2017
Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary

Florida Long-Term Care Medicaid Managed Care

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UnitedHealthcare®
Community Plan

Welcome

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

- **UnitedHealthcare Administrative Guide** for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- **West Capitated Administrative Guide**, or go to **uhcwest.com** > Provider, click Library at the top of the screen. The Provider Administrative Guides link is on the left.
- A different Community Plan manual – go to **uhccommunityplan.com**, click For Health Care Professionals at the top of the screen. Select the desired state.

You may easily find information in the manual using the following steps:

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

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

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

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

Important Information about the use of this manual

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

This manual will be amended as policies change.

Table of Contents

Chapter 1: Introduction

Purpose of This Manual

UnitedHealthcare Community Plan welcomes you as a participating care provider. You play a key role as we pursue our commitment to improve the health and well-being of the enrollees we serve.

The purpose of the Care Provider Manual is to serve as a resource and reference guide for participating care providers. The manual contains information about 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 contained is current as of the date it was published and may be modified by UnitedHealthcare Community Plan 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 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.

Important Information Regarding The Use of This Guide

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

In the event of a conflict or inconsistency between your participation agreement, this manual and applicable federal and state statutes and regulations, applicable federal and state statutes and regulations will control. We reserve the right to supplement this manual to help ensure that its terms and conditions remain in compliance with relevant federal and state statutes and regulations. This manual will be amended as operational policies change.

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 State of Florida by the Agency under s. 409.901 et seq., F.S.

Important Information Regarding The Statewide Medicaid Managed Care Program

Florida has offered Medicaid services since 1970. Medicaid provides health care coverage for eligible children, seniors, disabled adults and pregnant women. It is funded by both the state and federal governments. The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including LTC services. This program is referred to as statewide Medicaid Managed Care (SMMC) and includes two programs: one for medical assistance (MMA) and one for long-term care (LTC). Only members who meet eligibility requirements and are living in a region with authorized Managed Care Plans are eligible to enroll and receive services. UnitedHealthcare Community Plan serves members in the following regions:

Region 2 Counties: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington

Region 3 Counties: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union

Region 4 Counties: Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia

Region 5 Counties: Pasco and Pinellas

Region 6 Counties: Hardee, Highlands, Hillsborough, Manatee, and Polk

Region 7 Counties: Brevard, Orange, Osceola, and Seminole

Region 8 Counties: Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota

Region 9 Counties: Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie

Region 11 Counties: Miami-Dade and Monroe

What is UnitedHealthcare Community Plan LTC Medicaid Managed Care?

Managed care is when health care organizations manage how their enrollees receive health care services. Managed Care Organizations will work with different care providers to offer quality health care services to enrollees.

The goals of Florida LTC Managed Care are to provide:

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

Enrollees enrolled in LTC Medicaid Managed Care will have their services/care managed through the Managed Care health plan. We work with different care providers to offer quality health care services to help ensure enrollees have access to covered services.

The goals of the LTC Managed Care Plan are to provide coordinated long-term care services across different health care settings and to provide enrollee access to cost-effective community-based LTC services. The LTC Care Plan will not change Medicare benefits.

This section of your manual provides helpful information you will need to support the care manager and enrollee in coordination of services as determined by the individual enrollee care plan. Unless there is a discrepancy, the information contained in this section does not replace the information contained in other sections of this manual but highlights information pertinent to the LTC Managed Care Plan.

How the UnitedHealthcare Long-Term Care Medicaid Managed Care Plan Works

UnitedHealthcare Community Plan operates under a contract with the state of Florida Agency for Health Care Administration (AHCA). We are committed to supporting and coordinating all Medicaid-covered benefits for eligible enrollees using a care plan that helps the enrollee 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.

UnitedHealthcare LTC Medicaid Managed Care 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 their care and help them access their covered benefits. If the enrollee uses a non-contracted care provider, the services will not be covered unless authorized by the care manager. A Medicare beneficiary can access any Medicare-approved care provider without authorization.

The Enrollee and UnitedHealthcare Community Plan

Only Medicaid recipients who meet eligibility requirements and are living in a region with authorized Managed Care Plans may enroll and receive services from the LTC Medicaid Managed Care 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.

