances related to the member: (1) the member is unconscious upon presentation, and the care provider has not previously submitted a claim for the member; or (2) acts of nature impairing the facility's ability to verify a member's coverage/eligibility status. The request for retrospective review must include a reason and be submitted within 60 days of the service date. Not providing a reason for the retrospective review request will result in a denial.

For a retrospective review request:

- Call 866-604-3267, Monday-Friday, 8 a.m. – 5 p.m. Central Time. Emergency calls are accepted after hours.
- Fax: 888-310-6858

We do not conduct retrospective reviews for:

- Elective ambulatory or inpatient services on the UnitedHealthcare Community Plan advance notification list, found at **UHCCommunityPlan.com/health-professionals/ms.html**, for which prior approval did not occur before providing the services
- Emergency inpatient services on the advance notification list that did not meet notification requirements (Notification of inpatient admission is required within one business day of the admission date.)
- Services not requiring prior approval
- Reconsideration and/or review of an adverse benefit determination
- Previously submitted claim

You may request retrospective reviews when you could not determine a member's coverage status. In reasonable incidents, we will not deny payment for medically necessary services for lack of authorization.

For retrospective reviews you launch, we will not deny a claim because you did not file within a specified time period after the date of service when you could not have reasonably known the member's eligibility status during the timely filing period.

Preventive Health Care Standards

Our goal is to partner with you to help ensure members receive preventive care. We endorse and monitor 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 on the website. Education is provided to both members and you related to preventive health services. 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.

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).

Government Quick Reference Guide

Source: CDC and Advisory Committee on Immunization Practices

Cardiology Notification/Prior Authorization Protocol

The UnitedHealthcare Community Plan Cardiology Notification/Prior Authorization protocol is for UnitedHealthcare Community Plans. It applies to all participating care providers, facilities and other health care professionals who perform diagnostic catheterizations electrophysiology implant procedures, echocardiograms, and stress echocardiograms (herein referred to as "cardiac procedures") on our members. Notification/Prior Authorization for diagnostic catheterizations, echocardiograms and stress echocardiograms is required for outpatient and office-based services only. Notification/Prior Authorization for electrophysiology implants is required for outpatient, office-based and inpatient services. Cardiac procedures rendered in and appropriately billed with any of the following places of service do not require notification/prior authorization: emergency room, urgent care center or inpatient setting (except for electrophysiology implants).

Once notification of a cardiac procedure is received, and if the member's benefit plan requires health services to be medically necessary to be covered, we conduct a clinical coverage review to determine whether the service is medically necessary. You do not need to determine whether a clinical coverage review is required in a given case or for a given member because once we receive notification, we let you know whether a clinical coverage review is required pursuant to our prior authorization process.

Compliance with this protocol is required. If the entire following process is not completed before the cardiac procedure is rendered, an administrative claim reimbursement reduction, in part or in whole, occurs.

To see the most current listing of CPT codes for cardiac procedures, please refer to **UHCCommunityPlan.com**

Process for Care Providers

To receive payment for services rendered, prior to performing the stated cardiac procedure, must provide notification by contacting us:

- Online: **UHCCommunityPlan.com** (select Cardiology tab)
- By phone: 866-889-8054

The following information may be requested at the time notification is provided:

Member/procedure information

- Member's name and member's health care ID number
- Member's address and phone number
- Member's group number
- Member's date of birth.
- The examination(s) or type of service(s) being requested, with the CPT code(s).
- The primary diagnosis or "rule out" with the ICD-10-CM (or its successor) code(s).

Care Provider information

- Ordering care provider's name, TIN/NPI, specialty, address, and phone number.
- Care provider to whom the member is being referred, if specified, address and phone number.
- Rendering care provider's name and TIN/NPI.

Clinical information

- The member's clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.
- Dates of prior imaging studies performed.
- Any other information the ordering care provider

believes would be useful in evaluating whether the service ordered meets current evidence- based clinical guidelines, such as prior diagnostic tests and consultation reports.

Once we receive the planned cardiac procedure notification, if the member's benefit plan requires health services to be medically necessary to be covered, we conduct a clinical coverage review to determine whether the service is medically necessary pursuant to our prior authorization process. A prior authorization number is issued to the ordering care provider, if the service is medically necessary. A clinical denial is issued, and a prior authorization number is not issued, if it is determined during the prior authorization process or the retrospective review process that the service is not medically necessary.

Once we receive the planned cardiac procedure notification, if the member's benefit plan does not require health services to be medical necessary to be covered, and if the service is consistent with evidence-based clinical guidelines, a notification number is issued to the ordering care provider. If the service is not consistent with evidence-based clinical guidelines, or if additional information is needed to assess the request, we let the ordering care provider know whether they must engage in a physician-to-physician discussion to explain the request, to provide additional clinical information, and to discuss alternative approaches. Upon completion of the discussion, the care provider confirms the procedure ordered and a notification number is issued. If a physician-to-physician is required, that process must be completed to help ensure payment.

You do not need to determine whether a clinical coverage review is required in a given case or for a given member because once we are notified of a planned cardiac procedure we let you know whether a clinical coverage review will be conducted pursuant to the prior authorization process.

The purpose of the physician-to-physician discussion is to facilitate the provision of evidence-based health care through an open dialogue based on evidence-based clinical guidelines.

A notification number is issued to the ordering care provider when the process is completed. The notification number is communicated by phone, online or fax, consistent with how the request was initiated. To help promote proper payment, the notification number must be communicated by the ordering care provider to the rendering care provider scheduled to perform the cardiac procedure.

Subject to state regulation, receipt of a notification number or prior authorization number does not guarantee or authorize payment. Payment for covered services is contingent upon coverage within an individual member's benefit plan, the care provider being eligible for payment, any claim processing requirements, and the care provider's participation agreement with UnitedHealthcare Community Plan.

Standard authorization decisions are communicated within three calendar days and/or two business days following receipt of all clinical information for medically needed services. The standard authorization may be extended up to 14 additional calendar days upon request of the member or the care provider, or if UnitedHealthcare Community Plan justifies to Medicaid a need for additional information and how the extension is in the member's best interest.

Urgent requests during regular business hours
You may request a notification number or prior authorization number on an "urgent" basis if you determine it to be medically required. Urgent requests should be requested by calling 866-889-8054. You must state that the case is clinically urgent and explain the clinical urgency. We respond to urgent requests within three hours of our receipt of all required information. If you feel you cannot wait for a decision in three hours, a notification number or prior authorization number must be requested retrospectively following the retrospective review process.

Urgent requests outside of regular business hours
If you determine care is medically required on an urgent basis and a notification number or prior authorization number cannot be requested because it is outside of our normal business hours, the service may be performed and a notification number or prior authorization number must

be requested retrospectively following the retrospective review process described. You may also call 866-889-8054 and follow the phone prompts provided.

Retrospective Review Process

- Retrospective notification number and prior authorization number requests must be made within 15 calendar days for diagnostic catheterizations and electrophysiology implants, and two business days for echocardiograms and stress echocardiograms after the cardiac procedure is rendered.
- Documentation must include an explanation as to why the procedure was required on an urgent basis and why a notification number or prior authorization number could not have been requested during UnitedHealthcare Community Plan's normal business hours.
- You should follow the same process outlined above for a standard notification or prior authorization number request. If the member's benefit plan requires health services to be medically necessary to be covered, we will conduct a clinical coverage review to determine whether the service is medically necessary. Urgent services rendered without a required prior authorization number are subject to retrospective review for medical necessity, and payment may be withheld if the services are determined not to have been medically necessary. Please note: the member cannot be balance billed for any denied charges under these circumstances. Failure to obtain a notification number or prior authorization number either prospectively or retrospectively will result in administrative denial of the claim(s).

Rendering Care Provider (if different than the Ordering Care Provider)

To be eligible to receive payment for covered services rendered, (a) the rendering care provider must validate with us prior to performing a cardiac procedure that a notification number is on file or, (b) if the member's benefit plan requires that health services be medically necessary to be covered, the rendering care provider must validate with us prior to performing a cardiac procedure that the prior authorization process has been completed and a coverage decision has been issued before rendering the service. This must be done by contacting us as follows:

- Online: **UHCCommunityPlan.com** (select Cardiology tab)
- By phone: 866 889-8054 (select prompt 2 to check status of a notification request).

If the member's benefit plan does not require that services be medically necessary to be covered:

- If a cardiac procedure is rendered and a claim for the service is submitted without a notification number, an administrative claim reimbursement reduction, in part or in whole occurs. The member cannot be billed for the service.
- If the rendering care provider determines there is no notification number on file, and the ordering care provider participates in our network, we use reasonable efforts to work with the rendering care provider to obtain the notification number from the participating ordering care provider prior to the rendering of services.
- If the rendering care provider determines there is no notification number on file, and the ordering

UnitedHealthcare Community Plan maintains a timely and organized process using policies and procedures to help ensure prompt resolution of informal and formal complaints/grievances filed by members and you. Our system includes an appeal process and grievance process for both you and the member. The member has access to a State Fair Hearing process; you have access to an Administrative Hearing. We allocate qualified and trained personnel to establish, implement and maintain this process.

