2017

Care Provider Manual

UnitedHealthcare Community Plan, a Commonwealth Coordinated Care Plus Health Plan. Virginia Managed Long-Term Services and Supports (MLTSS)

Physician, Health Care Professional, Facility and Ancillary
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Welcome

Welcome to the UnitedHealthcare Community Plan Commonwealth Coordinated Care Plus (CCC Plus) provider manual. This complete and up-to-date reference PDF manual 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 additional electronic tools are available on our website at UnitedHealthcareOnline.com.

If you are looking for Medicare Advantage member information, click here to access the UnitedHealthcare guide. If you are looking for capitated provider info, click here or go to uhcwest.com > Provider, then click library menu at the top of the screen. If you are looking for a different Community and State manual, click here or go to uhccommunityplan.com > health-professionals, then select the correct state.

Easily find information in the manual using the following steps:

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

You may also be able use the binoculars icon on the top right hand side of the PDF.

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

Purpose of Care Provider Manual

The purpose of the care provider manual is to serve as a resource and reference for participating providers. The manual contains information regarding covered services and quality improvement programs, billing and claim procedures, and ID cards and eligibility verification. Please share it with others in your office or organization.

The information is current as of the date it was published and may be modified by UnitedHealthcare at any time. This manual was designed so that updates and changes from time to time can be done efficiently. If a section is updated or enhancements to the content are made, you will be provided with the material to replace the respective section.

In the event of a conflict of information between your agreement and the manual, the manual controls unless the agreement states otherwise.

In addition, information is available online at UnitedHealthcareOnline.com or UHCCommunityPlan.com.

For your ease, we have included a “Comments” section at the end of this manual for you to provide feedback or make recommendations.

Overview

What is Medicaid?
The medical assistance program authorized by Title XIX of the Social Security Act, 42U.S.C. §1396 et seq., and regulations thereunder, as administered in the Commonwealth of Virginia.

What is UnitedHealthcare Community Plan Commonwealth Coordinated Care Plus plan?
Managed care is when health care organizations manage how their enrollees receive health care services. Managed Care Organizations will work with different providers to offer quality health care services to enrollees.

The goals of UnitedHealthcare Community Plan CCC Plus plan are to provide:

• Coordinated long-term care across different health care settings
• A choice of the best long-term care plan for their needs
• Long-term care plans with the ability to offer more services
• Access to cost-effective community-based long-term care services

Enrollees enrolled in CCC Plus plan’s goals will have their services/care managed through the Managed Care Health Plan. UnitedHealthcare Community Plan works with you to offer quality health care services and to help ensure enrollees have access to covered services.

The CCC Plus plan’s goals are to provide coordinated long-term care services across different health care settings and to provide enrollee access to cost- effective community-based long-term care services.

Enrollment in the CCC Plus plan will not change an enrollee’s Medicare benefits.

These benefits allow at-risk individuals to remain at home and improve their quality of life.
This section of the care provider manual provides helpful information you need to support the care manager and enrollee in coordination of services as determined by the individual enrollee care plan. Unless a discrepancy appears, the information contained in this section does not replace the information contained in other sections of this manual but highlights information pertinent to CCC Plus.

How the CCC Plus Plan Works
UnitedHealthcare Community Plan operates under a contract with the Commonwealth of Virginia’s Department of Medical Assistance Services (DMAS).

UnitedHealthcare Community Plan supports and coordinates all CCC Plus-covered benefits for eligible enrollees. It uses a care plan that helps members remain in the community. Should the enrollee require facility care, the care plan is developed to provide the enrollee with every opportunity to improve quality of life and, when or if possible, allow for a successful transition back into the community.

This model uses covered benefits, enhanced benefits, community resources, caregiver/family support systems and primary care providers (PCPs) to meet the overall care needs of the enrollee. UnitedHealthcare Community Plan is also required to comply with any new Medicaid coverage decisions.

CCC Plus Plan Provider Relationship
The success of UnitedHealthcare Community Plan depends on strong relationships with you. We encourage enrollees to work with their care manager to coordinate care and help them access covered benefits. If the enrollee uses a non-contracted care provider, the services will not be covered unless services are authorized by the care manager.

The Enrollee and UnitedHealthcare Community Plan
Only CCC Plus plan recipients who meet eligibility requirements and are living in a region with authorized Managed Care Plans are eligible to enroll and receive services from the CCC Plus Plan. Each recipient will have a choice of Managed Care Plans and may select any authorized Managed Care Plan unless the Managed Care Plan is restricted by this contract to a specific population that does not include the recipient.

The Department of Medical Assistance Services or its agent will be responsible for enrollment, including enrollment into the CCC Plus Plan, disenrollment and outreach and education activities. UnitedHealthcare Community Plan will coordinate with The Department of Medical Assistance Services and its agent as necessary for all enrollment and disenrollment functions.

UnitedHealthcare Community Plan will accept Medicaid recipients without restriction and in the order they enroll. UnitedHealthcare Community Plan will not discriminate on the basis of religion, gender, race, color, age or national origin, health status, pre-existing condition or need for health care services and will not use any policy or practice that has the effect of such discrimination.

CCC Plus Plan Only Beneficiaries
Each enrollee has an assigned care manager who works with their care providers and authorized representatives to develop and coordinate the care plan. A Medicare beneficiary can access any Medicare-approved care provider without authorization.

UnitedHealthcare Community Plan and you, as a participating care provider, will treat all enrollees with dignity and respect and will recognize the enrollee’s right to privacy, regardless of race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment.

Cultural Competency Plan
UnitedHealthcare Community Plan believes in and supports the ability of individuals and systems to provide services effectively to people of various cultures, races, ethnic background and religions in a manner that recognizes values, affirms and respects the worth of individuals and respects and protects their dignity.

Please visit UnitedHealthcareOnline.com for a more complete description of the Cultural Competency Plan. You may request at no charge a copy of the Cultural Competency Plan by calling 877-843-4366.

UnitedHealthcare Dual Complete (HMO SNP)
Chapter 2: Important Contact Information

Frequently Used Phone Numbers

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<tr>
<th>Name</th>
<th>Contact Information</th>
<th>Details</th>
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<tbody>
<tr>
<td>Provider Services</td>
<td>Online: <a href="#">Link</a></td>
<td>Use the Provider Portal at Link</td>
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<td></td>
<td>Phone: 877-843-4366</td>
<td>Inquire about a patient’s eligibility, benefits or claim status</td>
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<td>(available 8 a.m. – 6 p.m. Eastern Time, Monday through Friday)</td>
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<td>Call Provider Services for any questions such as:</td>
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<td>• Claim status</td>
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<td>• Claim denial</td>
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<td>• Claim submission information needed</td>
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<td>• Claims payment address (verification or change)</td>
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<td>• New contract status</td>
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<td>• Provider Remittance Advice (PRA)</td>
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<td>• Resubmission of corrected claims</td>
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<td>• Unreconciled claims</td>
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<td>• Enrollee eligibility</td>
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<td></td>
<td>• Changes in your information, including name, address, telephone number</td>
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<td></td>
<td></td>
<td>• Federal Tax Identification number</td>
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<td></td>
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<td>• If you open or close an office</td>
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<td>• If you have reached capacity and you are no longer accepting new</td>
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<td>• Please provide the effective date and date anticipated for</td>
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<td>• Contract administration/implementation issues</td>
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<td>• Credentialing and re-credentialing</td>
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<td></td>
<td></td>
<td>• Reimbursement, payment or coding questions</td>
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<td>• Specific information about UnitedHealthcare Community Plan’s policies</td>
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<td>• Training for billing and claim submission</td>
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[UHCCommunityplan.com](#) © 2017 UnitedHealthcare
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<th>Contact Information</th>
<th>Details</th>
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<tbody>
<tr>
<td><strong>Dental Services</strong></td>
<td><strong>Phone:</strong> 855-586-1419 <strong>Online:</strong> uhcproviders.com</td>
<td>Customer service hours are Monday through Friday, 8 a.m. to 6 p.m., Eastern Time</td>
</tr>
<tr>
<td><strong>EDI Claim Issues</strong></td>
<td><strong>Phone:</strong> 800-210-8315 <strong>Online:</strong> unitedhealthcareonline.com</td>
<td>Call to inquire about claims issues or questions.</td>
</tr>
<tr>
<td><strong>EDI Log-on Issues</strong></td>
<td><strong>Phone:</strong> 800-842-1109</td>
<td>Information also available at UnitedHealthcareOnline.com</td>
</tr>
<tr>
<td><strong>Enterprise Voice Portal</strong></td>
<td><strong>Phone:</strong> 877-842-3210</td>
<td>The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.</td>
</tr>
<tr>
<td><strong>Fraud and Abuse</strong></td>
<td>Medicaid Fraud Control Unit (MFCU) Fraud and Abuse Hot line: 800-286-3932 UnitedHealthcare Fraud and Abuse Hot line: 800-455-4521 email at <a href="mailto:MFCU_mail@oag.state.va.us">MFCU_mail@oag.state.va.us</a></td>
<td>Notify us anonymously of suspected fraud or abuse on the part of a provider or member Medicaid Fraud and Abuse Complaint Form is available online at: <a href="http://oag.state.va.us">oag.state.va.us</a> &gt; Programs &amp; Initiatives &gt; Medicaid Fraud</td>
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<tr>
<td><strong>LabCorp for Care Providers</strong></td>
<td><strong>Phone:</strong> 888-522-2677</td>
<td>LabCorp is the preferred lab provider</td>
</tr>
<tr>
<td><strong>Community Mental Health Recover Services (CMHRS)</strong></td>
<td><strong>Phone:</strong> 800-424-4046</td>
<td>Contact Magellan for CMHRS-related issues</td>
</tr>
<tr>
<td><strong>Mental Health Inpatient, Residential and All Addiction Recovery Treatment Services (ARTS)</strong></td>
<td><strong>Phone:</strong> 877-843-4366 <strong>Online:</strong> providerexpress.com</td>
<td>Contact us for Mental Health Inpatient, Residential, and all ARTS services</td>
</tr>
<tr>
<td><strong>National Credentialing Center (VETTS line)</strong></td>
<td><strong>Phone:</strong> 877-842-3210</td>
<td>Self-service functionality to update or check credentialing information.</td>
</tr>
<tr>
<td><strong>OPTUM Health Nurseline</strong></td>
<td><strong>Phone:</strong> 877-543-4293</td>
<td>Available 24 hours a day/seven days a week</td>
</tr>
<tr>
<td><strong>OPTUM Support Center</strong></td>
<td><strong>Phone:</strong> 855-819-5909 <strong>Email:</strong> <a href="mailto:LinkSupport@optum.com">LinkSupport@optum.com</a></td>
<td>Available 7 a.m. to 9 p.m. Eastern Time Monday through Friday, 6 a.m. to 6 p.m. Eastern Time Saturday, and 9 a.m. to 6 p.m. Eastern Time Sunday</td>
</tr>
<tr>
<td><strong>Person-Centered Care Model (Care Management/Disease Management)</strong></td>
<td><strong>Phone:</strong> 866-815-5334</td>
<td>Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private duty nursing</td>
</tr>
<tr>
<td><strong>Pharmacy Technical help line</strong></td>
<td><strong>Phone:</strong> 877-305-8952 (OptumRx)</td>
<td>Prescription medication received at the pharmacy is covered through the members benefit</td>
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| **Transportation** | **Liberty phone:** 855-855-9080  
                      **Liberty TTY:** 855-762-6236  
                      **MTM phone:** 888-258-0521    | Call to schedule transportation or for transportation assistance.  
To arrange non-urgent transportation, please call three days in advance.  
  - MTM will service the Tidewater, Western/Charlottesville and Northern/Winchester regions.  
  - Liberty will service the Southwest, Roanoke/Alleghany, and Central regions.  
To confirm your region, go to the Regional Table in the Appendix. Please make reservations at least three days in advance. Available 8 a.m. – 8 p.m. Eastern Time, Monday through Friday only. |
| **Vision Services**| **Phone:** 855-476-2724  
                      **Online:** Marchvisioncare.com                                                | Contact MARCH Vision Care’s Provider Relations department for education on benefits, lab order submission and for any demographic changes. This includes changes to addresses and phone numbers, office hours, available providers, and Federal Tax Identification numbers. In addition, we welcome you to attend one of our training sessions on eyeSynergy®, our web portal that gives you 24/7 access to eligibility, benefit, claim and lab order information. |

### Claims and Appeals

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<th>Contact Information</th>
<th>Details</th>
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</table>
| **Claims — Medical and Behavioral**         | **Phone:** 877-843-4366  
                      **Online:** Use the LINK Provider Portal at UnitedHealthcareonline.com  
                      **Address:** UnitedHealthcare Community Plan  
                      P.O. Box 5270  
                      Kingston, NY 12402-5240  
                      For FedEx (use for large packages/over 500 pages)  
                      UnitedHealthcare Community Plan  
                      1355 S 4700 West,  
                      Suite 100  
                      Salt Lake City, UT 84104 | Inquire about the status of a claim or to ask questions about proper completion or submission of claims. Available 8 a.m. – 6 p.m. Eastern Time, Monday through Friday. |
# Claims and Appeals

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<th>Name</th>
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<tbody>
<tr>
<td>Claim Disputes</td>
<td>Phone: 877-843-4366</td>
<td>Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.</td>
</tr>
<tr>
<td></td>
<td>Online: Go to Link at UnitedHealthcareonline.com to process online</td>
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<tr>
<td></td>
<td><strong>Addresses:</strong></td>
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<tr>
<td></td>
<td>Reconsiderations mailing address:</td>
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<tr>
<td></td>
<td>UnitedHealthcare Community Plan</td>
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</tr>
<tr>
<td></td>
<td>P.O. Box 5270</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kingston, NY 12402-5240</td>
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<tr>
<td></td>
<td>Appeals mailing address:</td>
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<td></td>
<td>Community Plan Grievances and Appeals</td>
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<tr>
<td></td>
<td>P.O. Box 31364</td>
<td></td>
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<tr>
<td></td>
<td>Salt Lake City, UT 84131-0364</td>
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<tr>
<td>Behavior Health</td>
<td>UnitedHealthcare Community Plan</td>
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<tr>
<td>Appeals</td>
<td>Grievances and Appeals</td>
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<td></td>
<td>P.O. Box 30512</td>
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<tr>
<td></td>
<td>Salt Lake City, UT 84130-0512</td>
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<td></td>
<td>Fax: 855-312-1470</td>
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<tr>
<td></td>
<td>Phone: 866-556-8166</td>
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<tr>
<td>Provider Grievance</td>
<td><strong>Address:</strong> Office of Appeals Hearings</td>
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<td>Department of Medical Assistance Services (DMAS)</td>
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<td></td>
<td>Appeals Division</td>
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<tr>
<td></td>
<td>600 E Broad Street</td>
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<td></td>
<td>Richmond, VA 23219</td>
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<td></td>
<td><strong>Phone:</strong> 804-371-8488</td>
<td>Ask for an appeal hearing in writing at this address. You must exhaust appeals with UnitedHealthcare Community Plan before appealing to the Department of Medical Assistance Services (DMAS).</td>
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## Claims and Appeals

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<tr>
<td>Provider Advocate</td>
<td>Emails:</td>
<td>Notify the VA provider advocate to resolve a claim payment issue. Use this email address if you do not know who your provider advocate is. Advocates are assigned by territory.</td>
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<td>• Hospital/Medical</td>
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<td>Providers:</td>
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<td><a href="mailto:VA_PR_Team@uhc.com">VA_PR_Team@uhc.com</a></td>
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<td>• Skilled Nursing</td>
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<td><a href="mailto:virginia_snf_pra@optum.com">virginia_snf_pra@optum.com</a></td>
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<td>• Home and Community-</td>
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<td>Based Services</td>
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<td><a href="mailto:hcbs_northeast_pr@uhc.com">hcbs_northeast_pr@uhc.com</a></td>
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## Prior Authorization