Compliance With State Requirements

Our grievance and appeals system is HIPAA compliant and conforms to applicable federal and state laws,

care provider does not participate in our network, and is unwilling to obtain a notification number, the rendering care provider is required to obtain a notification number. If the rendering care provider does not obtain a notification number for cardiac procedures ordered by a non-participating provider, the rendering care provider's claim is denied administratively, in part or in whole, for failure to provide notification, and the member cannot be billed for the service.

If the member's benefit plan does require services to be medically necessary to be covered:

- If the rendering care provider determines a coverage determination has not been issued, and the ordering care provider participates in our network, we use reasonable efforts to work with the rendering care provider to urge the ordering care provider to complete the prior authorization process and care obtain a coverage decision prior to the rendering of services.
- If the rendering care provider determines a coverage determination has not been issued, and the ordering care provider does not participate in our network, and is unwilling to complete the prior authorization process, the rendering care provider is required to complete the prior authorization process and verify that a coverage decision has been issued prior to rendering the service. If the rendering care provider provides the service before a coverage decision is issued, the rendering care provider's claim is denied administratively, in part or in whole, and the member cannot be billed for the service.

Cardiology Crosswalk Table

Under the CPT Code Crosswalk Table, for certain specified CPT code combinations, care providers are not required to follow the Commercial Cardiology Prior Authorization protocol to modify the existing prior authorization record. A complete listing of applicable CPT code combinations is available at **UHCCommunityPlan.com** (select Cardiology tab). However, for code combinations not listed on the CPT Code Crosswalk Table, care providers must follow the Cardiology Prior Authorization protocol process set forth above for additional procedures.

For information on the Radiology Prior Authorization program, go to **UHCCommunityPlan.com**.

Outpatient Injectable Chemotherapy Prior Authorization Program

Prior authorization is required for outpatient injectable chemotherapy drugs given for a cancer diagnosis.

Appeals and Grievances

UnitedHealthcare Community Plan maintains a timely and organized process using policies and procedures to help ensure prompt resolution of informal and formal complaints/grievances filed by members and you. Our system includes an appeal process and grievance process for both you and the member. The member has access to a State Fair Hearing process; you have access to an Administrative Hearing. We allocate qualified and trained personnel to establish, implement and maintain this process.

Compliance With State Requirements

Our grievance and appeals system is HIPAA compliant and conforms to applicable federal and state laws, regulations and policies.

Member and Care Provider Notification: Upon enrollment, we inform members and you of our complaint/grievance and appeals procedures.

Information includes:

- The right to file grievances, appeals and claim disputes.
- The requirements and time frames for filing grievances, appeals and claim disputes.
- The availability of assistance for informal/formal grievance filing and process.
- That members may use a personal representative during the grievance process.
- You may request a copy of the clinical criteria from: P.O. Box 5032, Kingston, NY 12402-5032.
- Toll-free numbers to file a grievance or appeal by phone.
- Notice of grievance rights each time a covered service is denied, reduced or terminated.
- Notice of the right to appeal.
- Notification of the member's right to appeal the decision through a State Fair Hearing
- Administrative hearing
- The method for obtaining a hearing.
- The rules that govern representation at the hearing.
- Notice that, when timely filed, member-requested benefits continue during appeal/Administrative Hearing
- Notice that, if the final decision is adverse to the member, the member may be liable for the cost of any continued benefits.
- During the appeal/hearing process, the member and his/ her representative will have the opportunity to examine the member's case files, including any medical records and any other records considered during the appeals process.

We inform members of their right to file complaints/ grievances in the UnitedHealthcare Community Plan Member Handbook, new member welcome packet, and online through the UnitedHealthcare website. We inform members of the grievance process in prevalent non-English languages, through oral interpretation in any language and TTY/TTD services. We provide members with our member Grievance Policy and Appeal form, if requested, and assistance with filing grievances. Members may file a grievance either verbally or in writing. We inform you of the grievance and appeal process through the UnitedHealthcare Community Plan care provider manual and provider website. Grievance and Appeal Policies are given to you at the time of contract. If significant change is warranted in information and policy materials, written notification is provided at least 30 days before the intended effective date.

Notice of Adverse Action:
UnitedHealthcare Community Plan notifies the requesting care provider and provides written notice to members of adverse actions. An "action" includes: (a) denial or limited authorization of a requested service; (b) reduction, suspension or termination of a previously authorized service; (c) denial in whole or part of payment for a service (except where a care provider's claim is denied for technical reasons such as prior authorization rules, referral rules, late filing, invalid codes, etc.); (d) failure by us to render a decision within required time frames; and (e) denial of a member's request to exercise his or her rights under federal law to obtain services outside the network. The written notice explains the adverse action

taken; the member's right to file an appeal with us and to request a State Fair Hearing procedures for exercising appeal rights; and information about requesting expedited resolutions and continuation of benefits pending resolution of an appeal.

UnitedHealthcare Community Plan provides the notice of action within the following time frames:

- For termination, suspension or reduction of previously authorized services, at least three calendar or two business days prior to the effective date of the intended adverse action;
- For expedited requests, no later than 72 hours following receipt of the request; and
- For denial of payment, at the time of the action affecting the claim.
- For standard, non-inpatient, hospital service authorizations, no later than three calendar days or two business days following receipt of all requested information. This may be extended up to 14 additional calendar days if formally requested and the extension is the best interest of the member.

If UnitedHealthcare Community Plan does not make a decision within the applicable time frames (which constitutes a denial), the notice must be issued on the date the time frames expire.

Filing an Appeal:
The member, member's representative acting on behalf of the member, or you may appeal an adverse action within 60 calendar days from receipt of the notice of action. UnitedHealthcare Community Plan accepts appeals in writing or orally. However, oral appeal requests must be confirmed in writing unless the request is for an expedited resolution. The information is routed to the Escalated Tracking System, where a case file is created. An acknowledgment letter is generated in 10 working days for standard appeals.

The member or member's authorized representative has the opportunity before and during the process to examine the case file, including all medical records and any other material considered during the process. UnitedHealthcare Community Plan sends a copy of the file, upon request, to the member or authorized representative at no charge.

UnitedHealthcare Community Plan resolves an appeal and provides written notice of the resolution within 30 days of receipt for a standard appeal. We may extend this time frame by up to 14 calendar days upon request or if we demonstrate the need for more information and that a delay in rendering the decision is in the member's or your best interest. For any extension not requested, UnitedHealthcare Community Plan provides a written notice of the reason for delay.

The member or member's authorized representative will be provided the opportunity before and during the process to examine the case file including all medical records and any other material considered and present evidence of fact or law. A copy of the file, upon request, is sent to the member or their authorized representative free of charge.

The resolution notice includes the decision reached, the date of the decision, and, for appeals not resolved wholly in favor of the member or you, information on the right to request a hearing and how to do so, the right to receive benefits while a hearing is pending and how to make such a request, and an explanation of why the member may be liable for the cost of any continued benefits a hearing upholds our decision.

Expedited Review of Appeals.
UnitedHealthcare Community Plan expedites resolution of an appeal if, according to the information provided by the member or you, the standard resolution time frame could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function. Under these circumstances, we resolve the expedited appeal within 72 hours of initial receipt of the appeal. We may extend the resolution timeline by up to an additional 14 calendar days upon request or if we demonstrate the need for more information and that a delay in rendering the decision is in the member's or your best interest. If the member or you did not request the delay, we provide a written notice of the extension and the reasons for the delay.

UnitedHealthcare Community Plan makes reasonable efforts to give prompt verbal notice of an expedited appeal not resolved wholly in favor of the member or you and follows-up with a written notice of action within two calendar days. The written notice contains the same information as a resolution notice for a standard appeal, as described above (e.g., the right to request an Administrative Hearing if the resolution was not wholly in favor of the member or you).

If the request for an expedited appeal is denied, the appeal is transferred to the 30-day time frame for resolution of standard appeals. We will make reasonable efforts to give prompt oral notice of the decision to deny the request for an expedited appeal and will follow up with a written notice within two calendar days.

Filing an Appeal With DOM/State Fair Hearing Process:
Any adverse action or appeal not resolved wholly in favor of the member may be appealed to DOM for an Administrative Hearing. A member may appeal an action directly to the DOM; after exhausting all appeal rights with us. Appeals to DOM must be requested in writing by the member or the member's representative within 120 calendar days of our final decision.

Continuation of Benefits:
We will continue the member's benefits if all of the following are met:

1. Member or you files a timely appeal of our action (timely filing means within 10 days of our notice of action) or the member asks for a State Fair Hearing within 30 calendar days from the date on our notice of action
2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
3. Authorized care provider ordered services
4. The original authorization has not expired
5. Member requests extension of benefits within 10 days of receiving notice of action

We will provide benefits until one of the following occurs:

1. The member withdraws the appeal
2. 10 calendar days have passed since the date of the notice, provided the resolution of the appeal was against the member and the member has not requested an Administrative Hearing or taken any further action
3. The DOM issues an Administrative Hearing decision adverse to the member
4. The service limits of a previously authorized service has expired

If the final appeal resolution is adverse to the member, we may recover the cost of member services while the appeal was pending, if services were furnished solely because of the requirements of this section. If we or the DOM reverse a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, we will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires. If we or the DOM reverse a decision to deny, limit or delay services and the member received the disputed services while the appeal was pending, we will pay for these services.