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<th>Name</th>
<th>Contact Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Intake (Pre-Certifications)</td>
<td>Phone: 877-843-4366</td>
<td>Go to website for a current list of prior authorizations and forms. Call the phone number to request prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Online: UHCCommunityPlan.com &gt; Provider Information &gt; Prior Authorization</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Prior Authorizations</td>
<td>Phone: 800-310-6826</td>
<td>Pharmacy number for prior authorization submissions.</td>
</tr>
<tr>
<td></td>
<td>Fax: 866-940-7328</td>
<td></td>
</tr>
<tr>
<td>EviCore Radiology / Clinical</td>
<td>Phone: 866-889-8054</td>
<td>The Outpatient Radiology Prior Authorization Protocol is required for select Advanced Outpatient Imaging Procedures. Working with external physician advisory groups, UnitedHealthcare Community Plan has developed the Outpatient Radiology Prior Authorization Protocol to support a more consistent application of current scientific clinical evidence and professional society guidance to Advanced Outpatient Imaging Procedures.</td>
</tr>
<tr>
<td></td>
<td>Online: UHCCommunityPlan.com or UnitedHealthcareOnline.com &gt; Notifications/Prior Authorizations &gt; Radiology Notification &amp; Authorization – Submission &amp; Status</td>
<td></td>
</tr>
<tr>
<td>Cardiology Prior Authorization</td>
<td>Phone: 866-889-8054</td>
<td>Prior authorization numbers represent the specific procedure requested and are valid for 45 calendar days from the date they are issued.</td>
</tr>
</tbody>
</table>
## Member Contact Info

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Services</td>
<td>866-675-1607</td>
<td>Assist members with issues or concerns. Available 8 a.m. to 8 p.m. Eastern Time Monday through Friday</td>
</tr>
<tr>
<td>Member Appeals and Grievances</td>
<td>Address:</td>
<td>This information allows the member to file an appeal or grievance for a dispute.</td>
</tr>
<tr>
<td></td>
<td>UnitedHealthcare</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Grievances and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appeals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P.O. Box 31364</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Salt Lake City, UT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>84131-0364</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In person:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9020 Stony Point</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parkway, Building</td>
<td></td>
</tr>
<tr>
<td></td>
<td>II</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Richmond, VA 23235</td>
<td></td>
</tr>
<tr>
<td>Expedited Appeals</td>
<td>Phone: 800-595-9532</td>
<td>Expedited appeals are for healthcare services ONLY. Not claims.</td>
</tr>
<tr>
<td>Department of Medical Assistance</td>
<td>Fax: 804-452-5454</td>
<td>If the member has exhausted all appeal/grievance levels with UnitedHealthcare Community Plan and does not agree with the final decision, the member may file an appeal with DMAS. Appeals must be filed with DMAS within 30 days of receipt of notification of an adverse action.</td>
</tr>
<tr>
<td>Services (DMAS)</td>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appeals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Division</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dept. of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Assistance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>600 East Broad</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Street</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Richmond, VA 23219</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Website:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>dmas.virginia.gov</td>
<td></td>
</tr>
</tbody>
</table>

### UnitedHealthcare Online

**UnitedHealthcareOnline.com**: Forms, bulletins, eligibility and claim status look-up; and online claim submission.

### Community Plans Online

**UHCCommunityPlan.com**: Plan coverage and provider directory.
Chapter 3: Enrollee Identification

Enrollee Identification

Each UnitedHealthcare Community Plan enrollee receives an identification (ID) card to present to you when seeking health care services. See the following enrollee ID card.

This card identifies the enrollee as a UnitedHealthcare Community Plan CCC Plus Program enrollee. Medicaid will not be responsible for claims for this member while they are enrolled in the UnitedHealthcare Community Care plan. During that time, submit all claims to UnitedHealthcare Community Plan.

Enrollee ID Card

Sample of UnitedHealthcare Community Plan
CCC Plus Identification Card

In case of emergency call 911 or go to nearest emergency room. Printed: 01/01/01

This card does not guarantee coverage. To verify benefits or to find a provider, visit the website myUHC.com/CommunityPlan.com or call.

For Member Customer Service: 866-622-7982 TTY
  Behavioral Health: 866-622-7982 TTY
  Nurseline: 888-547-3674 TTY
  Smiles for Children: 888-912-3456

For Providers: www.unitedhealthcareonline.com 877-843-4366
Claims: PO Box 5270, Kingston, NY 12402

Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903
For Pharmacist: 1-855-873-3493

Health Plan (80840) 911-87726-04
Member ID: 999999999
Payer ID: 87726
Member: SUBSCRIBER M BROWN
PCP Name: PROVIDER BROWN
PCP Phone: (999) 999-9999
Group Number: 99999
Rx Bin: 610494
Rx Grp: ACUVA
Rx PCN: 4444

UnitedHealthcare Community Plan, a Commonwealth Coordinated Care Plus Health Plan
1-888-912-3456
The Role of the Primary Care Provider

The PCP plays a vital role in the UnitedHealthcare Community Plan system by improving health care delivery in four critical areas:

1. Access
2. Coordination
3. Continuity
4. Prevention

The PCP is responsible for the provision of initial and basic care to a member who has selected the PCP. The PCP makes referrals for specialty and ancillary care, and coordinates all care delivered to members. The PCP must provide 24-hour/ seven day coverage and backup coverage when they are not available.

UnitedHealthcare Community Plan works with members and care providers to help ensure that all participants understand, support, and benefit from the primary care case management system.

PCP Definition

A practitioner who provides preventive and primary medical care for eligible members and who certifies service authorizations and referrals for all medically necessary specialty services. PCPs may include pediatricians; family and general practitioners; internists; and specialists who perform primary care functions such as surgeons; and, clinics including, but not limited to, health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), etc.

PCP Responsibilities

In addition to the requirements applicable to all care providers, PCPs must:

- Offer access to office visits on a timely basis, in conformance with the standards outlined in Timeliness Standards for Appointment Scheduling.
- Conduct a baseline examination during the member’s first appointment. The PCP should attempt to schedule this appointment if the new member fails to do so.
- Treat general health care needs of members listed on the PCP’s panel roster.
- Provide all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to Medicaid members up to 21 years (including structured screenings for developmental delays and dental referrals where appropriate).
- Screen all children ages nine months to 19 months and before their third birthday for lead toxicity.
- Contact members identified as non-compliant with the EPSDT periodicity schedule and notify ACPA when they come into compliance. Document reasons for continued non-compliance.
- Refer to participating specialists for health problems not managed by the PCP.
- Complete the referral prescription form and assist the member in making an appointment.
- Document the reason for a specialist ‘referral’ and the outcome of the specialist intervention in the member’s medical record.
- Coordinate each member’s overall course or plan of care.
- Be available personally to accept UnitedHealthcare Community Plan members at each office location at least 20 hours a week.
- Be available to members by telephone 24 hours a day, seven days a week, or have on-call service or make arrangements with another UnitedHealthcare Community Plan participating PCP. (Recorded messages are NOT permitted).
• Respond to after-hour patient calls within 30–45 minutes for non-emergent symptomatic conditions and within 15 minutes for emergency situations.

• Contact new members identified as not having an encounter during the first six months of enrollment, and all members identified as not having an encounter during the previous 12 months.

• Identify and reschedule broken and no-show appointments

• Document procedures for monitoring patients’ missed appointments as well as outreach attempts to reschedule missed appointments.

• A PCP, dentist, or specialist must conduct affirmative outreach whenever a member misses an appointment and must document it in the medical record. Such an effort will be considered reasonable if it includes three attempts to contact the member. Attempts may include written attempts, telephone calls and home visits. At least one attempt must be a follow-up telephone call.

• Triage for medical and dental conditions and special behavioral needs for non-compliant individuals who are mentally deficient.

• Educate members about appropriate use of emergency services.

• Discuss available treatment options and alternative courses of care with members.

• Refer services requiring prior authorization to the

• Pre-Certification Department, Behavioral Health Unit, or Pharmacy as appropriate. UnitedHealthcare Community Plan recommends calling at least five days, but not later than 48 hours, in advance of the admission or surgery. The PCP, specialist, attending care provider, or the facility may appeal any adverse decision made by UnitedHealthcare Community Plan. Procedures for filing an appeal are in Provider Appeals.

• Inform UnitedHealthcare Community Plan Case Management at 800-366-7304 of any member showing signs of End Stage Renal Disease.

• Inform UnitedHealthcare Community Plan Case Management at 800-366-7304 of any member who requires a referral to a certified hospice.

• Admit UnitedHealthcare Community Plan members to the hospital when necessary and coordinate the medical care of the member while hospitalized.

• Assist the UnitedHealthcare Community Plan Case Manager in assessing a member’s needs and developing a plan for continuing care beyond discharge, if medically necessary.

• Respect the advance directives of the member 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 we have established.

• Transfer medical records upon request. Copies of members’ medical records must be provided to members upon request at no charge.

• Maintain staff privileges at a minimum of one UnitedHealthcare Community Plan participating hospital.

PCP as Specialist

If a care provider is credentialed as a specialist as well as a PCP, the care provider can accept referrals from members whose PCP is a different provider. If the PCP wants to provide specialty services to members on their own panel, UnitedHealthcare Community Plan must give prior authorization for the specialty services for the care provider to receive payment.

Panel Roster

PCPs may print a monthly PCP Panel Roster by visiting UnitedHealthcareOnline.com.

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

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

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

Assignment to PCP Panel Roster

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

Member Transfers and Panel Closures

Member transfer requests should be in writing and directed to the member call center.

UnitedHealthcare Community Plan will review your written request and supporting documentation. The member will be reassigned upon review and approval of the transfer request.

Until such time as the transfer to another care provider is complete, you are responsible for providing that member with medically necessary care. You may not request a member to be transferred to another care provider for reasons related to the member’s cost of care.

When closing a provider panel, you need to give UnitedHealthcare Community Plan prior written notice:

- Of your intent to close a provider panel, along with a specific closing date; and
- When reopening the provider panel, along with a specific reopening date.

Pediatric Primary Care Medical Records Documentation Standards

Pediatric medical records documentation must include:

- Documentation of health and developmental history (mental and physical)
- Growth and development chart
- Documentation of physical exam
- Documentation of anticipatory guidance and health education
- Flow chart for immunizations
- Documentation of compliance with Early and Periodic Screening, Diagnostic and Treatment guidelines for Medicaid members younger than 21 years old

Appointment Standards

Routine Primary Care Services

Make appointments within 30 calendar days of the member’s request. This standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 calendar days, or for routine specialty services like dermatology, allergy care, etc.

Emergency Services

Make appointments for emergency services immediately upon the member’s request.
Urgent Medical Conditions
Make all urgent care and symptomatic office visits within no more than 24 hours of the member’s request or as quickly as the symptoms demand. A symptomatic office visit is the presentation of medical symptoms or signs, but not requiring care in an emergency room setting.

After-Hours Accessibility Standards
The following are acceptable standards for the office phone:
A. Is answered after hours by an answering service that meets language requirements of the major population groups and which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes;
B. Is answered after normal business hours by a recording in the language of each of the major population groups served directing the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider’s phone. Another recording is not acceptable to meet the standard; and
C. Is transferred after office hours to another location that meets language requirements where someone will answer the phone and be able to contact the PCP or another designated medical practitioner, who must return the call within 30 minutes.

The following are unacceptable standards for the office phone:
A. Only answered during office hours;
B. Is answered after hours by a recording that tells members to leave a message or send a page;
C. Is answered after hours by a recording that directs members to go to an Emergency Room for any services needed; and
D. Returning after-hour calls outside of the 30 minute timeline.

Referrals
Please use UnitedHealthcare Community Plan’s Participating Network when making referrals for services. Submission of a paper referral is no longer required for claims payment under UnitedHealthcare Community Plan.

This applies to all services that previously required a UnitedHealthcare Community Plan paper referral for payment.

UnitedHealthcare Community Plan continues to expect our participating PCP to coordinate all aspects of our member’s care.

Communication with specialists, ancillary care providers, pharmacies, facilities, and labs is critical in providing comprehensive quality medical care. In turn, UnitedHealthcare Community Plan expects specialists to communicate to the PCP through consultation reports, which include a treatment/visit summary, significant findings, and recommendations for continuing care. A record of the referral and consultation reports must be documented in the member’s medical record.

Referring Guidelines
Refer only to UnitedHealthcare Community Plan participating care providers. Also:
• Record the referral in your patient’s medical record
• Refer patients to a specialist by calling, sending a letter, fax or prescription to the specialist’s office
• Include the following information in the referral to the specialists:
  – Patient’s name,
  – Reason for the referral,
  – Any medical records, lab and test results relevant to the reason for the referral,
  – Specialist’s name and National Provider Identifier (if known).

The request for non-network care providers must be obtained prior to service by contacting the Prior Authorization Department.

Failure to obtain a prior authorization will result in the denial of the claim.

Self-referred Services
Members may self-refer:
• In-network for dental, vision and OB/GYN. Find information about network dental and vision care in the Important Contact Information section of this manual.
• Family planning services and emergency care to any qualified care provider or facility.
Out-of-Network Referrals

We will consider special circumstances, including coordination of care, for out-of-network care providers. When referring to non-participating specialists, you must obtain prior authorization.

Second Opinions

All UnitedHealthcare Community Plan members are entitled to a second opinion from a UnitedHealthcare Community Plan participating care provider prior to initiating any recommended treatment plan.

The PCP or the member may initiate a referral for a second opinion to a participating care provider. This service should be no cost to the member.

If the referral is for an out-of-network provider, contact the Provider Services to request authorization.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

UnitedHealthcare Community Plan provides coverage through EPSDT for medically necessary benefits for children outside the basic CCC Plus plan benefit package including, but not limited to, extended behavioral health benefits, nursing care (including private duty), pharmacy services, treatment of obesity, neurobehavioral treatment, and other individualized treatments specific to developmental issues. This includes if it is determined that otherwise excluded services/benefits for a child are medically necessary and will correct, improve, or needed to maintain the child’s medical condition. UnitedHealthcare Community Plan covers medical services (even if experimental or investigational) for children through EPSDT guidelines if it is determined the treatment or item would be effective to address the child’s condition. The determination whether a service is experimental must be reasonable and based on the latest scientific information available.
### Chapter 5: Benefits

#### Summary Of Covered Services – Medical Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Type</th>
<th>Limits/Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortions, induced</td>
<td>Covered</td>
<td>Must meet current federal and state guidelines and be medically necessary</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Audiology</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Autism</td>
<td>Limited Coverage</td>
<td></td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Limited Coverage</td>
<td>(** See Chapter 4 for EPSDT services)</td>
</tr>
<tr>
<td>Clinic Services - preventative, diagnostic,</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>therapeutic, rehabilitative, or palliative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>services, including renal dialysis clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>visits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Community Intellectual Disability Case</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Court Ordered Services</td>
<td>Covered</td>
<td>Medical necessity rules apply</td>
</tr>
<tr>
<td>Dental</td>
<td>Covered</td>
<td>Dental coverage for adults 21 and older includes preventive and diagnostic services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>such as examination, X-rays and prophylaxis.</td>
</tr>
<tr>
<td>Developmental Disability Support</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis</td>
<td>Covered</td>
<td>(** See Chapter 4 for EPSDT services)</td>
</tr>
<tr>
<td>and Treatment (EPSDT) Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Intervention Services</td>
<td>Covered</td>
<td>(** See Chapter 4 for EPSDT services)</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Covered</td>
<td></td>
</tr>
</tbody>
</table>
### Chapter 5: Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Type</th>
<th>Limits/Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services - Post Stabilization Care</td>
<td>Covered</td>
<td>See Chapter 4 for criteria</td>
</tr>
<tr>
<td>End Stage Renal Disease (ESRD)</td>
<td>Covered</td>
<td>Limitations may apply</td>
</tr>
<tr>
<td>Experimental and Investigational Procedures</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>FQHC/RHC</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>HIV Testing and Treatment Counseling</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Covered</td>
<td>Home health aide visits are limited to 32 visits per year. Other limits may apply. Authorization requirements may apply</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Covered</td>
<td>Coverage only applies if you are younger than age of 21. Not covered if you are older than 21 (except for flu and pneumonia for those at risk)</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>Covered</td>
<td>Authorization requirements may apply</td>
</tr>
<tr>
<td>Infertility</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Laboratory, Radiology and Anesthesia Services</td>
<td>Covered</td>
<td></td>
</tr>
</tbody>
</table>
| Long-acting Reversible Contraceptives (LARCs) | Covered | Outpatient Inpatient*  
*You may be reimbursed if LARC is inserted after delivery in hospitals. |
| Mammograms | Covered | |
| Maternity Services | Covered | |
| Medical Supplies and Equipment | Covered | Authorization requirements may apply |
| Certified Nurse-Midwife Services | Covered | |
| Organ Transplantation | Covered | Authorization requirements may apply |
| Outpatient Hospital Services, including preventative, diagnostic, surgical services rendered by hospitals | Covered | Authorization requirements may apply |
| Pain Management/Clinic | Covered | |
| Pap Smears | Covered | |
| Personal Care | Limited Coverage | Coverage only applies for CCC Plus home and community-based service waivers or under EPSDT |
### Service Coverage Type Limits/Considerations

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Type</th>
<th>Limits/Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services</td>
<td>Covered</td>
<td>Authorization requirements may apply</td>
</tr>
<tr>
<td>Physician Services</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Podiatry- diagnostic, medical or surgical treatment of disease, injury, or defect to human foot.</td>
<td>Limited Coverage</td>
<td>Limitations may apply. Not covered: preventative care, routine foot care cutting/removal of corns, warts, calluses</td>
</tr>
<tr>
<td>Pregnancy-Related Services</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Covered</td>
<td>Copay and limits may apply</td>
</tr>
<tr>
<td>Private Duty Nursing (PDN)</td>
<td>Covered</td>
<td>Coverage only applies for CCC Plus home and community-based service waivers or under EPSDT</td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) and digital rectal exams</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Prosthetics/Orthotics</td>
<td>Covered</td>
<td>Authorization requirements may apply</td>
</tr>
<tr>
<td>Prostheses, Breast</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Radiology Scans (MRI, PET, MRA, CT)</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Reconstructive Breast Surgery</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Second Opinions</td>
<td>Covered</td>
<td>When medically necessary</td>
</tr>
<tr>
<td>School Health Services</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Telemedicine Services</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Covered</td>
<td></td>
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</tbody>
</table>
## Service Coverage Type Limits/Considerations

<table>
<thead>
<tr>
<th>Service</th>
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<th>Limits/Considerations</th>
</tr>
</thead>
</table>
| Vision Services          | Limited Coverage| Ages 20 and younger:  
• 1 exam per year  
• Frames: 1 unit every 2 years  
• Lens: 2 units every 2 years  
• Contact Lenses: only when medically necessary  
Ages 21 and older:  
• Exam: 1 per year  
• Frames: 1 unit every 2 years  
• Lenses: 2 units every 2 years  
• Contact Lens: Not covered |

## HCBS Benefits

In addition to the Medicaid benefits, as an HCBS Waiver provider, you also will provide some of the following services. The benefit chart shows what waivers cover each service. Prior Authorization is required for all of the following services. Some limitations may apply.