Filing a Grievance:
A "grievance" is an expression of dissatisfaction about any matter other than an "action" (as defined above). A member, their authorized representative as designated in writing, or you may file a grievance with us by calling the Call Center toll-free or by mailing a grievance to our Regional Mail Operations (RMO). Telephonic/verbal grievances are routed through the online routing system (ORS), technology that identifies call type and routes to other databases according to category. When the ORS identifies the call as a grievance, the information is logged into the system, and forwarded to a triage team who puts the information into the Escalated Tracking System (ETS), where a case file is created and populated. On receipt of a written grievance, appropriate personnel scan them into the ETS and create a case file. The grievance is logged and tracked by various criteria (e.g., member name/identification number, date received,

acknowledgment, description, staff assigned, disposition, tentative disposition date). We acknowledge receipt of each member grievance no later than 10 working days from initial receipt, grievances received orally may be acknowledged orally. Acknowledgement letters are generated automatically by the ETS Client Letter Tool.

Expedited Grievance Process
Members or their representatives have the right to request an expedited grievance. The member or representative may receive an expedited grievance orally or in writing. All oral requests for expedited grievances must be documented and maintained in case files. For grievances involving clinical issues, a health care professional reviews and investigates the clinical aspect of the grievance.

Expedited grievance requests must be resolved within 72 hours of receipt.

We must inform the member or their representative of the limited time available to present evidence and allegations in fact or law.

Resolving an expedited grievance may be extended by up to 14 calendar days if:

- The member or their representative requests the extension or if we demonstrate to the Medicaid division there is a need for additional information
- The extension is in the member's interest.

For any extension not requested by the member or their representative, we will provide written notice within two business days to the member or representative the reason for the decision to extend the time frame.

Upon resolution of the expedited grievance, we will:

- Make reasonable efforts to provide and document the decision with verbal notice to the member or representative.
- Follow up with a written notice within two calendar days of providing the verbal notification.

If the request does not meet the expedited criteria, we will:

- Transfer the expedited grievance to a standard grievance and follow the standard grievance process for resolution;
- Make reasonable efforts to give the member or their representative:
- Prompt verbal notice of the decision to deny the expedited request due to failure to meet the expedited grievance request criteria.
- Inform the member or their representative the request has been transferred to a standard grievance and advise of the time frame for resolution.
- Follow up with a written notice within two calendar days of providing verbal notification.

No punitive action may be taken against a member who requests an expedited grievance.

Process for Resolving a Grievance:
Our call center receives calls 24 hours a day, seven days a week to address various issues, including grievances. All calls related to grievances are recorded in the ORS. Even though the majority of grievances are resolved during the initial call, we maintain the data. Those not resolved are forwarded to our Grievances and Appeals department on priority and set in queue by First-in-First-Out for our resolving analysts to address. We educate our resolving analysts on complaint and grievance procedures, and member and your rights. On notification of a grievance, our resolving analysts conduct preliminary research and verify the appropriate grievance path.

We respond to all grievances no later than 30 days from the date of our receipt of the grievance. Grievances received orally may be responded to orally and need not be followed up with a written response unless requested.

The time to resolve a grievance may be extended by up to 14 calendar days if:

The member or representative requests the extension or if we demonstrate to the DOM a need for additional information and the extension is in the member's interest.

For any extension not requested by the member or representative, we will provide the member or representative with written notice of the reason for the extension within two working days of the decision.

The grievance response includes the decision reached and a clear explanation of any further rights available to the member or you under our grievance process.

Our review and response times meet HIPAA, federal, state and regulatory compliance.

Summary of Non-Expedited Member and Care Provider Complaints, Grievances and Appeals

Party	Action	Time Frame	Extensions Available
Complaint: An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one business day of receipt. Any complaint not resolved within one business day will be treated as a grievance. A complaint includes, but is not limited to inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information.			
Member or Care Provider	Submit a complaint	Member or authorized representative, within 30 calendar days of the date of the event causing the dissatisfaction. You must also submit the complaint within 30 calendar days of the adverse event.	
UnitedHealthcare Community Plan	Respond to a complaint	Within one calendar day	
Grievance: An expression of dissatisfaction received orally or in writing about any matter or aspect of the UnitedHealthcare Community Plan or its operation, other than a Contractor Action as defined in our contract with the state of Mississippi. A grievance includes, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a care provider or an employee, or failure to respect the members rights.			
Member or Care Provider	File a grievance	Members or authorized representatives may file a grievance any time after the event occurs. You may file within 30 days of the event.	
UnitedHealthcare Community Plan	Confirm receipt of the grievance and expected date of resolution	Within 5 calendar days of receipt of the grievance	
UnitedHealthcare Community Plan	Resolve a grievance	Within 30 calendar days of the date we receive the grievance or as expeditiously as the member's health condition requires	Contractor may extend time frames by up to 14 calendar days

Party	Action	Time Frame	Extensions Available
Appeal: A request for review by UnitedHealthcare Community Plan of a Contractor Action.			
Member or Care Provider	File an appeal	Members or authorized representative may file an appeal within 60 calendar days of the event. You may file within 30 days of the event.	
UnitedHealthcare Community Plan	Confirm receipt of the appeal and expected date of resolution	Within 10 calendar days of receipt of the appeal	
UnitedHealthcare Community Plan	Resolve an appeal	Within 30 calendar days of the date the contractor receives the appeal or as expeditiously as the member's health condition requires Within 72 hours after the contractor receives the request for an Expedited Resolution of an appeal	Contractor may extend time frames by up to 14 calendar days in accordance with 42 C.F.R. § 438.408(c)
Administrative Hearing: A hearing conducted by the DOM or its subcontractor when a member appeals an adverse action not resolved wholly in favor of the care provider or member. Formally, State Fair Hearings are for members. State Administrative Hearings are for care providers.			
Member or Care Provider	File a request for a hearing	Member or authorized representative may file for a hearing within 120 days from the date of the final decision we render. You may file for a hearing within 30 days from the date of the final decision.	
Division of Medicaid	Take final administrative action	Within 90 calendar days from the date the member filed for direct access to an Administrative Hearing	
We will resolve within the outlined time frames or as quickly as the member's health condition requires (shorter of the two). Circumstances that meet criteria for expedited resolution, as outlined in 42 C.F.R. SS 438.410(a), will be treated as such.			

Quality Management

Your Participation in Quality Management

UnitedHealthcare Community Plan has a Quality Management Committee (QMC), chaired by the CEO or designee of the CEO, which meets at least quarterly and has oversight responsibility for issues affecting health services delivery. The QMC is composed of our management staff and reports its recommendations and actions to the UnitedHealthcare Community Plan board of directors. The QMC has three standing sub committees:

- Provider Advisory Committee (PAC) reviews and recommends action on topics concerning credentialing and recredentialing of care providers and facilities, peer review activities, and your performance. Participating care providers give UnitedHealthcare Community Plan advice and expert counsel in medical policy, quality management and quality improvement. A medical director chairs the PAC.
- Health Care Utilization Management Subcommittee reviews statistics on utilization, provides feedback on UM and Case Management policies and procedures. It makes recommendations on clinical standards and protocols for medical care.
- Service Quality Improvement Subcommittee reviews timely tracking, trending and resolution of member administrative complaints and grievances. This subcommittee oversees member and care provider intervention for quality improvement activities as needed.

Quality Improvement Program

The Quality Improvement Program at UnitedHealthcare Community Plan is a comprehensive program under the leadership of the National Quality Oversight Committee (NQOC). A copy of our Quality Improvement Program is available upon request.

The Quality Improvement Program consists of the following components:

- Quality Improvement measures and studies.
- Clinical practice guidelines.
- Health promotion activities.
- Service measures and monitoring.
- Ongoing monitoring of key indicators (e.g., over and underutilization, continuity of care).
- Health plan performance information analysis and auditing (e.g., HEDIS®).
- Care coordination℠.
- Educating members and you.
- Risk management.
- Compliance with all external regulatory agencies.

Your participation is an integral component of our Quality Improvement Program.

As a participating care provider, you have a structured forum for input through representation on our Quality Improvement Committees and through individual feedback through your network account manager. We require your cooperation and compliance to:

- Participate in quality assessment and improvement activities.
- Provide feedback on our Care Coordination℠ guidelines and other aspects of providing quality care based upon community standards and evidence-based medicine.
- Advise us of any concerns or issues related to patient safety.
- Protect the confidentiality of patient information.
- Share information and follow up on other care providers and UnitedHealthcare Community Plan to provide seamless, cohesive care to patients.
- Use the Physician Data Sharing information we provide you to help improve delivery of services to your patients.

Your Satisfaction

On an annual basis, UnitedHealthcare Community Plan conducts ongoing assessments of care provider

satisfaction as part of our continuous quality improvement efforts. Key activities related to the assessment and promotion of satisfaction include:

- Annual care provider satisfaction surveys and Targeted Improvement Plans.
- Regular visits to care providers.
- Care provider town hall meetings.

Objectivity is our utmost concern in the survey process. To this end, we work with Survey Research Solutions and the Center for Study Services (CSS) to conduct our annual care provider satisfaction survey(s). Our surveys are targeted to PCPs and high-volume specialists. CSS draws the survey samples of eligible care providers working within our networks.

Survey results from all UnitedHealthcare health plans are aggregated annually and reported to our National Quality Management Oversight Committee. The results are compared by health plan year over year and also in comparison to other UnitedHealthcare plans across the country. The survey results include key strengths, secondary strengths, key improvement targets and secondary improvement targets.

Credentialing and Recredentialing

We are required to credential each health care professional, prior to the professional providing services to our members.

Care Provider Responsibilities

Immediately notify us, in writing, if your ability to practice medicine is restricted or impaired in any way, if any adverse action is taken, an investigation is initiated by any authorized city, state or federal agency. You will tell us of any new or pending malpractice actions, or of any reduction, restriction or denial of clinical privileges at any affiliated hospital.

Credentialing and Recredentialing Process

Our credentialing process uses standards set forth by nationally recognized applicable accreditation agencies, including primary verification of training/experience and office site visits. You are recredentialed at least every three years or such other time period as established by the NCQA or applicable law. UnitedHealthcare and Affiliates National Credentialing Committee (NCC) reviews credentialing information and recommends appointment to the panel. It is the applicant's responsibility to supply all requested documentation in a form that is satisfactory to the Credentialing Committee. Applications lacking supporting documentation will not be considered by the committee. We process the initial application and present for committee review upon receipt of a completed application. During processing of the initial application, if additional time is necessary to make a determination due to failure of a third party to provide necessary documentation, the NCC and its agents make every effort to obtain such information as soon as possible.

Confidentiality

All credentialing documents or other written information developed or collected during the approval processes are maintained in strict confidence. Except with authorization or as required by law, information contained in these records is not disclosed to any person not directly involved in the credentialing process.

HIPAA Compliance

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 health care system in the United States. While the portability and continuity of insurance

coverage for workers and greater ability to fight health care 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 health care industry. UnitedHealthcare Community Plan is a "covered entity" under the regulations, as are you if you 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 health care 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. If you conduct business electronically, you are required to do so using the standard formats adopted under HIPAA or a clearinghouse to translate proprietary formats into the standard formats for submission to us.

2. Unique Identifiers

HIPAA also requires the development of unique identifiers for employers, you, health plans and individuals for use in standard transactions (see NPI information).

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 health care delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, 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; and
4. Help ensure compliance with the Security Regulations by the covered entity's workforce.

UnitedHealthcare Community Plan expects you to be in compliance with the HIPAA regulations that apply to your practice or facility within the established deadlines. Additional information on HIPAA regulations can be obtained at **cms.hhs.gov**.

Member Rights and Responsibilities

Member Rights

Various privacy regulations provide comprehensive protection for the privacy of health care information. These regulations control the internal uses and the external disclosures of health information. The privacy regulations also create certain individual patient rights. Exercising these rights does not adversely affect the way UnitedHealthcare Community Plan treats members. The same member protection should be extended by you.

We also inform our members that 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 areas are:

1. A responsibility to supply needed information
2. A responsibility to follow mutually agreed upon care plans
3. A responsibility to understand health problems and participate in treatment goals

These rights are outlined to the member at **UHCCommunityPlan.com**, and are as follows::

- Get information about UnitedHealthcare Community Plan, its services, the doctors giving care, and member rights and responsibilities
- Be told by the doctor what is wrong, what can be done, and what the result may be in language understood by the member
- To request an Accounting of Disclosures of their PHI made by you or the health plan. This must include disclosures by business associates
- To request restrictions to your uses, and/or ours, and disclosures of PHI. Such requests may be denied but if it is granted, the covered entity is bound by any restrictions agreed upon and these restrictions must be documented
- To request that communication from you or the health plan be received at an alternate location or by alternate means. Reasonable requests must be accommodated
- Learn about options for treatment, regardless of cost or coverage, in a way that members can understand
- Voice complaints or appeals about UnitedHealthcare Community Plan and the care received
- Suggest changes to member rights and responsibilities
- Be cared for with respect and dignity and with regard to privacy, without regard for health status, physical or mental handicap, sex, race, color, religion, national origin, age, marital status, sexual orientation, ability to speak English or political beliefs
- Be told in writing by UnitedHealthcare when health services or treatments are reduced, suspended, terminated, or denied
- Be told where, when and how to get the services needed
- Choose a care provider who works with other in-network care providers
- Get a second opinion
- Communicate agreement to any treatment or care plan after it has been explained
- Refuse care, treatment, or services. This obligates the care provider to inform the member of what may happen and/or risks may result due to the refusal
- Be free from any restraint or seclusion as a means of coercion, discipline, convenience or retaliation
- Get a copy of the personal medical record, discuss it with the doctor, and ask that if be amended or corrected
- Be involved in deciding on the type of care wanted or not wanted
- Have medical records kept private, shared only when required by law or contract, or with member approval
- Get respectful care in a clean and safe environment, free of unnecessary restraints, including privacy when at an office visit or other care setting
- Get information about doctor incentives, provider compensation, cost control measures and service utilization
- Exercise member rights with no impact on the way members are treated
- Make an advance directive
- Receive emergency care without approval of their PCP or the health plan
- Make a decision on organ donation
- Receive services not denied or reduced solely because of diagnosis, type of illness, or medical condition
- Access oral interpretation and sign language services free of charge

Member Responsibilities

MississippiCAN members have the following responsibilities:

- Give information needed by UnitedHealthcare Community Plan and the doctor to appropriately provide care
- Listen to the doctor's advice, follow instructions, and ask questions
- Understand health problems and work with the doctor to set treatment goals
- Work with the doctor to guard and improve your health
- Find out how the health care system works
- Go back to the doctor or ask for a second opinion if health does not improve
- Treat health care staff with respect
- Tell UnitedHealthcare Community Plan of any problems with any health care staff
- Follow the appointment scheduling process
- Keep appointments - call as soon as possible if cancellation is necessary
- Call the doctor when medical care is needed - even after office hours
- Use the emergency room only for real emergencies
- Members must pay for unapproved health care received from non-participating care providers and have the right to know how to obtain approval for these services
- Inform the plan of changes in family size, address changes, or other health care coverage.

National Provider Identifier (NPI)

NPI is a standard unique identifier (a 10-character number with no imbedded intelligence) that HIPAA requires you to use during any transaction involving PHI.

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

The NPPES assists you with your application, processes the application and returns the NPI to you.

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

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

NPI Compliance

HIPAA mandates the adoption and use of NPI in all standard transactions (claims, eligibility, remittance advice, claims status request/response, and authorization request/response) for you if you conduct business electronically.

Additionally, most state agencies are requiring the use of the NPI on paper claims – UnitedHealthcare Community Plan requires NPI on paper claims also in anticipation of encounter submissions to the state agency.

NPI is the only health care provider identifier that can be used for identification purposes in standard transactions for those covered health care providers.

How to get an NPI

You can apply for NPIs in one of three ways:

- 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.

- Agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on your behalf (i.e., through a bulk enumeration process) if an EFIO requests your permission to do so.
- 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, N.D., whereby staff at the NPI Enumerator will enter the application data into NPPES. The form is available only upon request through the NPI Enumerator. 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

How to share your NPI with us

Once you have NPI, go to **UHCprovider.com** and choose National Provider Identifier from the Most-Visited section. There are downloadable forms on the website for you fill in the appropriate information.

You must provide to UnitedHealthcare Community Plan the NPI that aligns with their MS Medicaid ID. Failure to do so may impact claims payment.

You may also fax NPI information to 866-455-4068 or 414-721-9006. To assist us in expediting this process, please also include your name, address, and TIN.

Fraud, Waste and Abuse

Fraud, waste and abuse by you, members, health plans, employees, etc., hurts everyone. Your assistance in notifying us about any potential fraud, waste and abuse that comes to your attention and cooperation with evolving policies and initiatives to detect, prevent and combat fraud, waste and abuse, as well as 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, Waste and Abuse

There is no single definition of "fraud" in the health care industry. Generally speaking, fraud as a legal concept involves an intentional misrepresentation of a material fact made to induce detrimental reliance by another. A misrepresentation can entail an affirmative false statement or the omission of a material fact. Moreover, fraud can be both intentional (knowing), reckless, or negligent. Intentional or knowing fraud can include both misrepresentations made to deceive and induce reliance, and those made with the knowledge that they are substantially likely to induce reliance. Federal and state statutes and regulations variously

define fraud (e.g., 42 C.F.R. § 455.2 defines fraud as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person").

"Waste and abuse" in the context of health care claims are generally broader concepts than fraud. They include overuse of services and care provider and member practices inconsistent with sound fiscal, business, or medical practices that cause unnecessary costs or fail to meet professionally recognized health care standards.

Some typical general categorical examples of care provider health care fraud, waste and abuse include:

- Billing for services/goods never provided.
- Billing for services/goods not medically necessary.
- Billing for services/goods not covered (e.g., experimental services) and/or for services to ineligible members.
- Duplicative billing for the same services/goods.
- Billing without adequate supporting documentation.
- Billing for more costly/complex services/goods than those actually provided ("upcoding").
- Billing separately services/goods required to be billed collectively ("unbundling").
- Improper modifications of billing codes.

- Billings by fictitious, sanctioned, and/or unqualified care providers.
- Excessive fees charged for services/goods.
- Poor quality services that are tantamount to no services provided.
- Care provider/member identity theft.
- Care provider waiver of patient copayments.
- Misrepresentations in cost reports.
- Unlawful referrals of patients to related care providers.