### HCBS Waiver

<table>
<thead>
<tr>
<th>HCBS Waiver</th>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Personal Care (CD)</td>
<td>A range of support services necessary to enable an individual to remain at or return home rather than enter a nursing facility or Long Stay Hospital. These services include assistance with ADLs and IADLs, access to the community, self-administration of medication, other medical needs, supervision, and the monitoring of health status and physical condition.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Personal Care (AD)</td>
<td>A range of support services necessary to enable an individual to remain at or return home rather than enter a nursing facility or Long Stay Hospital. These services include assistance with ADLs and IADLs, access to the community, self-administration of medication, other medical needs, supervision, and the monitoring of health status and physical condition.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Respite Care (CD)</td>
<td>Respite services are unskilled services that provide temporary relief for the unpaid primary caregiver due to the physical burden and emotional stress of providing support and care to the individual.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Respite Care (AD)</td>
<td>Respite services are unskilled services or skilled services of a nurse (AD-skilled respite) that provide temporary relief for the unpaid primary caregiver due to the physical burden and emotional stress of providing support and care to the individual.</td>
</tr>
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<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Respite Care Agency Respite Services Skilled LPN</td>
<td>You may be reimbursed for respite services provided by a licensed practical nurse (LPN) or registered nurse (RN) with a current, active license and able to practice in the Commonwealth of Virginia as long as the service is ordered by a physician, and the provider can document the individual’s skilled needs. Respite care can be authorized as a sole program service, or it can be offered in conjunction with other services.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>PERS Nursing - RN (Personal Emergency Response System)</td>
<td>Electronic device capable of being activated by a remote wireless device that enables individuals to secure help in an emergency. PERS electronically monitors an individual’s safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation through the individual’s home telephone line or other two-way voice communication system. When appropriate, PERS may also include medication monitoring devices. PERS is not a stand-alone service. It must be authorized in conjunction with at least one other CCC Plus Waiver service.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>PERS Nursing - LPN (Personal Emergency Response System)</td>
<td>Electronic device capable of being activated by a remote wireless device that enables individuals to secure help in an emergency. PERS electronically monitors an individual’s safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation through the individual’s home telephone line or other two-way voice communication system. When appropriate, PERS may also include medication monitoring devices. PERS is not a stand-alone service. It must be authorized in conjunction with at least one other CCC Plus Waiver service.</td>
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<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>PERS Installation (Personal Emergency Response System)</td>
<td>Electronic device capable of being activated by a remote wireless device that enables individuals to secure help in an emergency. PERS electronically monitors an individual’s safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation through the individual’s home telephone line or other two-way voice communication system. When appropriate, PERS may also include medication monitoring devices. PERS is not a stand-alone service. It must be authorized in conjunction with at least one other CCC Plus Waiver service.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>PERS and Medication Installation (Personal Emergency Response System)</td>
<td>Electronic device capable of being activated by a remote wireless device that enables individuals to secure help in an emergency. PERS electronically monitors an individual’s safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation through the individual’s home telephone line or other two-way voice communication system. When appropriate, PERS may also include medication monitoring devices. PERS is not a stand-alone service. It must be authorized in conjunction with at least one other CCC Plus Waiver service.</td>
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<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>PERS Monitoring (Personal Emergency Response System)</td>
<td>Electronic device capable of being activated by a remote wireless device that enables individuals to secure help in an emergency. PERS electronically monitors an individual’s safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation through the individual's home telephone line or other two-way voice communication system. When appropriate, PERS may also include medication monitoring devices. PERS is not a stand-alone service. It must be authorized in conjunction with at least one other CCC Plus Waiver service.</td>
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<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>PERS and Medication Monitoring (Personal Emergency Response System)</td>
<td>Electronic device capable of being activated by a remote wireless device that enables individuals to secure help in an emergency. PERS electronically monitors an individual’s safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation via the individual’s home telephone line or other two-way voice communication system. When appropriate, PERS may also include medication monitoring devices. PERS is not a stand-alone service. It must be authorized in conjunction with at least one other CCC Plus Waiver service.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Adult Day Health Care</td>
<td>Adult Day Health Care (ADHC) services will be offered to persons who meet the preadmission screening criteria. Long-term maintenance or supportive services offered by a community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those CCC Plus Waiver individuals who are elderly or who have a disability and who are at risk of placement in a NF.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Transition Services</td>
<td>Services set up as expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence, where the person is directly responsible for their own living expenses</td>
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<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Environmental Modifications Only</td>
<td>Physical adaptations to an individual’s primary residence or primary vehicle which are necessary to help ensure the individual’s health, safety, or welfare. They may enable the individual to function with greater independence and without which the individual would require institutionalization.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Environmental Modification, Maintenance Costs Only</td>
<td>Physical adaptations to an individual’s primary residence or primary vehicle which are necessary to help ensure the individual’s health, safety, or welfare. They may enable the individual to function with greater independence and without which the individual would require institutionalization.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Assistive Technology Only</td>
<td>Specialized medical equipment and supplies, including those devices, controls, or appliances, not available under the State Plan for Medical Assistance, that enable individuals to increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live. This service includes ancillary supplies and equipment necessary for the proper functioning of such items. Assistive Technology will not be authorized as a standalone service.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Assistive Technology, Maintenance Costs Only</td>
<td>Specialized medical equipment and supplies, including those devices, controls, or appliances, not available under the State Plan for Medical Assistance, that enable individuals to increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live. This service includes ancillary supplies and equipment necessary for the proper functioning of such items. AT will not be authorized as a standalone service.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Service Facilitation Routine Visit</td>
<td>During visits with an individual, the Service Facilitator (SF) must observe, evaluate, and consult with the individual/OR, family/caregiver as appropriate and document the adequacy and appropriateness of the consumer-directed services with regards to the individual’s current functioning and cognitive status, medical and social needs, and the established Plan of Care. The individual’s satisfaction with the type and amount of service must be discussed. The SF must determine if the Plan of Care continues to meet the individual’s needs, and document the review of the plan.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Adult Day Health Care (per trip)</td>
<td>Adult Day Health Care (ADHC) services will be offered to persons who meet the preadmission screening criteria. Long-term maintenance or supportive services offered by a community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those CCC Plus Waiver individuals who are elderly or who have a disability and who are at risk of placement in a NF.</td>
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<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Service Facilitation Initial Comprehensive Visit</td>
<td>During visits with an individual, the Service Facilitator (SF) must observe, evaluate, and consult with the individual/OR, family/caregiver as appropriate and document the adequacy and appropriateness of the consumer-directed services with regards to the individual’s current functioning and cognitive status, medical and social needs, and the established care plan. The individual’s satisfaction with the type and amount of service must be discussed. The SF must determine if the care plan continues to meet the individual’s needs, and document the review of the plan.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Service Facilitation Consumer Training Visit</td>
<td>During visits with an individual, the Service Facilitator (SF) must observe, evaluate, and consult with the individual/OR, family/caregiver as appropriate and document the adequacy and appropriateness of the consumer-directed services with regards to the individual’s current functioning and cognitive status, medical and social needs, and the established care plan. The individual’s satisfaction with the type and amount of service must be discussed. The SF must determine if the care plan continues to meet the individual’s needs, and document the review of the plan.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Service Facilitation Management Training Hours</td>
<td>During visits with an individual, the Service Facilitator (SF) must observe, evaluate, and consult with the individual/OR, family/caregiver as appropriate and document the adequacy and appropriateness of the consumer-directed services with regards to the individual’s current functioning and cognitive status, medical and social needs, and the established care plan. The individual’s satisfaction with the type and amount of service must be discussed. The SF must determine if the care plan continues to meet the individual’s needs, and document the review of the plan.</td>
</tr>
<tr>
<td>Elderly or Disabled with Consumer-Direction (EDCD)</td>
<td>Service Facilitation Reassessment Visit</td>
<td>During visits with an individual, the Service Facilitator (SF) must observe, evaluate, and consult with the individual/OR, family/caregiver as appropriate and document the adequacy and appropriateness of the consumer-directed services with regards to the individual’s current functioning and cognitive status, medical and social needs, and the established care plan. The individual’s satisfaction with the type and amount of service must be discussed. The SF must determine if the care plan continues to meet the individual’s needs, and document the review of the plan.</td>
</tr>
<tr>
<td>Technology Assisted (Tech)</td>
<td>Environmental Modifications Structural Modification</td>
<td>Physical adaptations to an individual’s primary residence or primary vehicle which are necessary to help ensure the individual’s health, safety, or welfare or which enable the individual to function with greater independence and without which the individual would require institutionalization</td>
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<td></td>
<td>Supply Cost Only</td>
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<tr>
<td>Technology Assisted (Tech)</td>
<td>Environmental Modification</td>
<td>Physical adaptations to an individual’s primary residence or primary vehicle which are necessary to help ensure the individual’s health, safety, or welfare or which enable the individual to function with greater independence and without which the individual would require institutionalization.</td>
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<tr>
<td></td>
<td>Transportation Modification</td>
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<tr>
<td>Technology Assisted (Tech)</td>
<td>Environmental Modifications</td>
<td>Physical adaptations to an individual’s primary residence or primary vehicle which are necessary to help ensure the individual’s health, safety, or welfare or which enable the individual to function with greater independence and without which the individual would require institutionalization.</td>
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<tr>
<td></td>
<td>Maintenance</td>
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</tr>
<tr>
<td>Technology Assisted (Tech)</td>
<td>Environmental Modifications</td>
<td>Physical adaptations to an individual’s primary residence or primary vehicle which are necessary to help ensure the individual’s health, safety, or welfare or which enable the individual to function with greater independence and without which the individual would require institutionalization.</td>
</tr>
<tr>
<td></td>
<td>Rehab</td>
<td></td>
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<tr>
<td>Technology Assisted (Tech)</td>
<td>Assistive Technology Rehabilitation</td>
<td>Specialized medical equipment and supplies, including those devices, controls, or appliances, that are not available under the State Plan for Medical Assistance, that enable individuals to increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live. This service includes ancillary supplies and equipment necessary for the proper functioning of such items. AT will not be authorized as a standalone service.</td>
</tr>
<tr>
<td>Technology Assisted (Tech)</td>
<td>Assistive Technology Off the Shelf item</td>
<td>Specialized medical equipment and supplies, including those devices, controls, or appliances, that are not available under the State Plan for Medical Assistance, that enable individuals to increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live. This service includes ancillary supplies and equipment necessary for the proper functioning of such items. AT will not be authorized as a standalone service.</td>
</tr>
<tr>
<td>Technology Assisted (Tech)</td>
<td>Assistive Technology Maintenance Cost</td>
<td>Specialized medical equipment and supplies, including those devices, controls, or appliances, that are not available under the State Plan for Medical Assistance, that enable individuals to increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live. This service includes ancillary supplies and equipment necessary for the proper functioning of such items. AT will not be authorized as a standalone service.</td>
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<tr>
<td>Technology Assisted (Tech)</td>
<td>Respite Care: Agency Directed, RN Skilled Nursing</td>
<td>Providers may be reimbursed for respite services provided by a LPN or RN with a current, active license and able to practice in the Commonwealth of Virginia as long as the service is ordered by a physician and the provider can document the individual’s skilled needs. Respite care can be authorized as a sole program service, or it can be offered in conjunction with other services.</td>
</tr>
<tr>
<td>Technology Assisted (Tech)</td>
<td>Respite Care: Agency Directed, LPN Skilled Nursing</td>
<td>Providers may be reimbursed for respite services provided by a LPN or RN with a current, active license and able to practice in the Commonwealth of Virginia as long as the service is ordered by a physician and the provider can document the individual’s skilled needs. Respite care can be authorized as a sole program service, or it can be offered in conjunction with other services.</td>
</tr>
<tr>
<td>Technology Assisted (Tech)</td>
<td>Skilled Nursing Services, RN</td>
<td>In-home nursing services provided for individuals enrolled in the CCC Plus Waiver with a serious medical condition and/ or complex health care need. The individual requires specific skilled and continuous nursing care on a regularly scheduled or intermittent basis performed by a RN or a LPN under the direct supervision of a registered nurse.</td>
</tr>
<tr>
<td>Technology Assisted (Tech)</td>
<td>Skilled Nursing Services, LPN</td>
<td>In-home nursing services provided for individuals enrolled in the CCC Plus Waiver with a serious medical condition and/ or complex health care need. The individual requires specific skilled and continuous nursing care on a regularly scheduled or intermittent basis performed by a RN or a LPN under the direct supervision of a registered nurse.</td>
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<tr>
<td>Technology Assisted (Tech)</td>
<td>Personal Care</td>
<td>A range of support services necessary to enable an individual to remain at or return home rather than enter a nursing facility or Long Stay Hospital. These services include assistance with ADLs and IADLs, access to the community, self-administration of medication, or other medical needs, supervision, and the monitoring of health status and physical condition.</td>
</tr>
<tr>
<td>Technology Assisted (Tech)</td>
<td>Skilled Private Duty Nursing Congregate Nursing – LPN (Congregate Nursing – LPN)</td>
<td>Skilled nursing provided to three or fewer CCC Plus Waiver individuals who reside in the same primary residence. Congregate skilled PDN may be authorized in conjunction with skilled PDN in instances where individuals attend school or must be out of the home for part of the authorized PDN hours. Congregate skilled PDN hours will be determined and approved according to skilled nursing needs documented on the appropriate referral form.</td>
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</tr>
<tr>
<td>Technology Assisted (Tech)</td>
<td>Congregate Respite – LPN</td>
<td>Congregate respite nursing provided to three or fewer Program individuals who reside in the same primary residence. The provision of congregate respite nursing care for short period(s) of time (a maximum of 15 days or 360 hours per calendar year, per household) to provide the unpaid primary caregiver a break from caregiver responsibilities.</td>
</tr>
<tr>
<td>Technology Assisted (Tech)</td>
<td>Congregate Respite – RN</td>
<td>Congregate respite nursing provided to three or fewer Program individuals who reside in the same primary residence. The provision of congregate respite nursing care for short period(s) of time (a maximum of 15 days or 360 hours per calendar year, per household) to provide the unpaid primary caregiver a break from caregiver responsibilities.</td>
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<tr>
<td>Technology Assisted (Tech)</td>
<td>Environmental Modifications, Maintenance Costs Only</td>
<td>Physical adaptations to an individual’s primary residence or primary vehicle which are necessary to help ensure the individual’s health, safety, or welfare or which enable the individual to function with greater independence and without which the individual would require institutionalization.</td>
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<tr>
<td>Technology Assisted (Tech)</td>
<td>Transition Services</td>
<td>Services “setup” as expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence, where the person is directly responsible for their own living expenses.</td>
</tr>
</tbody>
</table>
UnitedHealthcare Community Plan CCC

Plus-Covered Level of Benefits

Covered benefits are available to enrollees only if they receive services from a UnitedHealthcare Community Plan participating care provider. If the enrollee receives services from a non-contracted provider, UnitedHealthcare Community Plan will provide an opportunity for the non-contracted provider to become contracted. If the care provider chooses to remain non-contracted, the care manager will work with the enrollee and our participating care providers to transition services. All services require case management authorization. Medicare enrollees may access any Medicare-approved care provider without authorization.

Exclusions

Certain services and/or service categories are excluded from coverage under UnitedHealthcare Community Plan. For a complete list of exclusions, contact Provider Services on the Important Phone Numbers page. In addition to the specific excluded services, UnitedHealthcare Community Plan may deny coverage if:

- The service is not medically necessary; or
- The service is not a CCC Plus-covered benefit.

Post-Stabilization, Emergency and Urgently Needed Services

Post-Stabilization Care Services – Covered services related to an emergency medical condition provided after an enrollee is stabilized to maintain, improve or resolve the enrollee’s condition pursuant to 42 CFR 422.113.

Urgent Care – Services for conditions, which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain) or substantially restrict an enrollee’s activity (e.g., infectious illnesses, influenza, respiratory ailments).

Emergency Services and Care – Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If such a condition exists, emergency services and care include the care or treatment necessary to relieve or eliminate the emergency medical condition within the service capability of the facility.

UnitedHealthcare Community Plan will help ensure enrollees are notified of their rights and responsibilities for how to obtain care and what to do in an emergency or urgent medical situation.

In the event of an emergency, the enrollee should seek immediate care or call 911 for assistance. Prior authorization is not required. UnitedHealthcare Community Plan may not deny payment if you instruct an enrollee to seek emergency services.

UnitedHealthcare Community Plan provides coverage, within the scope of covered benefits, for the treatment of an emergency medical condition. This is defined by the CCC Plus plan as a condition that manifests itself by acute symptoms of sufficient severity (including severe pain), such a prudent layperson, which possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

Post-stabilization care is covered if UnitedHealthcare Community Plan:

- Already authorized it.
- Did not respond to prior authorization request for stabilization services within one hour after you asked to approve the care.
- Could not be reached for prior authorization despite reasonable efforts.

Such automatic approval of post-stabilization care continues to be covered until UnitedHealthcare Community Plan has responded to the request and arranged for discharge or transfer.
Enrollees are encouraged to notify UnitedHealthcare Community Plan as soon as possible after receiving post-stabilization, emergency or urgently needed health services. You are required to notify us if an enrollee is admitted to the hospital.

**Behavioral Health**

For UnitedHealthcare Community Plan members enrolled in the CCC Plus Plan:

Magellan provides Community Mental Health Recovery Services (CMHRS) managed care services. UnitedHealthcare Community Plan provides Mental Health Inpatient and Residential managed care services and ARTS services. The ARTS program expands access to all levels of ASAM evidence-based addiction treatment for Medicaid enrollees in the Commonwealth of Virginia.

**Inpatient Concurrent Review: Clinical Information**

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

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

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

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

**Early Intervention Services**

UnitedHealthcare Community Plan will help ensure when the care provider has identified a developmental delay in an enrollee younger than 3, they make a referral to the Infant and Toddler Connection. They also document the referral in the member’s records. The Care Coordination team will collaborate with care providers to enable diagnosis and treatment or follow-up of all uncovered or suspected abnormalities. The team will also assist the family with scheduling appointments and transportation to Early Intervention (EI) appointments if needed:

- Once the LOC is entered, the EI services are billable based on the physician’s order on the IFSP.
- All EI service providers must be enrolled with the child’s health plan prior to billing.
- The care coordinators will collaborate with the EI providers to assist with DME needs.
- The care coordinators will collaborate with the interdisciplinary team to coordinate a transition plan when an enrollee is no longer eligible for EI.

**Coordination of Care**

**Communication with PCPs and Other Health Care Professionals**

To coordinate and manage care between behavioral health and medical professionals, we require you seek to obtain the member’s consent to exchange appropriate treatment information with medical care professionals (e.g., primary physicians, medical specialists) and/or other behavioral health care providers (e.g., psychiatrists, therapists). We require coordination and communication take place: at the time of intake, during treatment, the time of discharge or termination of care, between levels of care and at any other point in treatment that may be appropriate. Coordination of services improves the quality of care to members in several ways:

- It allows behavioral health and medical care providers to create a comprehensive care plan.
- It allows a PCP to know their patient followed through on a behavioral health referral.
- It minimizes potential adverse medication interactions for members treated with psychotropic and non-psychotropic medication.
- It allows for better management of treatment and follow-up for members with coexisting behavioral and medical disorders.
- It promotes a safe and effective transition from one level of care to another.
- It can reduce the risk of relapse.
To facilitate effective communication between treatment professionals involved in a member’s care, we require in-network care providers to coordinate services with the member’s PCP at a minimum, by applying the following standards for care coordination:

- During the diagnostic assessment session, request the member’s written consent to exchange information with all appropriate treatment professionals.
- After the initial assessment, provide other treating professionals with the following information within two weeks:
  - Summary of member’s evaluation
  - Diagnosis
  - Treatment plan summary (including any medications—prescribed)
  - Primary clinician treating the Member
- Attempt to obtain all relevant clinical information that other treating care providers may have pertaining to the member’s mental health or substance use problems.
- Update other behavioral health and/or medical clinicians when there is a change in the member’s condition or medication(s)
  - When serious medical conditions warrant closer coordination
  - At the completion of treatment, send a copy of the discharge summary to the other treating professionals.

Some members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Magellan, as well as accrediting organizations, expects you to make a “good faith” effort at communicating with other behavioral health care providers and any medical care providers who are treating the member as part of an overall approach to coordinating care.

Questions or Concerns

Contact Provider Services for further clarification of covered benefits.

Pharmacy Benefit Management Community Plan

VA CCC Plus members receive their outpatient prescription drugs through UnitedHealthcare Community Plan.

Member ID Cards for Prescription Benefit

All UnitedHealthcare Community Plan members must use their member ID card to obtain covered prescription drugs.

Prescription Drug Coverage

UnitedHealthcare Community Plan has an extensive pharmacy program, including a PDL and pharmaceutical management procedures. Medically necessary outpatient prescription drugs are covered when prescribed by a care provider licensed to prescribe federal legend drugs or medicines. Some items are covered only with prior authorization as outlined in our Prescription Drug List (PDL).

For details on drugs covered under the pharmacy benefit and list of drugs that require prior authorization, go to UHCCommunityPlan.com. Select VA as the state, and go to the Pharmacy Program menu on the right side of the screen.

Prescriptions Requiring Prior Authorization

To request a pharmacy prior authorization, including injectable drugs, call 800-310-6826 or fax the prior authorization request form. Prior authorization forms are located on our website at UHCCommunityPlan.com > VA > Pharmacy Program.

Review the UnitedHealthcare Community Plan Drug Formulary at UHCCommunityPlan.com > VA > Pharmacy Program to verify if prior authorization is necessary. You should receive prior authorization before giving a UnitedHealthcare Community Plan member a prescription for a medication that requires prior authorization. UnitedHealthcare Community Plan makes prior authorization determinations within 24 hours of receiving all the necessary information.

Pharmacy Network

Most chain pharmacies and independent pharmacies fill prescriptions for UnitedHealthcare Community Plan members.

To locate a pharmacy convenient for a member, please visit our website at UHCCommunityPlan.com > VA > Pharmacy Program.

Generic Drugs

Generic drugs are provided when available as required by state mandatory generic substitution regulations. Generic drugs are approved by the Food and Drug Administration (FDA) as equivalent to their brand name counterparts. If a generic drug is available, a brand-name drug will not be provided to the member.
Brand-Name Drugs
If a brand name is required based on medical necessity, you may request brand-name approval through a prior authorization.

Pharmacy Benefit Exclusion
Certain drugs are not covered by the pharmacy benefit. Drugs not covered include:

- Drugs used for anorexia or weight gain;
- Drugs used to promote fertility;
- Agents used for cosmetic purposes or hair growth;
- Agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA;
- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered;
- Drugs which have been recalled;
- Experimental drugs or non-FDA-approved drugs; and,
- Any drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program.

Existing UnitedHealthcare Community Plan members may continue taking a medication removed from the formulary if:

- Member is enrolled in UnitedHealthcare Community Plan (unless the medication has been deemed unsafe).
- You provide medical rationale to support continued use.
- You have consulted with and received approval from the member.

A member may change to a medication on UnitedHealthcare Community Plan formulary only if you and the member agree on the change. Members new to therapy will be required to use a medication on the formulary, unless otherwise authorized.

Day Supply Dispensing Limitations
Members may receive up to a one-month supply (31 days) of medication per prescription order or refill. Members may reorder or refill a medication after using 85 percent of the medication. If submitting a claim before using 85 percent of the medication, based on the original day supply submitted on the claim, the claim will reject with a "refill too soon" message.

Quantity Limitations
UnitedHealthcare Community Plan places quantity limitations on medications. Per state regulations, certain quantity limits apply to mental health drugs. The following are types of quantity limitations:

- Prescriptions for monthly quantities greater than the indicated limit require a prior authorization request.
- Quantity limits based on Efficient Medication Dosing (also known as Dose Optimization)
  - The Efficient Medication Dosing Program is designed to consolidate medication dosage to the most efficient daily quantity to increase adherence to therapy and also promote the efficient use of health care dollars.
  - The limits for the program are established based on FDA approval for dosing and the availability of the total daily dose in the least amount of tablets or capsules daily. Quantity Limits in the prescription claims processing system will limit the dispensing to consolidate dosing.
  - The Pharmacy Claims Processing System will prompt the pharmacist to request a new prescription order from you.

Additions to the Quantity Limitations program drug list will be made from time to time and you will be notified accordingly. Per state regulations, quantity limits do not apply to mental health drugs. Also, we recognize a number of patient-specific variables must be taken into consideration when drug therapy is prescribed and therefore overrides will be available through the medical exception (prior authorization) process. Find more information regarding drug-specific quantity limits at UHCCommunityPlan.com.

Emergency Prescriptions
Provide a three-day emergency medication supply when a medication is needed without delay and prior authorization (PA) cannot be resolved within 24 hours.

This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

If you cannot be reached, or are unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy may dispense a product packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply. You will receive a response by phone within 24 hours of a request for prior authorization.
Chapter 6: Enrollment

Eligibility requirements for CCC Plus are determined by the Department of Medical Assistance Services (DMAS) and compliance is essential. DMAS may, upon new state or federal regulations or department policy, modify the list of eligible/excluded individuals as appropriate. The following provides DMAS’s guidelines for both eligible and excluded populations.

1. Eligible CCC Plus Populations

The following populations are included in CCC Plus per DMAS’s eligibility requirements:

1) Dual eligible individuals with full Medicaid and any Medicare A and/or B coverage.

2) Non-dual eligible individuals who receive Long-Term Support Services (LTSS) services either through:
   a) An institution; or,
   b) Home and Community-Based Services (HBCS) 1915(c) waivers:
      i) Building Independence (BI);
      ii) CCC Plus;
      iii) Community Living (CL); and
      iv) Family and Individual Supports (FIS).

This includes individuals who transition from the Medallion 3.0 health and acute care (HAP) program.

3) Individuals enrolled in CCC will transition to CCC Plus on January 2018, which is after the standard CCC program ends.

4) Remaining Aged, Blind and Disabled (ABD) population (non-duals and those who do not receive LTSS). The majority of this population will transition from the DMAS’s Medallion 3.0 program to CCC Plus on January 1, 2018.

5) The CCC Plus populations listed above may include individuals enrolled in the Medicaid Works program, Native Americans, individuals with other comprehensive insurance, children in foster care and adoption assistance, and individuals approved by DMAS as inpatients in long-stay hospitals (DMAS recognizes two facilities: Lake Taylor [Norfolk] and Hospital for Sick Children [Washington, DC]).

6) In addition, individuals enrolled in the Building Independence, Community Living, and Family and Individual Supports Waivers will be enrolled in CCC Plus for their non-waiver services only (e.g., acute, behavioral health, pharmacy, and non-LTSS waiver transportation services).

7) DMAS reserves the right to transition additional populations and services into CCC Plus in the future.

2. Exclusions from the CCC Plus Population

Medicaid recipients in an eligibility category not listed above in the section “Eligible CCC Plus Populations” are excluded from enrollment in a managed care plan. This includes recipients in the following eligibility categories:

1) Individuals enrolled in the Commonwealth’s Medallion 3.0 and Title XXI CHIP programs (FAMIS, FAMIS MOMS).

2) Individuals enrolled in a PACE program.

3) Individuals enrolled in the Alzheimer’s Assisted Living Waiver.

4) Newborns whose mothers are CCC Plus members on their date of birth. However, the managed care plan must adhere to a process that assures newborns get enrolled in Medicaid as soon as possible.

5) Dual eligible individuals without full Medicaid benefits, such as:
   i. Qualified Medicare Beneficiaries (QMBs);
   ii. Special Low-Income Medicare Beneficiaries (SLMBs);
   iii. Qualified Disabled Working Individuals (QDWIs); or,
   iv. Qualifying Individuals (QIs).-Medicaid pays Part B premium.
6) Individuals who have any insurance purchased through the Health Insurance Premium Payment (HIPP) program.

7) Individuals with temporary coverage or who are in limited coverage groups, including:
   a) Individuals enrolled in Plan First (DMAS’s family planning program for coverage of limited benefits surrounding pregnancy prevention).
   b) Individuals enrolled in the Governor’s Access Plan (GAP), which provides basic medical and targeted behavioral health care to some uninsured Virginians with severe mental illness, or other limited benefit aid categories.

8) Individuals enrolled in a Medicaid-approved hospice program at the time of enrollment. However, if an individual enters a hospice program while enrolled in CCC Plus, the member will remain enrolled in CCC Plus.

9) Individuals who live on Tangier Island.

10) Individuals younger than age 21 who are approved for DMAS residential treatment Level C (RTC) programs as defined in 12VAC 30-130-860.

11) Individuals with end stage renal disease (ESRD) at the time of enrollment into CCC Plus (DMAS will manually exclude these individuals upon notification). However, an individual who develops ESRD while enrolled in the CCC Plus program will remain in CCC Plus.

12) Individuals who are institutionalized in state or private ICF/ID and state ICF/MH facilities. A state acute care facility is not excluded.

13) Individuals who reside at Piedmont, Catawba, and Hancock State facilities operated by DBHDS.

14) Individuals who reside in nursing facilities operated by the Veterans Administration.

15) Individuals enrolled in the Department’s Money Follows the Person (MFP) Demonstration project.

16) Individuals participating in the CMS Independence at Home (IAH) demonstration (DMAS will manually exclude these individuals). However, IAH individuals may enroll in the CCC Plus program if they choose to disenroll from IAH.

17) Certain individuals receiving treatment in facilities located outside of Virginia as authorized by DMAS.

18) Individuals who are incarcerated. (Individuals on house arrest are not considered incarcerated.)

DMAS will, upon new state or federal regulations or Department policy, modify the list of excluded individuals as appropriate. If DMAS modifies the exclusion criteria, all managed care plans will comply with the amended list of exclusion criteria.

3. Member Orientation

Once UnitedHealthcare Community Plan receives enrollment data from DMAS, each new member receives a letter stating the effective date of coverage and a packet of information about the plan.