Some examples of member/beneficiary health care fraud, waste and abuse include:

- Selling/loaning member identification information.
- Intentional receipt of unnecessary/excessive services/goods.
- Unlawful sales of prescriptions and/or prescription medications.
- Misrepresentations to establish program/plan eligibility (e.g., non-disclosure of income/assets).

Reporting Fraud, Waste and Abuse

If you suspect another care provider or a member has committed fraud, waste or abuse, you have a responsibility and a right to report it. Call the Anti-Fraud and Recovery Solutions (AFRS) unit at Optum at 866-242-7727 to make anonymous reports and offer tips about suspected fraud, waste or abuse. Hours of operation are Monday – Friday, 8 a.m. – 4:30 p.m., Central Time. This number is accessible to both you and members. After-hours calls have the option to leave a message and/or request a call back.

For care provider-related matters (e.g., doctor, dentist, hospital), please furnish the following:

- Name, address and phone number of care provider.
- Medicaid number of the care provider.
- Type of care provider (physician, physical therapist, pharmacist, etc.).
- Names and phone numbers of others who can aid in the investigation.
- Dates of events.
- Specific details about the suspected fraud or abuse.

For member-related matters (beneficiary/recipient), please furnish the following:

- The person's name, date of birth, Social Security number, ID number.
- The person's address.
- Specific details about the suspected fraud or abuse.

Ethics and Integrity

Introduction

We are dedicated to conducting business honestly and ethically with members, you, suppliers and governmental officials and agencies. The need to make sound, ethical decisions as we interact with physicians, other health care providers, regulators and others has never been greater. It's not only the right thing to do. It is necessary for our continued success and that of our business associates.

Compliance Program

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

- Oversight of the Ethics and Integrity Program;
- Development and implementation of ethical standards and business conduct policies;

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

UnitedHealthcare Community Plan has compliance officers located in each health plan. In addition, each health plan has an active compliance committee, consisting of senior managers from key organizational functions. The committee provides direction and oversight of the program with the health plan.

Reporting and Auditing

Any unethical, unlawful or otherwise inappropriate activity by a UnitedHealthcare Community Plan employee which comes to your attention should be reported to a UnitedHealthcare senior manager in the health plan or directly to the corporate compliance department.

An important aspect of the corporate compliance program is assessing high-risk areas of our operations and implementing reviews and audits to help ensure compliance with law, regulations, and contracts. When informed of potentially irregular, inappropriate or potentially fraudulent practices within the plan or by you, we will conduct an appropriate investigation. You are expected to cooperate with the company and government authorities in any such inquiry, both by providing access to pertinent records (as required by the provider agreement) and access to your office staff. If activity in violation of law or regulation is established, appropriate governmental authorities will be advised.

Let us know if the government investigates you or asks you for documents about your practice. (This does not apply to a routine regulatory request). Also let us know what gave rise to the inquiry. The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are estimated to reduce program spending by $11 billion over five years. These provisions are aimed at reducing Medicaid fraud.

Under Section 6032 of the DRA, every entity that receives at least $5 million in Medicaid payments annually must establish written policies for all employees of the entity, and for all employees of any health plan or agent of the entity, providing detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a contracted care provider with UnitedHealthcare Community Plan, you and your staff are subject to this provision. The policy, titled “Integrity of Claims, Reports and Representations to Government Entities” can be found at **UHCCommunityPlan.com**. This policy details our commitment to compliance with the federal and state false claims acts, provides a detailed description of these acts and of the mechanisms in place within our organization to detect and prevent fraud, waste and abuse, as well as the rights of employees to be protected as whistleblowers.

Claims Filing & Processing

Claims Billing Procedures

Electronic claims reduce errors and shorten payment cycles.

Electronic Data Interchange (EDI) Claims - 800-842-1109

UnitedHealthcare Community Plan connects with multiple clearinghouses to allow you to submit claims electronically through your practice management software. To answer questions regarding your EDI options for electronic claims submission, obtain a list of clearinghouses that submit directly to UnitedHealthcare Community Plan, or assistance in establishing an EDI connection, call 800-842-1109. Visit our **EDI Education for Electronic Transactions** site for valuable information regarding EDI. EDI issues can also be submitted online EDI Issue Submission.

If you must submit a claim on paper, send claims to the following address:

UnitedHealthcare Community Plan
P.O. Box 5032
Kingston, NY 12402-5032.

Claims Format

You must submit all medical or hospital services claims using standard CMS1500, UB-04 (also known as CMS1450), or respective electronic format. We recommend the use of black ink when completing a CMS 1500. Black ink on a red CMS 1500 form allows for optimal scanning into the claims processing system. No matter which format you use to submit the claim, help ensure that all appropriate secondary diagnosis codes are captured and indicated for line items. This allows for proper reporting on encounter data.

Claim Processing Time

Please allow 30 days before inquiring about claims status. The standard turnaround time for clean claims is 10 business days, measured from date of receipt.

Claims Submission Rules

You MUST submit the following clams on paper due to required attachments:

- Timely filing reconsideration requests;
- Correct Coding Initiative (CCI) edit reconsideration; and
- Unlisted procedure codes if sufficient information is not sent in the notes field.

Please do not send claims on paper with attachments unless requested by the health plan.

Paper claim specific rules include:

- Submit corrected claims electronically; however the words “corrected claim” must be in the notes field. Your software vendor can instruct you on correct placement of all notes.
- Submit unlisted Procedure Codes with a sufficient description in the notes field. Your software vendor can instruct you on correct placement of all notes. If sufficient information cannot be submitted in the notes field, paper must be submitted. X-ray, lab and drug claims with unlisted procedure codes should be submitted electronically with notes.
- We follow CMS NUCC Manual guidelines for placement of data for both CMS 1500 and UB-04.

The health plan does not accept span dates for these types of claims.

Payment Policies and Tools

Reimbursement Policies

To align with federal mandates regarding enforcement of CCI and Fraud, Waste and Abuse Prevention tools, the health plan performs coding edit procedures.

These program integrity activities are referred to as reimbursement policies.

Reimbursement policies are based on external sourcing including:

- CMS National CCI.
- CMS National/Local Coverage Determinations (NCDs/LCDs).
- Current Procedural Terminology (CPT).
- Specialty Societies including:
  - American Society of Anesthesiologists (AMA).
  - American College of Cardiologists (ACC).
  - American College of Obstetrics and Gynecology (ACOG).
- National Physician Fee Schedule (NPFS)/Relative Value File.

Reimbursement policies are available online at: UHCCommunityPlan.com. Reimbursement policies may be referred to in your agreement with UnitedHealthcare Community Plan as "payment policies."

UnitedHealthcare may revise/update or add to these policies on occasion. As a participating care provider, you agree to abide by these policies. UnitedHealthcare Community Plan is committed to notifying care providers affected by policy changes/additions.

Payment of a claim is subject to our payment policies (reimbursement policies) and medical policies, which are available to you online or upon request to your Network Management contact.

Policies do not cover all issues related to reimbursement for services rendered to UnitedHealthcare Community Plan members as legislative mandates, the physician or other care provider contract documents, the member's benefit coverage documents, and the care provider manual all may supplement or in some cases supersede these policies.

Physician Claim-Editing Tools

We use a customized version of the INGENIX Claim Edit System known as iCES Clearinghouse. iCES-CH is a clinical edit system application that analyzes health care claims based on business rules designed to automate our reimbursement policy and industry standard coding practices. Claims are analyzed prior to payment to validate billings to minimize inaccurate claim payments.

Facility Claim Editing

We use the Ingenix Facility Editor® for claims for outpatient and inpatient services provided to Medicaid beneficiaries. The Facility Editor is a rules-based software application that evaluates claims data for validity and reasonableness. The edits are based on CCI guidelines and other CMS rules established for government programs.

Outpatient Code Edits

These reasonableness tests incorporate the Outpatient Code Edits (OCE) developed by the Centers for Medicare and Medicaid Services (CMS) for hospital outpatient claims. The Facility Editor is used to examine outpatient facility-based claims prior to payment to validate billings to minimize inaccurate claim payments.

The CMS OCE edits applied by the Facility Editor include:

1. Basic field validity screens for patient demographic and clinical data elements on each claim;
2. Effective-dated ICD-10-CM, CPT-4 and HCPCS Level II code validation, based on service dates and patient clinical data;
3. Facility-specific National CCI edits. The NCCI edits identify pairs of codes that are not separately payable, except under certain circumstances. NCCI edits were developed for use by all health care providers; the Facility Editor incorporates those NCCI edits that are applicable to facility claims. The NCCI edits in the Facility Editor are applied to services billed by the same hospital for the same beneficiary on the same date of service. There are two categories of NCCI edits: (a) Comprehensive code edits, which identify individual codes, known as component codes, which are considered part of another code and are designed to prevent unbundling; and (b) Mutually exclusive code edits, which identify procedures or services that could not reasonably be performed at the same session by the same care provider on the same beneficiary; and
4. Other OCE edits for inappropriate coding, including incorrect coding of bilateral services, evaluation and management services, incorrect use of certain modifiers, and inadequate coding of services in specific revenue centers are also included in the Facility Editor.

Inpatient Code Edits:

The inpatient editing rule sets are also developed by the CMS for hospital inpatient claims. As with the outpatient edits, the claims-editing tool reviews claims prior to payment to validate billings to minimize inaccurate claims payments.