The following documents are provided to new members:

- Welcome letter
- Member handbook
- Member ID card
- Provider directory
- Insurance Portability and Accountability Act (HIPAA) privacy notice

Upon enrollment, UnitedHealthcare Community Plan will contact new members by phone and conduct a Health Risk Assessment (HRA). This HRA is used as the basis for working toward development of a plan of care for the member and a visit is scheduled with member. The member orientation is completed during the member visit by the assigned care manager and includes the following topics:

- The role of the member’s PCP
- How to access long-term care services
- Behavioral health and substance abuse services

Chapter 6: Enrollment
• How to access urgent care and emergency care
• Use of non-contracted providers and practitioners
• Filing a grievance or appeal
• Member rights and responsibilities
• Member right to self-determination
• The care manager’s role with the member and their PCP
• How to disenroll voluntarily
• Customer service number and use

4. Member Rights

UnitedHealthcare Community Plan CCC Plus members have certain rights to:

• Receive timely access to care and services.
• Take part in decisions about health care, regardless of cost or benefit coverage, as well as the right to choose providers from network and to refuse treatment.
• Choose to receive long-term services and supports in home, community, or nursing facility.
• Confidentiality and privacy about medical records and when to get treatment.
• Receive information and discuss available treatment options and alternatives presented in a manner and language they understand, including oral translation services free of charge.
• Receive readable materials and information in an alternative format or language.
• Receive reasonable accommodations to help ensure effective access and communicate with care providers, including auxiliary aids, interpreters, flexible scheduling, and physically accessible buildings and services.
• Receive information necessary for the member to give informed consent before the start of treatment.
• Be treated with respect and dignity.
• Get a copy of their medical records and ask that the records be amended or corrected.
• Be free from restraint or seclusion unless ordered by a care provider when there is an imminent risk of bodily harm to the member or others or when there is a specific medical necessity. Seclusion and restraint will never be used as a means of coercion, discipline, retaliation, or convenience.

• Get care without regard to disability, gender, race, health status, color, age, national origin, sexual orientation, marital status or religion.
• Be informed of where, when and how to obtain the services needed from the CCC Plus plan, including how members receive benefits from out-of-network providers if the services are not available in the plan’s network.
• Complain about UnitedHealthcare Community Plan Commonwealth Coordinated Care Plus to the state. Members call the CCC Plus Helpline at 844-374-9159 or TDD 800-817-6608 to make a complaint about us.
• Appoint someone to speak about care and treatment and to represent member in an appeal.
• Make advance directives and plans about care if they are not able to make own health care decisions.
• Change health plan once a year for any reason during open enrollment or change MCO after open enrollment for an approved reason.
• Appeal any adverse benefit determination by UnitedHealthcare Community Plan CCC Plus the member disagrees with relating to service coverage or payment.
• File a complaint about concerns they have with our customer service, the services received, or the care and treatment received from one of our network care providers.
• To receive information about our plan, covered services, care providers in our network, and about rights and responsibilities.
• To make recommendations regarding our member rights and responsibility policy, for example by joining or Member Advisory Committee.

UnitedHealthcare Community Plan CCC Plus members have a responsibility to:

• Carry the UnitedHealthcare Community Plan CCC Plus card at all times.
• Learn and follow the UnitedHealthcare Community Plan CCC Plus rules.
• Supply information to the UnitedHealthcare Community Plan CCC Plus plan and care provider needed to provide care.
• Contact UnitedHealthcare Community Plan CCC Plus, the case worker and care provider about important
changes, such as changes in a name, address and telephone number.

• Get medical services from the UnitedHealthcare Community Plan CCC Plus care providers.

• Get an authorization from the PCP before seeing a consultant or specialist, except for dental, family planning, vision care or OB/GYN services.

• Use the emergency room only in cases of an emergency.

• Treat health care providers with courtesy, consideration, respect and dignity. This includes scheduling appointments, arriving on time for scheduled appointments and canceling appointments when they cannot keep them.

• Request protected health information by calling the UnitedHealthcare Community Plan CCC Plus Member Helpline at 800-414-9025.

• Ask questions to understand health problems and work with the care provider and UnitedHealthcare Community Plan to develop agreed upon treatment goals.

• Follow treatment plans and instructions for care agreed on with care provider.

• Learn about any condition, procedure or treatment and to think about it before it is done.

• Learn about any procedure or treatment and think about the outcome of refusing suggested treatment.

• Consider health care choices carefully.

• State complaints and concerns in a polite and appropriate way.

• Report symptoms, problems and related health information to the PCP.

• Tell the PCP about themselves and sign consent forms so the PCP can get a copy of old records.

5. Disenrollment

General Provisions

A) UnitedHealthcare Community Plan will help ensure it does not restrict the member’s right to disenroll voluntarily in any way.

B) UnitedHealthcare Community Plan or its agents will not provide or assist in the completion of a disenrollment request or assist DMAS’s contracted enrollment broker in the disenrollment process.

C) UnitedHealthcare Community Plan will help ensure members who are disenrolled and wish to file an appeal have the opportunity to do so. All members have the right to file an appeal on disenrollment except for the following reasons:

• Moving out of the region;

• Loss of Medicaid eligibility;

• Determination that a member is in an excluded population; and

• Member death.

D) A member subject to open enrollment may submit to DMAS or their enrollment broker a request to disenroll. This may be done without cause during the 90-calendar day change period following member’s initial enrollment date with UnitedHealthcare Community Plan, or the date DMAS or their enrollment broker sends the member notice of the enrollment, whichever is later. A member may request disenrollment without cause every 12 months thereafter during the annual open enrollment period.

E) Those not subject to open enrollment may disenroll at any time. The effective date of an approved disenrollment will be the last calendar day of the month disenrollment was made effective by DMAS or its enrollment broker. If DMAS or its enrollment broker fails to make a disenrollment determination within this time frame, the disenrollment is considered approved as of the date DMAS’s action was required.

F) On the first day of the month after receiving notice that the member has moved to another region, DMAS or its enrollment broker will automatically disenroll the member from UnitedHealthcare Community Plan and treat the member as if they are a new Medicaid-eligible member able to choose another care provider pursuant to DMAS’s enrollment assignment process.

When Disenrollments Can Occur

A member may request disenrollment at any time. DMAS or their enrollment broker performs disenrollment as follows:

• For cause, at any time

• Without cause, for members subject to open enrollment, at the following times:

  – During the 90 days following the enrollee’s initial enrollment, or the date DMAS or its enrollment
broker sends the member notice of the enrollment, whichever is later;
  – At least every 12 months;
  – If the temporary loss of Medicaid eligibility has caused the member to miss the open enrollment period; or
  – When DMAS or its enrollment broker grants the member the right to terminate enrollment without cause (done on a case-by-case basis).
• Without cause, for members not subject to open enrollment, at any time.

**Cause For Disenrollment**

A) A member may request disenrollment from UnitedHealthcare Community Plan for cause at any time. Such requests will be submitted to DMAS or its enrollment broker.

B) The following reasons constitute cause for disenrollment from UnitedHealthcare Community Plan:

• The member does not live in a region where UnitedHealthcare Community Plan is authorized to provide services, as indicated by DMAS’s enrollment system.

• The member is excluded from enrollment.

• A substantiated marketing or community outreach violation has occurred.

• The member is in the wrong managed care plan as determined by DMAS or its enrollment broker.

• UnitedHealthcare Community Plan is not authorized to provide services in the member’s region.

• DMAS has imposed intermediate sanctions upon UnitedHealthcare Community Plan.

• The member needs related services performed concurrently, but not all related services are available within UnitedHealthcare Community Plan’s network, or the member’s PCP has determined receiving services separately would subject the member to unnecessary risk.

• UnitedHealthcare Community Plan does not, because of moral or religious objections, cover the service the member seeks.

• The member who receives LTSS would have to change their residential, institutional, or employment supports care provider based on that provider’s change in status from an in-network to an out-of-network care provider with UnitedHealthcare Community Plan and, as a result, would experience a disruption in their residence or employment; and

• Other reasons per 42 CFR 438.56(d)(2), including, but not limited to: poor quality of care; lack of access to services covered under the contract; service access impairments due to significant changes in the geographic location of services; an unreasonable delay or denial of service; lack of access to care providers experienced in dealing with the member’s health care needs; or fraudulent enrollment.

**Re-Enrollments**

CCC Plus members who have been previously enrolled with UnitedHealthcare Community Plan and who regain eligibility for the CCC Plus program within 60 calendar days of the effective date of exclusion or disenrollment will be reassigned to the UnitedHealthcare Community Plan without going through the selection or assignment process. DMAS will send members a notice informing them of their re-enrollment.

**Involuntary Disenrollments**

A. With proper written documentation, the following are acceptable reasons UnitedHealthcare Community Plan may submit involuntary disenrollment requests to DMAS or its enrollment broker:

• Fraudulent use of the member ID card. In such cases, UnitedHealthcare Community Plan will report the event to the Program Integrity team.

• The member’s behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the UnitedHealthcare Plan seriously impairs our ability to furnish services to either the member or other members.
  – This section does not apply to members with medical or mental health diagnoses if the member’s behavior is attributable to the diagnoses.

• An involuntary disenrollment request related to member behavior must include documentation that UnitedHealthcare:
  – Provided the member at least one (a) oral warning and at least one (b) written warning of the full implications of the member’s actions;
  – Attempted to educate the member regarding rights and responsibilities;
Offered assistance through care coordination/case management that would enable the member to comply; and

- Determined that the member’s behavior is not related to the member’s medical or mental health condition.

- Falsification of prescriptions by a member.

B) UnitedHealthcare Community Plan will promptly submit such disenrollment requests to DMAS. UnitedHealthcare Community Plan will not submit a disenrollment request that would cause the disenrollment to be effective later than 45 calendar days after the involuntary disenrollment receipt. UnitedHealthcare Community Plan will help ensure involuntary disenrollment documents are maintained in an identifiable member record.

C) All requests will be reviewed on a case-by-case basis and subject to the sole discretion of DMAS. Any request not approved is final and not subject to UnitedHealthcare Community Plan dispute or appeal.

D) UnitedHealthcare Community Plan will not request disenrollment of a member due to:

- Health diagnosis;
- Adverse changes in an member’s health status;
- Utilization of medical services;
- Diminished mental capacity;
- Pre-existing medical condition;
- Uncooperative or disruptive behavior resulting from the member’s special needs; or
- Attempt to exercise rights under UnitedHealthcare Community Plan’s grievance system.

E) When UnitedHealthcare Community Plan requests an involuntary disenrollment, it will notify the member in writing that UnitedHealthcare Community Plan is requesting disenrollment, the reason for the request, and an explanation that UnitedHealthcare Community Plan is requesting the member be disenrolled in the next contract month, or earlier if necessary. Until the member is disenrolled, UnitedHealthcare Community Plan will be responsible for the provision of services to that member.
Chapter 7: Credentialing and Re-Credentialing

Credentialing

UnitedHealthcare Community Plan is responsible for the credentialing and re-credentialing of the care provider network. You must successfully meet UnitedHealthcare Community Plan standards for network participation.

UnitedHealthcare Community Plan will credential and re-credential you according to the National Committee of Quality Assurance (NCQA) standards, as well as applicable State and Federal regulations. The following key elements are required to begin the credentialing process:

• A completed Credentialing Application including Attestation Statement
• Current Medical License;
• Current DEA Certificate;
• Current Professional Liability Insurance;

Information from primary sources regarding licensure, education and training, board certification, Medicare/Medicaid sanctions and malpractice claims history will be verified as part of the credentialing process.

Disclosure of Ownership Form is requirement of enrollment.

Types of Care Providers Subject to Credentialing and Recredentialing

UnitedHealthcare Community Plan credentials and recredentials the following types of practitioners:

• CRNPs (Certified Nurse Practitioners)
• Behavioral Health Clinicians (Psychologists, Clinical Social Workers, Masters Prepared Therapists)

Health Facilities

Facility care providers such as hospitals, home health agencies, skilled nursing facilities and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements.

Facilities must meet the following requirements or verification:

• Meet state and federal licensing, regulatory requirements and National Provider Identifier (NPI) number. Current unrestricted license to operate
• Confirm the care provider has been reviewed and approved by an accrediting body
• Malpractice coverage/liability insurance that meets contract minimums
• Site visit if not accredited by the Joint Commission (JC) or other recognized accrediting agency
• No Medicare/Medicaid sanctions

Excluded from the credentialing and recredentialing process are practitioners who:

• Practice exclusively within an inpatient setting
• Hospitalists who are employed solely by the facility

UnitedHealthcare Community Plan does not make credentialing and recredentialing decisions based on an applicant’s race, ethnic/national identity, gender, age, sexual orientation, type of procedure, or specialist’s patient type.

Credentialing and Recredentialing activities are completed by our National Credentialing Center (NCC). Applications are retrieved from the Council for Affordable Quality Healthcare (CAQH) website. To initiate credentialing with UnitedHealthcare Community Plan, please call the National Credentialing Center (VETTS line) at 877-842-3210. Speak to a representative to obtain CAQH number or provide them with your CAQH number, then go to CAQH to complete or update your application on line at caqh.org.
Chapter 7: Credentialing and Re-Credentialing

Recredentialing Process
UnitedHealthcare Community Plan recredentials you every three years to assure time-limited documentation is updated, changes in health and legal status are identified, and practitioners comply with UnitedHealthcare Community Plan’s guidelines, processes, and performance standards. You are required to maintain updated credentialing information through CAQH throughout your contact with UnitedHealthcare Community Plan. If your information is not current, you will be notified prior to your next credentialing cycle to complete your application on the CAQH website. Failure to respond to our request for recredentialing information will result in administrative termination of your privileges as a UnitedHealthcare Community Plan participating care provider. You will be afforded multiple opportunities to respond to our request for recredentialing information before action is taken to terminate your participation privileges.

As part of the recredentialing process, UnitedHealthcare Community Plan queries its Quality Management database for information regarding your performance. This includes:

- Member complaints
- Quality of care issues

Applicant Rights and Notification
You have the right to review the information in support of credentialing/ recredentialing applications and to request your application status. This review is at your request and is facilitated by the credentialing staff. The credentialing staff notifies you of any information obtained during the credentialing or recredentialing process that varies significantly from the information you give to UnitedHealthcare Community Plan. You have the right to correct erroneous information of the request for clarification by the credentialing staff.

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 will not be disclosed to any person not directly involved in the credentialing process.

Adverse Credentialing Determination Appeals
You must meet UnitedHealthcare Community Plan’s protocols for continued participation. You receive written notice of such protocols in the contract between you and UnitedHealthcare Community Plan (care provider contract), in the credentialing policies and procedures, and in other communication vehicles from time to time. If UnitedHealthcare Community Plan makes an adverse determination regarding your continued participation, you will be notified of such decision in writing and given an opportunity to initiate a formal appeal.

NPI Filing Requirements
A National Provider Identifier (NPI) is required for all medical care providers. All provider identifiers must be valid NPI numbers. This includes billing, servicing, rendering, attending, operating, referring and prescribing a service. If a field is optional, you do not have to include an NPI number; however, if something is submitted in optional fields, it must follow the NPI requirements.

Virginia Medicaid Provider Identification Number
All care providers serving Medicaid members are encouraged to apply for participation in the Medicaid fee-for-service program and obtain a provider identification number. While not a current requirement for billing, future claims submitted by providers without this ID may be rejected. Once you have received your Medicaid provider ID, please supply it to UnitedHealthcare for inclusion on your record. To apply for participating provider status with the Commonwealth of Virginia go to: virginiamedicaid.dmas.virginia.gov.
Chapter 8: Health Services and Quality Improvement Programs

Care Management Model

The care management model is a clinically grounded, mission-driven model that focuses on optimizing the health and well-being of the UnitedHealthcare Community Plan enrollee and builds upon existing community relationships. The following principles guide the direction and focus of care-management activities:

- Enrollees are at the center of all care decisions.
- Provide care and services in a variety of settings at differing levels of intensity.
- Care-management activities must emphasize the provision of the right services, at the right time, in the right place, for the right reason, and at the right cost.
- Care management guidelines and practices are built from evidence-based practices.

This unique innovative model uses advanced technology to improve communications and streamline day-to-day operations. The model incorporates health-risk screening, medical/social assessment, care planning and ongoing service-plan monitoring to identify and address enrollee needs. This model is founded upon principles for the care of geriatric, chronically ill and frail individuals.

Care managers (CM) will interface with the PCP, specialist, enrollee, and authorized representative on an ongoing basis. The CM will develop and implement the care plan in collaboration with the enrollee’s care team, for example, scheduling appointments or arranging for home and community-based services (HCBS).

Other Care Provider and Subcontractor Responsibilities

You are required to comply with all sections of the contract agreement between UnitedHealthcare Community Plan and the subcontractor. Requirements include:

- Care provider credentialing requirements;
- Make available your administrative, financial, documentation and data records to all authorized state, federal and oversight agencies. The records should relate to how you spend CCC Plus money on the delivery of items or services. Provide access during normal business hours, except under special circumstances when UnitedHealthcare Community Plan Commonwealth Coordinated Care Plus and the Virginia attorney general have after-hours admission;
- Adherence to the False Claim Act;
- Eligible for participation in CCC Plus. However, you are not required to participate in CCC Plus as a care provider. You will be assigned a CCC Plus ID number for the purpose of reporting encounter data to UnitedHealthcare Community Plan Commonwealth Coordinated Care Plus;
- Adequate record system for recording services, charges, dates, and all other commonly accepted information elements for services rendered;
- HIPAA privacy and security provisions; and
- Cooperate with the care manager in providing services established in the enrollee care plan.

Initial Assessment

All UnitedHealthcare Community Plan Commonwealth Coordinated Care Plus enrollees will receive initial and ongoing face-to-face care management assessments.

The care manager will develop and implement an individualized care plan for enrollees requiring services, review the enrollee’s progress and adjust the care plan as necessary to help ensure the enrollee continues to receive an appropriate level of care. The care manager documents all of the orientation; health assessments, reassessment, and care plan findings in UnitedHealthcare Community Plan care management system software program.

Enrollee Records

UnitedHealthcare Community Plan will make use of the usual and customary protocols within the care provider community by using the enrollee records maintained by you. These records will include enrollee’s diagnoses, medical conditions, medications, scheduled appointments, progress notes and services/treatments provided on behalf of the enrollee.
You must maintain confidentiality and accuracy of an enrollee’s record at all times. UnitedHealthcare Community Plan requires you to comply with standards under HIPAA for privacy and protection of enrollee data. You must safeguard privacy of any information that identifies a particular enrollee. You may only release information from or copies of an enrollee’s record to authorized individuals. You must help ensure unauthorized individuals cannot gain access to or alter an enrollee’s record. You must ensure you release original records in accordance with state laws, court orders or subpoenas, and timely enrollee access to the information that pertains to them.

Additionally, you and UnitedHealthcare Community Plan must abide by all federal and state laws regarding confidentiality and disclosure of all enrollee records and information.

You must maintain records for 10 years. Additionally, there must be prominent documentation in the record demonstrating whether or not an enrollee has executed an advance directive. UnitedHealthcare Community Plan, Commonwealth of Virginia, and any federal or state agency, and their designees, must have access to enrollee records.

Every enrollee must have an individual record which meets the following standards:

- Identifying information on the enrollee, including name, identification number, date of birth, sex, and legal guardianship (if applicable);
- The record is legible and maintained in detail;
- All entries are dated and signed;
- Reflect the primary language spoken by the enrollee;
- Identify enrollees needing communication assistance in the delivery of care services;
- Contain documentation the enrollee was provided written information concerning the enrollee’s rights regarding advanced directives (written instructions for living will or power of attorney), and whether or not the enrollee has executed an advance directive.
- You will not, as a condition of treatment/services, require the enrollee to execute or waive an advance directive in accordance with section 765.110, F.S.
- Screening for domestic abuse and/or violence will be noted with an indication of referral to an appropriate agency is required, when appropriate.

**Access to Care Standards**

UnitedHealthcare Community Plan Commonwealth Coordinated Care Plus is offered in a defined service area approved by the Commonwealth of Virginia Agency for Health Care Administration. Within the service area, UnitedHealthcare Community Plan must offer a uniform benefit package and maintain a network of participating care providers to meet access standards. UnitedHealthcare Community Plan must help ensure all covered services are available and accessible, and available 24 hours a day, seven days a week. UnitedHealthcare Community Plan complies with the LTC provider qualifications and Network Adequacy Requirements established by the Commonwealth of Virginia in development of its provider network for the UnitedHealthcare Community Plan Commonwealth Coordinated Care Plus plan.

UnitedHealthcare Community Plan helps ensure the hours of operation of participating care providers do not discriminate against the enrollee, and services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

You are contractually bound to provide appropriate assistance to enrollees with limited English proficiency or reading skills. If you are unable to accommodate the enrollee, you must contact UnitedHealthcare Community Plan for assistance by calling the Customer Service number in the 'Important Phone Numbers' section in this manual. A translation service using Language Line is available at the request of the enrollee or you.

**Meeting the needs of our enrollees out of network:**

(Requires care management approval):

When an enrollee has service needs that cannot be met by in-network providers, UnitedHealthcare Community Plan initiates a Letter of Agreement (LOA) with a care provider so service requirements can be met by out-of-network resources.

**Short-Term Intervention:** If a participating care provider is not able to meet enrollee service requirements, we will use out-of-network care providers through a LOA to help ensure enrollee needs are met.

Out-of-network care providers are reimbursed at an in-network rate. Prior to implementation of the LOA process, we validate a care provider’s licensure status and good standing with the state.
Long-Term Intervention: If a care provider meets credentialing requirements, they can become a participating network provider (e.g., in-network), thereby expanding network options for services.

Clinical Practice Guideline References

As part of our quality improvement process, UnitedHealthcare Community Plan adopts clinical practice guidelines based on valid and reliable clinical evidence. UnitedHealthcare Community Plan reviews and updates the guidelines periodically as appropriate. Special emphasis is placed on the following conditions:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Diabetes
- Depression
- Human immunodeficiency virus (HIV)
- Pressure ulcers

Quality Improvement Enhancement

The Quality Improvement program and committee monitors:

- Quality and appropriateness of care provided to enrollees including, but not limited to, review of quality of care and service concerns, grievances, enrollee rights, adverse events, enrollee safety and utilization review processes;
- Monitoring and evaluation of network quality including, but not limited to, credentialing and re-credentialing processes;
- Performance improvement projects;
- Performance measurement;
- Problem resolution and improvement approach and strategy;
- Annual program evaluation;
- Metrics for monitoring the quality and performance of participating providers related to their continued participation in the network;
- Approval of policies and procedures;
- Define and implement improvements in processes that enhance clinical efficiency, provide effective utilization and focus on improved outcome management achieving the highest level of success; and
- Define interventions that best help manage the care and enrollee outcomes.

Enrollee Bill of Rights

The state must help ensure each enrollee is free to exercise their rights, and the exercise of those rights does not adversely affect the way the UnitedHealthcare Community Plan CCC Plus plan and its providers treat the enrollee.

We tell our customers they have the following rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you. These rights and responsibilities are reprinted from our customer handbook.

Customers have the right to:

- Receive information about UnitedHealthcare Community Plan, our services and network providers in accordance with federal and state regulations;
- To be treated with respect and with due consideration for their dignity and privacy by UnitedHealthcare Community Plan personnel, network physicians, and health care professionals as well as privacy and confidentiality for treatments, tests or procedures received;
- Voice concerns about the service and care they receive as well as register complaints and appeals concerning their health plan or the care provided to them and receive timely responses to their concerns;
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee’s condition and ability to understand, regardless of cost or benefit coverage;
- Participate with their doctor and other caregivers in decisions about their health care, including the right to refuse treatment;
- Be informed of, and refuse to participate in, any experimental treatment;
- Have coverage decisions and claims processed according to regulatory standards;
- Choose an advance directive to designate the kind of care they wish to receive should they be unable to express their wishes;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and
- Request and receive a copy of their records, and request that they be amended or corrected.
Customers have the responsibility to:

- Know and confirm their benefits before receiving services;
- Contact an appropriate health care professional when they have a medical need or concern;
- Show their identification card before receiving health care services;
- Verify you are from the UnitedHealthcare Long-Term Care network;
- If applicable, pay any necessary copayment at the time they receive treatment;
- Provide information needed for their care;
- Follow the agreed upon care provider instructions and

Notify Customer Service of a change in address, family status or other coverage information.

UnitedHealthcare Community Plan CCC Plus enrollees receive a complete list of their enrollee rights and responsibilities in their Enrollee Information Guide.

Sanctions

Upon written notification from DMAS – by letter or the list published by the Office of the Inspector General and the Government Accountability Office – of your exclusion from original Medicare or Medicaid, UnitedHealthcare Community Plan will send you a letter. This letter will state you will be removed from the UnitedHealthcare Community Plan list of participating providers as of a given date. Enrollees are notified you are no longer contracted and are advised to select a new care provider.

You are prohibited from employing or contracting with an individual who is excluded from participation in CCC Plus, or with an entity that employs or contracts with such an individual, for the provision of services, utilization review, medical social work or administrative services.

Upon reinstatement by the appropriate government entity, you are responsible for notifying UnitedHealthcare Community Plan and applying for reinstatement.

Care Provider Risk Arrangements

UnitedHealthcare Community Plan is required to disclose care provider incentive arrangements upon request. The purpose of this disclosure is to allow the Commonwealth of VA to monitor entities that hold their care providers at “substantial financial risk.” In addition, UnitedHealthcare Community Plan is required to disclose to current and potential enrollees upon request information regarding care provider incentive arrangements. Disclosed information will describe the plan’s arrangements in general, but will not disclose incentive arrangements specific to any care provider. Your cooperation is necessary for UnitedHealthcare Community Plan to comply with these requirements. Please respond promptly to our requests for information as required.

Surveys

Commonwealth of VA requires an annual enrollee satisfaction survey. Enrollees will be polled to determine satisfaction with the care manager, customer service, network availability/service provision and enrollee materials. A survey or focus group may be conducted with enrollees who are non-English speaking, or have physical disabilities, or are part of a minority ethnic group.
Chapter 9: Billing and Payment

Billing and Claims

When submitting a UnitedHealthcare Community Plan claim, you are indicating:

- An understanding of your affirmative duty to supervise the provision of, and be responsible for, the covered services claimed you provided,
- Supervision and responsibility for preparation and submission of the claim
- The claim is true and accurate
- The service is medically necessary for UnitedHealthcare Community Plan CCC Plus-covered services and
- Services were furnished to the recipient prior to submitting your claim.

Use LINK at UnitedHealthcareOnline.com to:

- Check enrollee eligibility
- Check claims status
- Submit claims (CMS 1500) electronically, for faster claims payment.

This website is a service provided free to you as a network care provider.

Electronic Claim Submission

In addition to LINK at UnitedHealthcareOnline.com, you may also submit electronic claims through the Electronic Data Interchange (EDI) using a claims clearinghouse.

For more information about EDI, contact your claims clearinghouse vendor or UnitedHealthcare Community Plan at 800-842-1109.

Use, for the purpose of submitting claims, Office Ally: officeally.com

For electronic claim submissions please use or have the clearinghouse use Payer ID 87726.

There may be costs associated with EDI submission. Please check with the clearinghouse for details.

Paper Claim Submission

For submitting a claim standard mail, complete on either a CMS 1500 or UB-04 claim form.

- Use a UB-04 for facility or hospital claims
- Use a CMS 1500 for physician and ancillary claims

You may find detailed directions for completing the CMS 1500 and UB-04 in the Claims Submission Completion. All required fields are included in the Claim Completion Requirements section.

Once the claims are completed accurately with all required information, mail paper claims to the claims address on the enrollee’s ID card, which is:

UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402

Please do not bill Commonwealth of VA CCC Plus directly.

Payment Information

UnitedHealthcare Community Plan’s policy is to encourage you to submit claims for covered benefits as soon as possible and no later than the time frames set forth in your participation agreement.

Unless otherwise specified in your contract, UnitedHealthcare Community Plan must receive all information necessary to process the claims no more than 365 days from the date of discharge from a facility; or 365 days from the date the services are rendered to the UnitedHealthcare Community Plan CCC Plus enrollee. Any claims received after this time may be rejected for payment at UnitedHealthcare Community Plan’s discretion.

UnitedHealthcare Community Plan will pay claims for health services provided to an enrollee in accordance to the contractual agreement.
Enrollee Payment Liability

You must submit claims on the enrollee’s behalf and work directly with UnitedHealthcare Community Plan for reimbursement. Enrollees should not be asked to submit claims for services rendered.

You cannot bill the enrollee for services provided if you fail to submit a claim. You cannot balance bill the enrollee for services covered under the contractual agreement at a pre-determined contracted rate.

CCC Plus members are exempt from cost-sharing other than for any patient pay established by DSS toward LTSS. (Refer to Patient Pay Section of the Contract.)

If a claim is filed within the time allowed under CCC Plus plan, the service is UnitedHealthcare Community Plan liability, the claim must be paid by UnitedHealthcare Community Plan, even if the contract between the Commonwealth of VA and UnitedHealthcare Community Plan is no longer in effect; or if the enrollee has disenrolled from UnitedHealthcare Community Plan, provided the enrollee was enrolled and effective at the time service(s) were rendered and the service was a covered benefit through the UnitedHealthcare Community Plan CCC Plus.

Common Claim Administration Issues

Should you submit two identical claims for the same service on the same date (for the same enrollee), one will be denied as an “exact duplicate.”

Make sure the correct UnitedHealthcare Community Plan enrollee ID number is legible and included on the claim.

Use only valid procedure codes for CMS 1500 and UB-04 claims. Review your care provider agreement Payment appendix for submitting claims with approved codes.

Obtain CMS 1500 claim forms by contacting the American Medical Association at 312-464-5000 or toll free at 800-621-8335.

Claim Completion Requirements

Patient information required for each claim:

- Enrollee’s 16-digit UnitedHealthcare At-Home identification number (unique for each enrollee);
- Enrollee’s name – enter the enrollee’s last name, first name and middle initial, if any as shown on enrollee’s UnitedHealthcare ID card;
- Enrollee’s address;
- Enrollee’s birth date and sex;
- Enrollee’s authorization (signature on file); and
- Other health insurance coverage, if applicable.

Care provider information required for each claim includes your:

- Name
- DBA name, if applicable
- Unique seven-digit UnitedHealthcare number (unique for each care provider)
- Referring care provider, if applicable
- Federal Tax ID Number and
- Signature/date – for HCFA 1500 claims.

Service information required for each claim:

- Itemization of services;
- Date(s) of service;
- CPT/Revenue codes or HCPCS procedure code;
- ICD-10-CM diagnosis code and description specified to the fourth and fifth digit;
- Procedure code modifiers when applicable;
- Charges/total charges;
- Days or units;
- Service location – for CMS 1500 claims; and
- Standard CMS site codes are required to indicate where services were rendered.

Guidelines for submitting claims:

- Submit claims for only one enrollee and one care provider per claim form.
- For CMS 1500 claims, itemize multiple visits rendered over several, by date of service. (See section on – How to Bill CMS 1500.‖ on page 45.
- For UB-04 see section on – How to Bill UB-04 on page 44.
- Modifiers are located at the beginning of each major
CPT section. The modifiers provide the service definition which better describe the circumstances of the service. When appropriate, use the two-digit modifier immediately following the five-digit procedure code. (Do not insert a space or a dash.)

Why claims are returned to you:
Original claim submittals will be returned for any of the following reasons:
- Enrollee’s UnitedHealthcare Community Plan ID number is invalid for date of service and/or missing
- Enrollee’s UnitedHealthcare Community Plan At-Home ID number does not match enrollee name
- Bill type is missing
- ICD-10 diagnosis code is invalid and/or missing the fourth and fifth digit
- Revenue or CPT code is invalid and/or missing
- Claim was not submitted on appropriate form (i.e., CMS 1500 or UB-04)
- Date span for services requiring authorization does not match dates authorized

Claims Paid and/or Denied in Error
You must resubmit claims receiving partial/incorrect payments or inappropriate denials using the Adjustment Request Form. Failure to use the Adjustment Request Form may cause a delay in adjusting the claim.

Form and Instructions can be located at UnitedHealthcareOnline.com.

Claim Denials
Claims denied for any inaccurate or missing information will be noted on the Provider Remittance Advice. The denied claims will be listed with a denial code. The denial code will identify the error you must correct prior to resubmitting the claim. Resubmit the claim noting Corrected Claim in the Comments section to help ensure the claim will be reprocessed appropriately. For questions concerning claim resubmission, contact your local Provider Relations Advocate. Reference the ‘Important Contact Information’ for information on how to reach the Provider Relations Advocate.