The inpatient edits are sourced to:
Medicare Code Editor (MCE), which include (but are not limited to) the following edit rules:

- Data Validation Edits.
- Age and Gender to Diagnosis/Procedure Edits.
- Coding Convention Edits.
- E-Codes and Manifestations Code Edits.
- Medicare Coding Guideline Edits.
- Medicare Coverage Edits.

We update/enhance these rules on occasion to align with federal and state mandates. We notify you when changes materially affect reimbursement.

We administer professional claims only for MississippiCAN. Inpatient facility claims should be filed directly to Medicaid for processing.

Medicaid ID Edit:

An enhanced denial edit helps ensure that no payments are made to you without a MS Medicaid ID on file. If your claims have denied due to missing Medicaid ID and you have a current MS Medicaid ID, please contact the Provider Services hotline at 877-743-8734 so we can update your records and adjust applicable claims.

If you do not have a current MS Medicaid ID, a Provider Enrollment application can be found at **ms-medicaid.com/msenvision**.

Tax Identification Numbers/ Provider IDs

Submit standard transactions using your tax identification number and your NPI. To help ensure proper claims adjudication, please use the ID that best represents the health care professional that performed the service.
If you have questions about IDs, call your local office or our EDI Performance Team at 800-210-8315 or email **AC_EDI_OPS@uhc.com**.

Coordination of Benefits

Coordination of Benefits (COB) helps avoid duplicate payment for covered services. COB is applied whenever the member covered by the health plan is also eligible for health insurance benefits through another insurance company. You agree to cooperate with the health plan toward the effective implementation of COB procedures, including identification of services and individuals for which there may be a financially responsible party other than the health plan, and assist in efforts to coordinate payments with those parties.

How to file:

- When the health plan is primary, submit directly to us.
- When the health plan is secondary, submit to primary carrier first, then, submit the EOB with the claim to the health plan for consideration. EOBs can be submitted to the health plan electronically, in the Provider to Payer ANSI COB Model.

Refer to "Claims Submission Rules" in this manual.

- Secondary COB claims may be submitted if the following "required" fields are included on the electronic submission in the Provider to Payer ANSI COB Model.
  - **Professional:** Payer Paid Amount, Line Level Allowed Amount, Patient Responsibility, Line Level Discount Amount (Contractual Discount Amount of Other Payer), Patient Paid Amount (amount that the payer paid to the member not you).
  - **Dental:** Payer Paid Amount, Patient Responsibility Amount, Discount Amount (Contractual Discount Amount of Other Payer), Patient Paid Amount (amount that the payer paid to the member not you).

Electronic Claims Submission and Billing

All documents, frequently asked questions and other information regarding electronic claims submission can be found at **EDI Education for Electronic Transactions** site, or you may call **800-842-1109**.

Please share this information with your software vendor. Your software vendor can help in establishing electronic connectivity. Please note the following:

- Our Payer ID is 87726.
- All claims are set up as "commercial" through the clearinghouse regardless of product, Medicaid, Medicare or commercial.
- Clearinghouse Acknowledgement Reports and Payer specific Acknowledgment Reports identifying claims failing to successfully transmit electronically.

Importance and Usage of EDI Acknowledgment/Status Reports

Software vendor reports only show that the claim left the 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. Acknowledgement reports show you the status of your electronic claims after each transmission. By analyzing these reports, you know if your claims have reached the health plan for payment or if it has been rejected for an error or additional information.

You MUST review your reports, clearinghouse acknowledgement 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 and will instruct you in how your office will receive Clearinghouse Acknowledgement 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 according to contract terms because this can differ by contract, the CLAIM WILL BE CONSIDERED LATE BILLED and denied as not allowed for timely filing.

EDI Companion Documents

Our companion guides are intended to convey information that is within the framework of the ASC X12N Implementation Guides (IG) adopted by HIPAA. The companion guides identify the data content being requested when data is electronically transmitted. The companion documents are located on our website at **UHCCommunityPlan.com**.

We use the companion guides to:

- Clarify data content that meets the needs of our business purposes when the IG allows multiple choices.
- Outline which situational elements we require.
- Provide values that we return in outbound transactions.

Section 1 provides general information.

Section 2 provides specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements.

As we make information available on various transactions, we identify our requirements for those transactions in Section 2 of the Companion Guide. Additional comments may also be added to Section 1 as needed. Changes are included in Change Summary located in each section of the Companion Document.

e-Business Support

Our interactive voice response (IVR) telephone system is available to members 24 hours a day, seven days a week, as well as our Nurse triage hotline for health-related issues.

- ERA – to enroll for 835 Electronic Remittance Advice, go to Optum EDI Client Center at **enshealth.com**.
- EFT – EFT enrollment forms are located at **UHCCommunityPlan.com**. For electronic fund transfer, please call our e-Business support at: 800-210-8315.

Contact your software vendor and/or clearinghouse prior to contacting us.

Span Dates

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

Effective Date/Termination Date

Coverage is effective on the date the member is effective with the health plan, as assigned by the DOM. Coverage terminates on the date the member's benefit plan terminates with the health plan. If a portion of the services or confinement take place prior to the effective date, or after the termination date, an itemized split bill is required.

Please be aware that effective dates for MississippiCAN members are frequently revised, as individual members re-verify with the Division of Medicaid. You should verify eligibility at each visit, to assure coverage for services.

Overpayments

If an overpayment has been made, please include reference to the claim number or member ID and date of service. The best way to handle a potential overpayment is to call Customer Service.

Our claim processing system automatically deducts any overpayment made from the next remittance advice. If an overpayment is identified, contact Customer Service. Customer Service will submit an overpayment request. Checks should not be sent for overpayment-related issues unless specifically requested.

Subrogation

We do not override timely filing denials based on decisions received from third-party carriers on subrogation or workers' compensation claims. At the time of service, please submit all claims to us for processing.

Through recovery efforts, we work to recoup dollars related to subrogation and workers' compensation.

In addition, if your office receives a third-party payment, notify Customer Service so the overpayment will be recouped.

Care Provider/Member Cost Sharing Responsibilities

No copayments, deductibles or other cost sharing is allowed for MississippiCAN members. You also may not charge members for missed appointments.

Timely Filing and Late Bill Criteria

Effective for dates of service on and after 7/1/2014, timely filing limit is 180 days from date of service.

Claim Reconsideration Requests

If you believe the claim you submitted to us was not paid correctly, submit a claim reconsideration.

- The quickest way to submit a claim reconsideration request is online. Go to **UHCprovider.com/claims**.
- Please identify the specific claims in "paid" or "denied" status which you believe should be adjusted and give a description of the requested adjustment.
- The Claim Reconsideration Form can also be mailed to the following address:

  UnitedHealthcare Community Plan
  P.O. Box 5032
  Kingston NY 12402-5032
- You can view other important information on claims reconsiderations on the cover sheet and information sheet that accompanies the form on the website. The information sheet also explains the reasons and definitions for submitting the requested information

we need to complete the claim reconsideration request.

- Alternatively, you can call the Customer Care number to request an adjustment for a claim that does not require written documentation.
- If you have a request involving 20 or more paid or denied claims, aggregate these claims on the Claim Project online form and submit the form for research and review. Go to **UHCprovider.com/claims** > Submit Reconsideration Requests for Multiple Claims.

Care Provider Appeals

You may appeal a denial or other adverse determination within 30 calendar days from formal notice.

To expedite the processing of Provider Appeals, use the Provider Appeal Form located at **UHCCommunityPlan.com**.

Completed Appeal Forms should be submitted to the following address:

P.O. Box 5032
Kingston, NY 12402-5032

We will issue a written determination within 30 calendar days of receipt of a written appeal. Upon receipt of notice of an appeal denial from UnitedHealthcare Community Plan, you may appeal the determination to the Division of Medicaid.

Refer to page 38 for a summary of how UnitedHealthcare Community Plan handles complaints, grievances, and appeals. Please call the Provider Services helpline at 877-743-8734 to initiate any requests for resolution of complaints.

Resolving Disputes

Agreement concern or complaint

If you have a concern or complaint about your relationship with us, send a letter containing the details to the address listed in your agreement with us. A representative will look into your complaint and try to resolve it through an informal discussion. If you disagree with the outcome of this discussion, an arbitration proceeding may be filed as described and in your agreement with us.

If your concern or complaint relates to a matter involving our administrative procedures, such as the credentialing, notification, or appeal processes described in this manual, we follow the dispute procedures set forth to resolve the concern or complaint. After following those procedures, if you remain dissatisfied, an arbitration proceeding may be filed as described and in our agreement.

If we have a concern or complaint about your agreement with us, we'll send you a letter containing the details. If we cannot resolve the complaint through informal discussions with you, an arbitration proceeding may be filed as described in your agreement with us.

Arbitration proceedings are held at the location described in your agreement with us or if a location is not specified in your agreement, then at a location as described in the arbitration counties by location section.

The Correct Coding Initiative

The health plan performs coding edit procedures, based primarily on the CCI and other nationally recognized and validated sources. The health plan continues to develop and apply additional edits as necessary to implement program integrity initiatives in response to current circumstances and requirements.

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 that 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 care provider. 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 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 Technology Information Service, or NTIS. They can be reached at 800-363-2068, or on the web at **ntis.gov**.