Resubmitting Denied Claims
Claims denied for any inaccurate or missing information will be noted on the Provider Remittance Advice. The denied claims will be listed with a denial code. The denial code will identify the error you must correct prior to resubmitting the claim. Resubmit the claim noting Corrected Claim in the Comments section to help ensure the claim will be reprocessed appropriately. For questions concerning claim resubmission, contact your local Provider Relations Advocate. Reference the ‘Important Contact Information’ for information on how to reach the Provider Relations Advocate.

Claims Forms Used
- Care provider claims ..............................................CMS 1500
- Ancillary claims ..........................................................CMS 1500
- Facility claims .............................................................UB-04
# How to Bill a UB-04

This list contains the information required to process a claim on a UB-04. Any missing/invalid data will result in a non-paid claim. Claim information must match authorization information.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Box Number</th>
<th>Description of Information to Provide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider's name and address</td>
<td>1</td>
<td>Name and billing address</td>
</tr>
<tr>
<td>Bill Type</td>
<td>4</td>
<td>3 digit type of bill</td>
</tr>
<tr>
<td>Federal Tax ID</td>
<td>5</td>
<td>Facility Federal Tax ID</td>
</tr>
<tr>
<td>Date of Service (start and end date)</td>
<td>6</td>
<td>From and to dates of services authorized</td>
</tr>
<tr>
<td>Enrollee Name</td>
<td>12</td>
<td>Enrollee's name</td>
</tr>
<tr>
<td>Enrollee Address</td>
<td>13</td>
<td>Nursing home address</td>
</tr>
<tr>
<td>Birth date</td>
<td>14</td>
<td>Enrollee's date of birth</td>
</tr>
<tr>
<td>Sex</td>
<td>15</td>
<td>Enrollee's gender</td>
</tr>
<tr>
<td>Revenue Code</td>
<td>42</td>
<td>Revenue Code as required by contract</td>
</tr>
<tr>
<td>Description</td>
<td>43</td>
<td>Write in Long-Term Care or Respite # as authorized</td>
</tr>
<tr>
<td>HCPCS Rates</td>
<td>44</td>
<td>Rates as determined in contract</td>
</tr>
<tr>
<td>Service Date</td>
<td>45</td>
<td>Service dates</td>
</tr>
<tr>
<td>Service Units</td>
<td>46</td>
<td>The number of days at the specific level</td>
</tr>
<tr>
<td>Total Charges</td>
<td>47</td>
<td>Total dollars for service dates</td>
</tr>
<tr>
<td>Payer</td>
<td>50</td>
<td>UnitedHealthcare Community Plan DO NOT BILL MEDICAID</td>
</tr>
<tr>
<td>Provider ID</td>
<td>51</td>
<td>Your UnitedHealthcare Community Plan provider number</td>
</tr>
<tr>
<td>Enrollee ID</td>
<td>60</td>
<td>16-digit UnitedHealthcare Community Plan At-Home Enrollee ID Number</td>
</tr>
<tr>
<td>Authorization number</td>
<td>63</td>
<td>Authorization number when required (optional)</td>
</tr>
<tr>
<td>Procedure Codes</td>
<td>67-81</td>
<td>ICD-10-CM diagnosis code and written diagnosis with fourth and fifth digit as required</td>
</tr>
<tr>
<td>Provider Name</td>
<td>82</td>
<td>Your name and provider number</td>
</tr>
</tbody>
</table>
How to Bill a CMS 1500

This list contains the minimum amount of information required to process a claim on a CMS 1500. Any missing/invalid data will result in a non-paid claim. Claim information must match authorization information.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Box Number</th>
<th>Description of Information to Provide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured ID number</td>
<td>1a</td>
<td>16-Digit Enrollee ID Number</td>
</tr>
<tr>
<td>Name</td>
<td>2</td>
<td>Enrollee name</td>
</tr>
<tr>
<td>Enrollees Birth Date</td>
<td>3</td>
<td>Date of birth and gender</td>
</tr>
<tr>
<td>Enrollees Address</td>
<td>5</td>
<td>Enrollee’s address</td>
</tr>
<tr>
<td>Origin of enrollees condition</td>
<td>10</td>
<td>Please select appropriate response (For Electronic claims only)</td>
</tr>
<tr>
<td>Enrollees Authorization</td>
<td>12,13</td>
<td>Enrollee’s authorization (signature on file)</td>
</tr>
<tr>
<td>Name of Referring Physician</td>
<td>17,17a</td>
<td>Provider name and provider number</td>
</tr>
<tr>
<td>Outside lab</td>
<td>20</td>
<td>Please select if you are an outside lab provider Yes or No (For Electronic claims only)</td>
</tr>
<tr>
<td>ICD-10-CM</td>
<td>21-24 e</td>
<td>ICD-10-CM diagnosis codes and written diagnosis. Include the fourth and fifth digit specificity as appropriate</td>
</tr>
<tr>
<td>Itemization of Services</td>
<td>24</td>
<td>Itemize the services provided to enrollee</td>
</tr>
<tr>
<td></td>
<td>24 a, b.</td>
<td>Dates of service</td>
</tr>
<tr>
<td></td>
<td>24c</td>
<td>Type of service (For Electronic claims only)</td>
</tr>
<tr>
<td></td>
<td>24d</td>
<td>CPT or HCPCS codes, with modifier when applicable</td>
</tr>
<tr>
<td></td>
<td>24e</td>
<td>ICD-10-CM Diagnosis Code- specific to the procedure with fourth and fifth digit specificity as appropriate</td>
</tr>
<tr>
<td></td>
<td>24f</td>
<td>Charges</td>
</tr>
<tr>
<td></td>
<td>24g</td>
<td>Days or units</td>
</tr>
<tr>
<td>Federal Tax ID number</td>
<td>25</td>
<td>Federal Tax ID number must match W9 submitted</td>
</tr>
<tr>
<td>Enrollee account number</td>
<td>26</td>
<td>Enrollee account number or last name (For Electronic claims only)</td>
</tr>
<tr>
<td>Accept Medicare Assignment</td>
<td>27</td>
<td>If applicable, should be yes</td>
</tr>
<tr>
<td>Total Charges</td>
<td>28</td>
<td>Total charges from column 24f</td>
</tr>
<tr>
<td>Physician Signature/Date</td>
<td>31</td>
<td>Provider signature and date</td>
</tr>
<tr>
<td>Facility information</td>
<td>32</td>
<td>Address where services were rendered</td>
</tr>
<tr>
<td>Provider Name, Address and ID</td>
<td>33</td>
<td>Provider name, payment address and seven-digit UnitedHealthcare Community Plan number</td>
</tr>
</tbody>
</table>
Claim Submission Address

All paper claims must be submitted to:
UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402-5240

Do not submit claims to CCC Plus:
Claims submitted to CCC Plus are denied and returned to you, delaying payment for services.

All electronic claims may be submitted using:
EDI: Through a clearinghouse using payer ID 87726*  
Web: UnitedHealthcareOnline.com (CMS 1500 claims only)

*Please see Billing and Claims section for additional information concerning electronic submission of claims.

Provider Remittance Advice

A Provider Remittance Advice (PRA) is a payment summary made on all claims processed. This statement is called an Explanation of Benefits (EOB) when it is sent to the UnitedHealthcare Community Plan CCC Plus plan enrollee. (An EOB is a statement sent to a covered person by the health plan listing services provided, amount billed, and the payment made. It is not a bill).

A PRA is issued for each unique care provider number for a paid/denied claim.

A PRA is included with each check sent to you.

The PRA provides the information needed to accurately post the payments received.

What information can be found on a PRA?
The PRA is an enrollee-by-enrollee accounting of the amount billed, the amount disallowed (if any), as well as the amount paid. An amount disallowed is a denial for portions of the claimed amount. (Examples of amount disallowed: non-covered benefits or amounts over the fee maximum.)

Enrollees are listed alphabetically by last name and identified by your own in-house account number if this information was included on the original claim at the time of submission.

UnitedHealthcare Community Plan sends payment to the address listed in claim processing system. The claim form address must match either the place of service or the billing address listed in UnitedHealthcare Community Plan’s claims processing system to timely process the claim.

All online transactions for members enrolled in Medicaid are accessible on Link. If you are not already registered on Link, you may do so directly on the Link home page. We have Claims and Payments tutorials online at Unitedhealthcare.com > Help > Claims and Payments.

Coordination of Benefits

UnitedHealthcare Community Plan is the primary payer, except in case of:

- Enrollees who have Medicare benefits
- Workers’ compensation insurance
- Black lung benefits
- Automobile medical insurance
- No fault insurance
- Any liability insurance
- All other insurance coverage determined to be primary payer source for covered benefits

The enrollee may receive a request from UnitedHealthcare Community Plan for information about other insurance he/she may have. If the enrollee has other insurance, UnitedHealthcare Community Plan may require the enrollee assist in obtaining payment and/or payment information from the other insurer. Deductibles and copayments will not be applied to balances remaining after the primary carrier’s payment. In no event will payment exceed 100 percent of billed charges, or possible amount required by state regulation, after the primary carrier and UnitedHealthcare Community Plan have reached final claim disposition.
Chapter 10: Appeals and Grievances

Claim Correction

What is it?
A corrected claim is a replacement of a previously submitted claim.

When to use:
You should only submit a corrected claim for a claim already processed. The purpose of claim correction is to correct information on the original submission.

How to use:
Use the claims reconsideration application on Link. To access Link, sign in to UnitedHealthcareOnline.com using your Optum ID.

You may also submit the claim by mail with a claim reconsideration request form.

Allow up to 30 days to receive payment for initial claims and 30 days to receive a response to adjustment requests.

Mailing address:
UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402-5240

Additional Information:
• Institutional claims—When correcting or submitting late charges on 837 institution claims, use bill type xx7, Replacement of Prior Claim. Do not submit corrected or additional information charges using bill type xx5, Late Charge Claim.

Resubmitting a Claim

What is it?
When you resubmit a claim, you are creating a new claim.

When to use it:
If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission. A denied claim has been through claim processing and determined it cannot be paid. You may appeal a denied claim by submitting the corrected claim information or appealing the decision. See Claim Correction and Reconsideration sections of this chapter for more information.

A rejected claim is one that has not been processed due to problems detected before claim processing. Claims are typically rejected for incorrect patient names, date of birth, insurance ID’s, address, etc. Since rejected claims have not been processed yet, there is no appeal — the claim just needs to be corrected through resubmission.

Common Reasons for Rejected Claims
Some of the common causes of claim rejections are:
• Errors to patient demographic data — age, date of birth, sex, etc. or address
• Errors to provider data
• Incorrect patient insurance ID
• No referring provider ID or NPI number

How to use:
To resubmit the claim, follow the same submission instructions as a new claim.

Mail-To mail your resubmission, provide all claim information.

Mailing address:
UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402-5240

Reconsideration (step one of dispute)

What is it?
Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.

A claim reconsideration request is typically the quickest way to address any concern you have about whether a claim was paid correctly. You may submit a claim reconsideration request electronically, by phone, mail or fax.
When to use:
You think a claim has not been properly processed. If you disagree with the outcome of a claim determination, the first step is to submit a claim reconsideration request in one of the following ways:

How to use:
Electronically—Claim Reconsideration application on Link. To access Link, sign in to UnitedHealthcareOnline.com using your Optum ID.

Phone—Call Provider Services at 866-815-5334 or use the number on the back of the member’s ID card.
- If the reconsideration is called in, the Tracking number will begin with SF and be followed by 18 numeric digits

Mail—Submit paper claim reconsideration request, using the Claim Reconsideration Request Form
- The Claim Reconsideration Request Form is available at UnitedHealthcareOnline.com > Tools & Resources > Forms
- Mailing address:
  UnitedHealthcare Community Plan
  P.O. Box 5270
  Kingston, NY 12402-5240
- Fax— 801-994-1224

Valid Proof of Timely Filing Documentation (Reconsideration)

What is it?
When the patient provides incorrect insurance information at the time of service, proof of timely filing includes:
- A denial or rejection letter from another insurance carrier
- Another insurance carrier’s explanation of benefits
- Letter from another insurance carrier or employer group indicating:
  - Coverage termination prior to the date of service of the claim
  - No coverage for the patient on the date of service of the claim

A submission report alone is not considered proof of timely filing for electronic claims. It must be accompanied by an acceptance report. Timely filing denials are often upheld due to incomplete or invalid documentation submitted with a reconsideration request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use: Use the Reconsideration process for timely filing issues. You may submit electronically, phone, mail or fax.

Electronic claims — include confirmation using your EDI acceptance report stating we received your claim. For mailed or faxed reconsiderations, submit a screen shot from your accounting software that shows the date you submitted the claim. The screen shot must show:
- Correct patient name
- Correct date of service
- Submission date of claim

Additional Information:
Timely filing limits can vary greatly based on state requirements and contract types. If you are not aware of your timely filing limit, please refer to your provider agreement.

Appeal (step two of dispute)

What is it?
An appeal is a second review in which you did not agree with the outcome of the reconsideration.

When to use:
If you do not agree with the outcome of the Claim Reconsideration decision in step one, you may use the Claim Appeal process.

How to use:
Submit all relevant documentation with your appeal within 60 calendar days from the PRA date. This may include a cover letter, the medical records, and any additional information. You may choose to send your information electronically, by mail or fax.

Electronic claims—Use the Claims Management or ClaimsLink application on Link. To access Link, sign in to UnitedHealthcareOnline.com using your Optum ID. The system allows you to upload attachments for additional information.
Our provider advocates are available to assist you in navigating our processes to better serve our members.

**Tips for successful claims resolution**

Use the following tips to help process claim reconsiderations:

- Do not allow claim issues to accumulate or go unresolved.
- Provider contracts only allow a limited time to request an adjustment.
- If you cannot verify a claim is on file, then call Provider Services.
- Do not resubmit validated claims on file unless submitting a corrected claim.
- File claims disputes within contractual time requirements.
- For claim/service denied for exceeding the maximum daily frequency allowed for the procedure:
  - If exceeding the maximum daily frequency is required, please submit the medical records justifying medical necessity. If you have questions about the maximum daily frequency of a CPT/HCPCS, please contact Provider Services.
- UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible members. Therefore, you must bill and obtain an Explanation of Benefits (EOB) from other insurance or source of healthcare coverage prior to billing UnitedHealthcare Community Plan, as required by contract.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid, and why.
- You should refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Please attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

**Overpayment**

**What is it?**

If you or UnitedHealthcare Community Plan identifies an overpaid claim you do not dispute, you must send us the overpayment within the time specified in your contract. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our agreement and applicable law.

**How to use:**

If you have identified an overpayment and prefer we recoup the funds in your next payment, please call Provider Services.

You must notify UnitedHealthcare Community Plan of an overpayment on a claim. Send refunds to UnitedHealthcare Community Plan with an Overpayment Return Check or the Return Overpayment through Adjustment Request form.

If you are mailing a refund check, please send a letter with the check and include the following:

- Name and contact information for the person who is authorized to sign checks or approve financial decisions.
- Member identification number
- Date of service
- Original claim number (if known)
- Date of payment
- Amount paid
- Amount of overpayment
- Overpayment reason
- Check number

**Where to send:**

Send refunds requested by UnitedHealthcare Community Plan with an Overpayment Return Check or the Return Overpayment through Adjustment Request form to:
Chapter 10: Appeals and Grievances

Mailing address
UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0800

Instructions and the forms are located on unitedhealthcarecommunityplan.com > Providers > Forms

If you do not agree with the overpayment findings, you may submit a dispute within the required timeframe as listed in your contract.

We typically make claim adjustments without requesting additional information from you. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional or correct information is needed, we will ask you to provide it.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal the determination. See Dispute section in this chapter.

Sample Overpayment Report

*The information provided below is sample data only for illustrative purposes. Please populate and return with the data relevant to your claims that have been overpaid.

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Member Appeals and Grievances Definitions and Procedures

UnitedHealthcare Community Plan uses the Centers for Medicare and Medicaid Services (CMS) definitions related to Appeals and Grievances.

Appeals
What is it?
Appeal is a formal expression of dissatisfaction with an adverse benefit determination.

An adverse benefit determination is when the plan:

- Denies or limits authorization of a requested service based on type, level, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- Lowers, suspends, or ends a previously authorized service.
- Denies all or part of a service payment.
- Does not provide services in a timely manner, as defined by the state.
- Does not resolve a grievance or appeal within the standard resolution time frames as
stated in § 438.408(b)(1) and (2).

• Denies an enrollee who lives in a rural area with only one MCO their right to obtain services outside the network.
• Denies an enrollee’s request to dispute an out-of-pocket cost.

When to use:
You play an integral role in the appeal process for UnitedHealthcare Community Plan members. This includes you acting on the member’s behalf with written consent, and providing medical records and certification of the emergent nature of appeals as appropriate.

Where to send:
• Appeal the decision by calling or writing to Member Services within 60 calendar days from the date of our adverse benefit determination notice at:

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

• Member has the right to present the appeal in person Monday through Friday, 8 a.m. to 5 p.m. Eastern Time at:

  9020 Stony Point Parkway, Building II
  Richmond, VA 23235

How to use:
CMS allows UnitedHealthcare Community Plan members the right to appeal any decision regarding provision of services or claim payment whether the decision is made by UnitedHealthcare Community Plan or by you. The member has the right to:

• Receive a copy of the rule used to make the decision
• Ask someone (a family member, friend, lawyer, health care provider, etc.) to help with the appeal with the member’s written consent.
• The member has the right to present evidence, and allegations of fact or law, in person as well as in writing.
• The enrollee or representative may review the case file, including medical records and any other documents or records, before and during the appeal process.
• Send written comments or documents to be considered in deciding the appeal.
• Ask for an expedited appeal if waiting for this health service would increase the risk to the patient’s health.

• Ask for continuation of services during the appeal. However, the patient may be required to pay for the health service if the service is continued and it is decided the patient should not have received the service.
• Time frame we have to resolve standard appeal is 30 calendar days from the day we receive the appeal.
• Time frame we have to resolve an expedited appeal is 72 hours from the time we receive the appeal.
• We may extend the expedited appeal response up to 14 calendar days if any other following conditions apply:
  1. Enrollee requests an extension
  2. We show the satisfaction of Department of Social Services upon request there is need for additional information and how the delay is in the enrollee’s interest.

Grievance
What is it?
Grievance is an expression of dissatisfaction about any matter other than an action adverse benefit determination. Grievances may include, but are not limited to:

• The quality of care or services provided.
• Relationship aspects, such as rudeness of a care provider or employee.
• A care provider not representing the enrollee’s rights regardless of whether remedial action is requested.
• A member’s dispute over an extension UnitedHealthcare Community Plan proposes to make an authorization decision.

When to use:
You may file a grievance when acting as the member’s authorized representative with their written consent.

Where to send:
You or the member may file a grievance by calling Member Services or writing UnitedHealthcare Community Plan:

Mailing address:

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

You should receive an answer no longer than 30 calendar days from the date you filed the grievance.
State Fair Hearings

What is it?
A State Fair Hearing is a chance for a member to share why they think a decision about their claim is wrong when services are denied, reduced or terminated.

When to use:
After a member has exhausted our appeals process and received an adverse benefit determination.

How to use:
A member or a member’s representative has 120 calendar days after receiving our final decision to request a State Fair Hearing. They may ask for one in writing at the following address:

Department of Medical Assistance Services (DMAS)
Appeals Division
600 E Broad Street Richmond, VA 23219
Chapter 11: Fraud, Waste and Abuse

Reporting and Auditing

Any unethical, unlawful or otherwise inappropriate activity by a UnitedHealthcare Community Plan employee that comes to your attention should be reported to a UnitedHealthcare Community Plan senior manager in the health plan or directly to the Ethics and Compliance Help Center at 800-455-4521.

An important aspect of the Ethics and Integrity Program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing periodic reviews and audits to help ensure compliance with law, regulations and contracts. When informed of potentially irregular, inappropriate or fraudulent practices within the plan or by our care providers, UnitedHealthcare Community Plan will conduct an appropriate investigation. You are expected to cooperate with the company and government authorities in any inquiry, both by providing access to pertinent records (as required by the Participating Provider Contract) and access to provider office staff. If activity in violation of law or regulation is established, appropriate governmental authorities will be advised.

If you become the subject of a governmental inquiry or investigation, or a government agency requests or subpoenas documents relating to your operations (other than a routine request for documentation from a regulatory agency), you must advise UnitedHealthcare Community Plan of the details and of the factual situation that led to the inquiry.

Fraud, Waste and Abuse

UnitedHealthcare Community Plan’s Anti-fraud, Waste and Abuse Program focuses on proactive prevention, detection, and investigation of potentially fraudulent and abusive acts committed by care providers and plan members. A toll-free Fraud, Waste and Abuse Hotline (866-242-7727) has been set up to facilitate the reporting process of any questionable incidents involving plan members or care providers.

Through the program, UnitedHealthcare Community Plan’s mission is to prevent paying fraudulent, wasteful and abusive health care claims, as well as identify, investigate and recover money it has paid for fraudulent, wasteful or abusive claims through evolving policies and initiatives to detect, prevent and combat fraud, waste and abuse.

UnitedHealthcare Community Plan will also appropriately refer suspected cases to law enforcement, regulatory, and administrative agencies based on state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and fiscal integrity of the company and its employees, members, care providers, government programs, and the public, as well as safeguard the health and well-being of its members.

UnitedHealthcare Community Plan is committed to compliance with its Anti-fraud, Waste and Abuse Program and all applicable programs. Federal and state regulatory requirements governing UnitedHealthcare Community Plan recognizes that state and federal health plans are particularly vulnerable to fraud, waste and abuse, and it strives to tailor its efforts to the unique needs of its members and CCC Plus plan, Medicare and other government partners.

All suspected instances of fraud, waste and abuse in any way and in any form is thoroughly investigated.

In appropriate cases, the matter is reported to law enforcement and/or regulatory authorities, in accordance with federal and state requirements. UnitedHealthcare Community Plan cooperates with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid/CCC Plus aimed at reducing fraud within the health care programs funded by the federal government. Under Section 6032 of the DRA, every entity that receives at least $5 million in Medicaid payments annually must establish written policies for all employees of the entity, and for all employees of any contractor or agent of the entity, providing detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws.
As a participating care provider, you and your staff are subject to this provision. You may find the UnitedHealth Group policy, titled “Integrity of Claims, Reports and Representations to Government Entities” 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 our organization to detect and prevent fraud, waste and abuse, as well as the rights of employees to be protected as whistleblowers.

HIPAA and Compliance/Provider Responsibilities

Health Insurance Portability and Accountability Act
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is aimed at improving the efficiency and effectiveness of the 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 is a “covered entity” under the regulations as are all health care providers who conduct business electronically.

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 Codesets Rule. If you conduct business electronically, you are required to do so using the standard formats adopted under HIPAA or to use a clearinghouse to translate proprietary formats into the standard formats for submission to UnitedHealthcare Community Plan.

National Provider Identifier

The National Provider Identifier (NPI) is the standard unique identifier for health care providers. The NPI is a 10-digit number with no embedded intelligence that covered entities must accept and use in standard transactions. While the HIPAA regulation only requires the NPI be used in electronic transactions, many state agencies require the identifier on fee-for-service claims and on encounter submissions. For this reason, UnitedHealthcare Community Plan requires the NPI on paper transactions.

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

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 on paper, in computers or communicated orally.

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. In addition, the regulation is designed 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, and individual organizations and individuals.

Security

The Security Regulations require covered entities meet basic security objectives:

- Help ensure the confidentiality, integrity and availability of all electronic PHI the covered entity creates, receives, maintains and transmits;
- Protect against any reasonably anticipated threats or hazards to the security or integrity of such information;
• Protect against any reasonably anticipated uses or disclosures of such information not permitted or required under the Privacy Regulations; and
• Help ensure compliance with the Security Regulations by the covered entity’s workforce.

UnitedHealthcare Community Plan expects you to comply with the HIPAA regulations that apply to your practice or facility within the established deadlines. Additional information on the HIPAA regulations can be obtained from the website: cms.hhs.gov

Exclusion Checks

First tier, downstream, and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub delegates. Employees and/or contractors should not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists on a monthly basis. For more information or access to the publicly accessible excluded party online databases, please see the following links:
Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE) at oig.hhs.gov or General Services Administration (GSA) System for Award Management at SAM.gov

What You Need to Do for Exclusion Checks

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may request documentation of the exclusion checks to verify they were completed. If you identify compliance issues and/or potential fraud, waste, or abuse, please report it to us immediately so that we can investigate and respond. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

Examples of Healthcare Fraud, Waste & Abuse

By Members
• Someone uses another person’s Medicare card to receive medical care, supplies, or equipment
• A member agrees to let a healthcare provider bill Medicare for services they did not receive
• Member does not disclose other health insurance coverage
• Member misrepresents medical condition to obtain services
• Member provides false information on enrollment form

By Care Providers
• Unnecessary care
• Incorrect coding/billing practices
• Fraudulent diagnoses
• Billing for services not rendered
• Kickbacks/solicitations

By Employees
• False claims address or PO box
• Selling members’ or providers’ identification
• Misrepresenting facts to deny or grant benefits
• Obtaining kickbacks for referrals

Sales and Marketing
• Forging members’ signatures for enrollment purposes
• Advising beneficiaries to enroll in a plan that is unnecessary or unwanted
• Misrepresenting benefits
• Impersonating a government employee

By Pharmacies
• Inappropriate billing practices
  – Billing multiple payers for the same prescription
  – Billing for non-existent prescriptions
  – Billing for brand when generics are dispensed
  – Billing for an item not dispensed
  – Prescription splitting to receive additional dispensing fees
• Prescription drug shorting
• Bait and switch pricing
• Prescription forging or altering
• Dispensing expired prescription drugs
• Prescription refill errors
• Failure to offer negotiated prices

Coding
• Upcoding (using codes that pay at a higher rate)
• Bundling/unbundling of claims
• Routinely submitting duplicate claims
Chapter 12: Long-Term Social Services and Home Care-Based Services

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

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

The goals of the HCBS program include:

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

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

Disability Sensitivity

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

Overview of HCBS Programs

The Commonwealth of Virginia now fully integrates the HCBS under the Commonwealth Coordinated Care Plus Waiver (formerly the Elderly or Disabled with Consumer Directed Services (EDCD) and Technology Assisted (TECH) Waivers. While no longer directly administering the valuable services for these HCBS programs, the Commonwealth of Virginia retains authority and oversight of these programs.

Eligibility for all of the HCBS programs is determined by the state or state designees. For information on the following, please refer to the CCC Plus Program provider manual available on the DMAS web portal at: virginiamedicaid.dmas.virginia.gov

Commonwealth Coordinated Care Plus Waiver

The Commonwealth CCC Plus Waiver covers a range of community support services offered to older adults, individuals who have a disability, and individuals who are chronically ill or severely impaired, having experienced loss of a vital body function, and who require substantial and ongoing skilled nursing care. The individuals, in the absence of services approved under this waiver, would require admission to a nursing facility, or a prolonged stay in a hospital or specialized care nursing facility. Individuals in this waiver are eligible to participate in the CCC Plus program.

The waiver covers the following services:

- Adult day health care
- Assistive technology
- Environmental modifications
- Personal care
- Personal emergency response system and medication monitoring
- Respite care
- Services facilitation
- Private duty nursing
- Transition services

Consumer-Directed Services

Consumer-Directed Services are an option available for those members who are eligible under the CCC Plus HCBS Waiver. Eligible personal care and respite services may be provided by a
Chapter 12: Long-Term Social Services and Home Care-Based Services

health agency (known as agency-directed or AD services) or by a personal attendant hired by the consumer (known as consumer-directed or CD services). CD services afford individuals the opportunity to act as the employer in the self-direction of their personal care or respite services. This involves hiring, training, supervision, and termination of self-directed personal care assistants.

Members selecting the CD services option will work with their assigned UnitedHealthcare Community Plan Care Manager to select a Service Facilitator. The selected Service Facilitator will be responsible for supporting the member, member’s family/caregiver, or Employer of Record, as appropriate, by helping ensure the development and monitoring of the CD services Plan of Care, providing employee management training, and completing ongoing review activities as required by DMAS for CD personal care and respite services. The Service Facilitator works closely with the member’s assigned Care Manager to help ensure alignment and compliance with the member’s Plan of Care.

The selected Service Facilitator will also work with a Financial Management Service that will manage the budgeted number of service hours established for members, process timesheets submitted by personal care/respite workers, and pay these workers on the member’s behalf. Members are able to change their selected Service Facilitator at any time.

HCBS Care Provider Responsibilities
HCBS care providers will provide based on the plan of care, including amount, frequency, duration, and scope of each service in accordance with the member’s service schedule.

HCBS care providers using Electronic Visit Verification (EVV) will access the EVV system to submit claims.

HCBS Care Provider Credentialing/Verification
UnitedHealthcare Community Plan follows the care provider requirement guidelines defined in Chapter IV of the Nursing Facilities Manual to credential nursing facility providers and the CCC Plus provider manual for providers of HCBS services.

Initial Verification /Credentialing: The initial verification/credentialing process includes verification of required documents outlined in the Virginia HCBS Care Provider Application, in addition to care provider requirements defined by the state. You must submit the Certificate and/or Licenses applicable to the services you are providing and each license will be verified with its issuing licensing board. You will provide proof of general liability insurance that meets the minimum required amount set by the Commonwealth of Virginia applicable to the services you are contracted to provide. You will also provide proof of malpractice insurance, as applicable, as required by state guidelines.

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

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

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

Applicants have the right to be notified of the credentialing decision within 60 calendar days of the decision.

Electronic Visit Verification Requirements
The Electronic Visit Verification (EVV) system provides “real time” monitoring of a service provision, verifies that service visits occur, and documents the precise times service provision begins and ends. Some of these services may be non-medical (atypical) in nature like personal care, or construction work like installing a shower bar to hopefully prevent the member from falling. Typical services are provided with assistance with activities of daily living (ADL).

Home and Community-Based Services
Find a summary of the HCBS services, including benefit limitations, unit definitions and billing codes in the CCC Plus provider manual available on the DMAS web portal at: virginiamedicaid.dmas.virginia.gov.

Claim Filing Information for HCBS Care Providers
HCBS program codes and limits apply to all Home and Community-Based Services. Covered services, service definitions, units and benefit limitations are consistent with the CCC Plus provider manual available on the DMAS web portal at: virginiamedicaid.dmas.virginia.gov Please refer to the state’s CCC Plus provider manual for specific service definitions.
Use the CMS 1500 claim form or an accepted electronic equivalent when requesting payment for HCBS services. Receive claims through your Electronic Data Interchange (EDI) vendor and communicate through the OptumInsight clearinghouse (formerly Ingenix) using payer ID 87726.

**Electronic Funds Transfer (EFT)**
EFT is a method of transferring funds between bank accounts. EFT eliminates the need for paper checks and improves cash flow timing. You may request EFT by submitting the EFT form on UHCCommunityPlan.com or requested through your provider advocate. Return EFT forms as soon as possible to allow adequate time for processing.

**Documentation**

**Client Obligation**
The state will communicate each member’s client obligation, as applicable, to UnitedHealthcare Community Plan through the member enrollment file we receive. If you have been assigned a client obligation, you should not reduce the billed amount on the claim by the client obligation amount because it will be deducted as claims are processed.

UnitedHealthcare Community Plan will make every effort to assign the client obligation, as applicable, to you that was historically assigned the client obligation by the state. The client obligation will typically be assigned to a single provider (if a single provider’s services will offset the client obligation amount). In addition, we will make every effort to assign the client obligation to a single service, when possible, if the total services provided each month for that service are sufficient of offset the monthly client obligation amount. In the absence of state direction, we will assign the client obligation to the care provider who has the largest cost of services for the month.

On a monthly basis, UnitedHealthcare Community Plan will mail a notification letter to each member and to care provider for whom client obligation has been assigned.

**Date Span Billing**
You may bill for date spans. This means submitting claims for outpatient and/or professional services with multiple dates of service on a single claim. Claims may not contain a combination of ICD-9 and ICD-10 codes;

You are able to bill non-consecutive days with date span billing. You cannot overlap billed date spans. Otherwise, the claims may experience possible duplication edits and/or other claim errors.

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

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

## CENTRAL REGION

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## TIDEWATER REGION

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## NORTHERN & WINCHESTER REGION

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### ROANOKE/ALLEGHANY REGION

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### SOUTHWEST REGION

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