Vaccines For Children (VFC) Billing

UnitedHealthcare Community Plan provides for administration of all mandated childhood immunizations according to the recommended schedule of the Advisory Committee on Immunization Practices (ACIP) standards, a current copy of which is included on **UHCCommunityPlan.com**.

All vaccines for members are provided through the Mississippi State Department of Health, which distributes vaccines to you if you are willing to participate in the vaccine program.

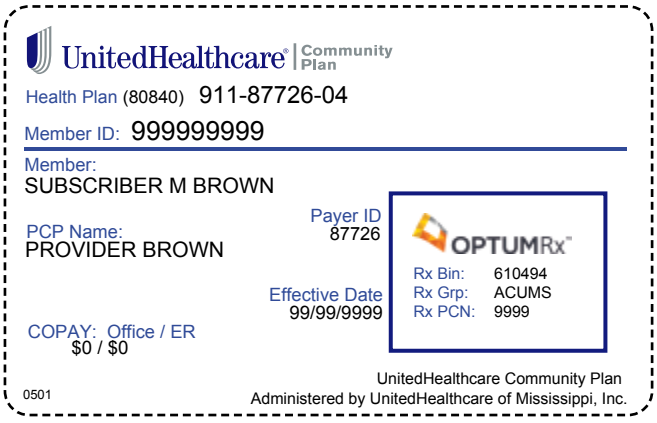
The cost of the vaccine is not billed to UnitedHealthcare Community Plan. The only cost associated with immunizations to be reimbursed under the contract will be the cost to administer the vaccine. Vaccines may be administered by network care providers, including school-based nurses, by a non-participating care provider to whom UnitedHealthcare Community Plan has referred the member or by the State Health Department. If you administer vaccines, you must agree to participate in the State's Immunization Registry. We must reimburse you in alignment with Medicaid policy (i.e. Fee-For-Service or Vaccines For Children Program). Other non-routine immunizations, such as influenza vaccine or tetanus boosters provided pursuant to an injury, will be covered as any other covered service. We will submit a monthly report containing a list of care providers, their contact information, claimant information and corresponding vaccine administrations to the Mississippi State Department of Health.

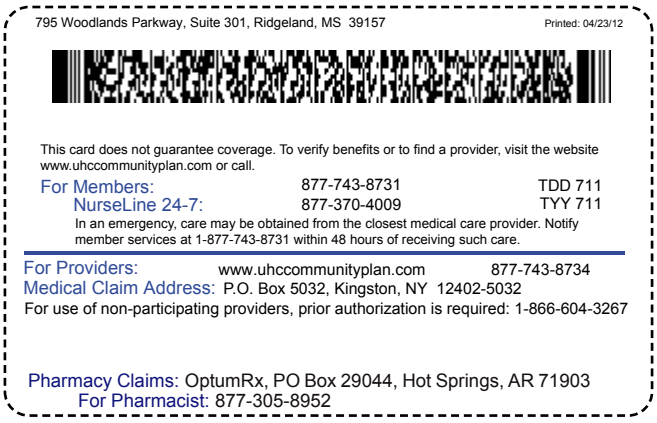
Member Identification Cards

UnitedHealthcare Community Plan members receive an ID card containing information that helps you submit claims accurately and completely.

Be sure to check the member's ID card at each visit and to copy both sides of the card for your files.

Sample Member ID Card





Care Provider Standards and Policies

Role of the PCP

The PCP plays a vital role as a case manager in the UnitedHealthcare Community Plan system by improving health care delivery in four critical areas — access, coordination, continuity, and prevention. 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 coverage 24 hours a day/seven days a week and backup coverage when they are not available.

We expect all care providers 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.

Women can choose any of our OB/GYN or midwives to deal with women's health issues. They never need a referral for family planning, well-women care, or care during pregnancy. Women can have routine checkups (twice a year), follow-up care if there is a problem and regular care during pregnancy.

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

Responsibilities of the PCP

In addition to the requirements applicable to all care providers, PCP responsibilities 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 Administrative Guide.
- Conduct a baseline examination during the member's first appointment. This should occur within 90 days of a new member's enrollment. The PCP should attempt to schedule this appointment if the new member fails to do so.
- Treat general health care needs of members. Use nationally recognized clinical practice guidelines as a guide for treatment of important medical conditions. Such guidelines are referenced on the **UHCCommunityPlan.com** website.
- 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**.
- 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.
- Call Provider Services at 877-743-8734 for questions related to member lists, practice guidelines, medical records, government quality reporting, HEDIS, etc.
- Give 30 days' notice to terminate members.
- Provide all Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services to members up to 21 years.
- EPSDT services include:
  - A comprehensive unclothed physical exam
  - Comprehensive family/medical/developmental history
  - Immunization status, any shots that are needed
  - Lead assessment and testing
  - Necessary blood and urine screening
  - TB skin test
  - Developmental assessment
  - Nutritional assessment/counseling
  - Adolescent counseling
  - Vision testing/screening
  - Hearing testing/screening
  - Dental referral services

For proper reimbursement, PCP must remain current with all documentation required by the Division of Medicaid.

Documentation may include, but is not limited to:

  - EPSDT/Mississippi Cool Kids program enrollment
  - Care provider disclosures forms
  - Self-attestation for incentive payments
- Screen members for behavioral health problems.
- Coordinate each member's overall course of care.
- Be available personally to accept our 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 telephone coverage by another participating PCP or an answering machine directing the member to a live voice.
- 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.
- Contact members who are non-compliant with EPSDT services. Report repeated non-compliance to the DOM and UnitedHealthcare Community Plan's Case Management office at 877-743-8731.
- Discuss available treatment options and alternative courses of care with members.
- Refer services requiring prior authorization to the Prior Authorization department or pharmacy as appropriate.
- Inform UnitedHealthcare Community Plan Case Management at 877-743-8731 of any member showing signs of End Stage Renal Disease.
- Admit our 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 health care and in accordance with standards established by UnitedHealthcare Community Plan.
- Document procedures for monitoring patients' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records to other medical practitioners for the purpose of continuity of care within 10 business days of a 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 participating hospital.
- Report infectious diseases, lead toxicity, and other conditions as required by state and local laws and regulations.
- Offer the same office hours to UnitedHealthcare Community Plan members as those offered to our commercial plan members.
- Allow members to change PCPs through a member-selected or contractor-reassignment process. This can be due to a variety of reasons including when a care provider terminates relationship with us or Medicaid, when a member chooses to seek a new care provider, or a formal grievance or complaint is filed.

For any reason, including panel size, if the PCP is unable to assume care for assigned member(s), the PCP should notify us by regular mail:

UnitedHealthcare Community Plan
c/o Medical Director
795 Woodlands Parkway-Suite 301
Ridgeland, MS 39157

Responsibilities of Specialists

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

- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by the member's PCP.
- 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 participating hospital.
- Report infectious diseases, lead toxicity, and other conditions as required by state and local laws and regulations.
- Offer the same office hours to UnitedHealthcare Community Plan members as those offered to our commercial plan members.

Member Notification of Termination

At least 15 calendar days prior to the effective date of your termination or your group's termination from the network, MississippiCAN will send, through regular mail, notification to our affected members/your patients. Your affected patients/our members will include those MississippiCAN members for whom a claim was filed on your behalf or on behalf of your medical group within the six months prior to the effective date of termination or departure.

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.

Standards for Appointment Scheduling

Type	Appointment Scheduling Time Frame
PCPs (well care visit)	Not to exceed 30 calendar days
PCP (routine sick visit)	Not to exceed seven calendar days
PCP (Urgent Care visit)	Not to exceed 24 hours
Specialists	Not to exceed 45 calendar days
Dental Providers (routine visit)	Not to exceed 45 calendar days
Dental Providers (Urgent Care)	Not to exceed 48 hours
Behavior Health Providers (routine visit)	Not to exceed 21 calendar days
Behavior Health Providers (urgent visit)	Not to exceed 24 hours
Behavior Health Providers (post-discharge from an acute psychiatric hospital when the contractor is aware of the member's discharge)	Not to exceed seven calendar days
Urgent Care Providers	Not to exceed 24 hours
Emergency Providers	Immediately (24 hours a day, seven days a week) and without Prior Authorization

Timeliness Standards for Notifying Members of Test Results

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

Allowable Office Waiting Times

Members with appointments should not routinely be made to wait longer than one hour.

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 you 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. For more information, the provider relations advocate may conduct periodic site visits to identify PCP offices that meet ADA standards. If a PCP is planning to relocate an office, an advocate may perform a site visit before care can be rendered at the new location.

You are expected to provide family-centered care. As such, interpretive and language assistance services may be necessary. If you provide necessary services, UnitedHealthcare's Member Services can help at no cost to members. For interpretation assistance, at least 72 hours before a scheduled appointment, please call 877-743-8731, TTY: 711. Sign language services require a two-week notice.

Medical Record Charting Standards

You are required to maintain medical records in a complete and orderly fashion that promotes efficient and quality patient care. As part of this process, you are required to participate in our quality review of medical records and meet the following requirements for medical record keeping.

Confidentiality	• The office has a policy and procedure in place that addresses the confidentiality of the patient medical record. • Office staff receive initial and periodic training in maintaining the confidentiality of patient records. • Medical records are released only to the patient and/or entities as designated in accordance with HIPAA regulations. • Medical records are stored in a manner that helps ensure patient confidentiality. Records are kept in a secure area which is only accessible to authorized personnel.
Organization	• Medical records are filed in a manner in which they are easily retrievable. • Medical records are readily available to the treating care provider whenever the patient is seen at the site where they generally receive care. • Medical records are sent promptly to specialty care providers upon patient request. For urgent issues, records are made available within 48 hrs. • There is a policy for medical record retention. • The contents of medical records must be organized in such a manner that reports, problem lists, immunization records, etc. are easily retrievable and are located in the same area in each record. • There is one medical record per patient. • Pages in the medical record are secure.
Medical Record Documentation Standards	• The chart is legible. • The chart contains at a minimum the following patient identifiers: name, sex, address, phone # and DOB. • The patient name/ID # is located on each page of the medical record. • Each entry is dated and signed by the treating practitioner(s). • An initial history and physical is present. • Documentation of the presence or absence of allergies or adverse reactions is clearly noted. • Screenings for high risk behaviors such as drug, alcohol and tobacco use are present. • Screening for behavioral health issues including depression. • Documentation of the presence or absence of an executed advanced directive. • An updated problem list includes medical and psychological conditions. • A Medication List includes current and past meds. • Progress notes from each visit that document the reason for the visit, the physical findings, the diagnosis, and treatment plan. • Documentation of need for follow-up visits. • Documentation of member input and/or understanding of the treatment plan. • Documentation that reflects compliance with EPSDT standards for all pediatric patients. • Maintenance of a current immunization record for all pediatric patients. • Tracking and referral for age appropriate preventive health screenings such as mammography, pap smears, colorectal screen and flu shots are noted. • Appropriate use of lab testing (HbA1c, LDL, lead screen). • Results of lab, X-ray, and other tests as ordered by the practitioner including indication of physician review. • Notation of treating specialists (including behavioral health) as well as copies of consultant reports ordered by the practitioner. • Continuity of care demonstrated by evidence of copies of Home Health Nursing reports, Hospital Discharge summaries, Emergency Room visits, and physical or other therapies as ordered by the practitioner. • Use of Clinical Practice Guidelines or flowsheets for the management of chronic conditions (diabetes, asthma, etc.). • Mechanism for tracking and management of no-shows.

Screening and Documentation Tools

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

Medical Record Review

On a routine basis, we review the medical records you maintain for our members. Care providers 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 health care professionals.
- Notation regarding the date of return visit or other needed follow-up care for each encounter.
- Consultations, lab, imaging and special studies initialed by PCP 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 mental health assessment (CAGE, TWEAK).

Medical Record Documentation Standards Audit Tool

Provider Name:	Provider ID#:						Provider Specialty:		
Reviewer Name:	Review Date:						Score		
Member Initials/DOB:									
Member ID#:									
Confidentiality and Record Organization and Office Procedures	**Yes**	**No**	**N/A**	**Yes**	**No**	**N/A**	**Yes**	**No**	**N/A**
1. The office has a policy regarding medical record confidentiality that addresses office staff training on confidentiality; release of information; record retention; and availability of medical records housed in a different office location (as applicable).									
2. Staff are trained in medical record confidentiality.									
3. The office uses a Release of Information form that requires patient signature.									
4. There is a policy for timely transfer of medical records to other locations/care providers.									
5. There is an identified order to the chart assembly.									
6. Pages are fastened in the medical record.									
7. Each patient has a separate medical record.									
8. Medical records are stored in an organized fashion for easy retrieval.									
9. Medical records are available to the treating practitioner where the member generally receives care.									
10. Medical records are released to entities as designated consistent with federal regulations.									
11. Records are stored in a secure location only accessible by authorized personnel.									
12. There is a mechanism to monitor and handle missed appointments.									

Procedural Elements	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. The medical record is legible.*									
2. All entries are signed and dated.									
3. Patient name/identification number is located on each page of the record.									
4. Medical records contain patient demographic information.									
5. Medical record identifies primary language spoken and any cultural or religious preferences if applicable.									
6. Adults 18 and older, emancipated minors, and minors with children have an executed advance directive in a prominent part of the medical record.									
6a. OR If the answer to the above #6 is No, then adults 18 and older, emancipated minors, and minors with children are given information about advance directives which is noted in a prominent part of the medical record.									
7. A problem list includes significant illnesses and active medical conditions.									
8. A medication list includes prescribed and over-the-counter medications and is reviewed annually.									
9. The presence or absence of allergies or adverse reactions is clearly displayed.									

History	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. Medical and surgical history is present.									
2. The family history includes pertinent history of parents and/or siblings.									
3. The social history minimally includes pertinent information such as occupation, living situation etc.									

Preventive Services	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. Evidence of current age appropriate immunizations.									
2. Annual comprehensive physical (or more often for newborns).									
3. Documentation of mental and physical development for children and/or cognitive functioning for adults.									
4. Evidence of depression screening.									
5. Evidence of screening for high risk behaviors such as drug, alcohol and tobacco use, sexual activity, exercise and nutrition counseling .									
6. Evidence that Medicare patients are screened for functional status and pain.									
7. Evidence of tracking and referral of age and gender appropriate preventive health services.									
8. Use of flow sheets or tools to promote adherence to Clinical Practice Guidelines/ Preventive Screenings.									
9. A medication list includes prescribed and over-the-counter medications and is reviewed annually.									

Problem Evaluation and Management	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
Documentation for each visit includes:									
1. Appropriate Vital Signs (e.g., Weight, height, BMI measurement annually).									
2. Chief complaint.									
3. Physical assessment.									
4. Diagnosis.									
5. Treatment plan.									
Treatment plans are consistent with evidence-based care and with findings/diagnosis.									
6. Appropriate use of referrals/consults, studies, tests.									
7. X-rays, labs, consultation reports are included in the medical record with evidence of practitioner review.									

Problem Evaluation and Management (cont'd)	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
8. Timeframe for follow-up visit as appropriate.									
9. Follow-up of all abnormal diagnostic tests, procedures, X-rays, consultation reports.									
10. Unresolved issues from the first visit are followed-up on the subsequent visit.									
11. There is evidence of coordination of care with behavioral health.									
12. Education, including counseling is documented.									
13. Patient input and/or understanding of treatment plan and options is documented.									
14. Copies of hospital discharge summaries, home health care reports, emergency room care physical or other therapies as ordered by the practitioner are documented.									

(Questions) (# N/A) (Adjusted # of Questions) (# Yes) (Adjusted # of Questions) (Score)

Note: For each of the first three charts there are a possible total of 34 questions.

If a care provider scores less than 85%, review an additional five charts. Only review those elements that the care provider received a "NO" on in the initial phase of the review. Upon secondary review, if a data element scores at 85% or above, that data element will be recalculated as all "YES" in the initial scoring. If upon secondary review, a data element scores below 85% the original calculation of that element will remain.

* Items are MUST PASS

Advance Directives

The member has the right to make health care decisions and to execute advance directives. An advance directive is a formal document, written by the member in advance of an incapacitating illness or injury.

Several types of advance directives are available to a member. If completed, the member (or member's designee) keeps the original. Be aware of and maintain in the patient's medical record a copy of the member's completed directive or health care proxy. Do not send a copy to UnitedHealthcare Community Plan. Members are not required to initiate an advance directive or proxy and cannot be denied care if they do not have an advance directive. If a member believes that you have not complied with an advance directive, they may file a complaint with the UnitedHealthcare medical director or physician reviewer.

Protect Confidentiality of Member Data

Our 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 who need that information to fulfill our obligations and to facilitate improvements to our members' health care 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 will comply with applicable regulatory requirements, including those relating to confidentiality of member medical information. You agree specifically to comply in all relevant respects with the applicable requirements of 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 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.

Care Provider Communications and Outreach

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

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

Care Provider Website

UnitedHealthcare Community Plan promotes the use of web-based functionality among its care provider population. The web-based care provider portal facilitates provider communications pertaining to administrative functions. Our interactive website enables you to electronically determine member eligibility, submit claims, and ascertain the status of claims. UnitedHealthcare Community Plan has implemented an internet-based prior authorization system on **UHCprovider.com**, which allows you, if have internet access, the ability to request their medical prior authorizations online rather than telephonically. The website also contains an online version of the care provider manual, the provider directory, the PDL (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 Community Plan also posts notifications regarding changes in laws, regulations and subcontract requirements to the portal.

A web portal is also available to members including access to the member handbook, newsletters, provider search tool and other important plan bulletins.

Care Provider Office Visits

Provider service advocates visit PCPs, specialist and ancillary provider offices on a regular basis. Each provider service advocate is assigned to a geographic territory to deliver face-to-face support to our 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 health care disparities.

Care Provider Newsletters and Bulletins

We produce and distribute a care provider newsletter to the entire MississippiCAN network at least three times a year. The newsletters contain program updates, claims guidelines, information regarding policies and procedures, cultural competency and linguistics information, clinical practice guidelines, information on special initiatives, and other articles regarding health topics of importance. The newsletters also include notifications regarding changes in laws, regulations and subcontract requirements. UnitedHealthcare Community Plan uses electronic bulletins, posted on the **UHCCommunityPlan.com** website, to rapidly disseminate urgent information that affects the entire network.

We publish this manual online, which includes an overview of the program, toll-free number to our Provider Services hotline, a removable quick reference guide, and a list of additional resources and incentives. Care providers without internet access may request a hard copy of the manual by contacting Provider Services.