AHCA or its agent is responsible for enrollment, including enrollment into the UnitedHealthcare LTC Managed Care Plan, disenrollment and outreach and education activities. UnitedHealthcare Community Plan will coordinate with the agency and its agent as necessary for all enrollment and disenrollment functions.

UnitedHealthcare Community Plan accepts Medicaid recipients without restriction and in the order in which they enroll. We do 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. We do not use any policy or practice that has the effect of such discrimination.

Medicaid-Only Beneficiaries

Each enrollee has an assigned care manager who works with their health 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 its participating care providers treat all enrollees with dignity and respect. We 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.

Visit **UHCCommunityPlan.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 800-791-9233.

Send request in writing to:

UnitedHealthcare Community Plan
LTC Medicaid Managed Care Plan
3100 SW 145th Avenue – 2nd Floor
Miramar, FL 33027

Outreach and Marketing Guidelines

You may make available and/or distribute Managed Care Plan marketing materials as long as you and/or the facility distributes or makes available marketing materials for all Managed Care Plans with which you participate.

If you agree to make available and/or distribute Managed Care Plan marketing materials, you should do so knowing you must accept future requests from other Managed Care plans with which you participate. You are also permitted to display posters or other materials in common areas such as the waiting room. Additionally, LTC facilities are permitted to provide materials in admission packets announcing all Managed Care Plan contractual relationships.

Through education, outreach and monitoring, we work with you to help ensure you are aware of and comply with the following:

1. You may engage in discussions with recipients should a recipient seek advice. However, you must remain neutral when assisting with enrollment decisions.
2. You may not:
   a. Offer marketing/appointment forms.
   b. Make phone calls or direct, urge or attempt to persuade recipients to enroll in a Managed Care Plan based on financial or any other interests that you may have.
   c. Mail marketing materials on behalf of a Managed Care Plan.
   d. Offer anything of value to induce recipients/members to select them as their care provider.
   e. Offer inducements to persuade recipients to enroll in a Managed Care Plan.
   f. Conduct health screenings as a marketing activity.
   g. Accept compensation directly or indirectly from a Managed Care Plan for marketing activities.
   h. Distribute marketing materials within an exam room setting.
   i. Furnish to Managed Care Plans, lists of their Medicaid patients or the membership of any Managed Care Plan.
3. You may:
   a. Provide the names of the Managed Care Plans with which they participate.
   b. Make available and/or distribute Managed Care Plan marketing materials.
   c. Refer your patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office.
   d. Share information with patients from the AHCA website or CMS website.
4. Care Provider Affiliation Information
   a. You may announce new or continuing affiliations with a Managed Care Plan through general advertising (e.g., radio, television, websites).
   b. You may make new affiliation announcements within the first 30 calendar days of the new care provider agreement.
   c. You may make one announcement to patients of a new affiliation that names only that Managed Care Plan when such announcement is conveyed through direct mail, email, or phone.
   d. Additional direct mail and/or email communications from you to patients regarding affiliations must include a list of all Managed Care Plans with which you contract.
   e. Any affiliation communication materials that include Managed Care Plan-specific information (e.g., benefits, formularies) must be prior approved by the agency.
5. You may distribute printed information provided by a Managed Care Plan to their patients comparing the benefits of all of the different Managed Care Plans with which you contract. The Managed Care Plans will help ensure that:
   a. Materials do not “rank order” or highlight specific Managed Care Plans and include only objective information.
   b. Such materials have the concurrence of all Managed Care Plans involved in the comparison and are approved by the agency prior to distribution.
   c. The Managed Care Plans identify a lead Managed Care Plan to coordinate submission of the materials.

Chapter 2: How to Reach

Contacts

Administrative Office	800-791-9233
Provider Relations Administrative Office	800-791-9233 or email: fl_ltc_network@uhc.com
Customer Service	Customer service representatives are available between 8 a.m. and 7 p.m. ET, Monday through Friday at 800-791-9233 or TTY 771 for the hearing impaired.
Plan Address	UnitedHealthcare Community Plan LTC Medicaid Managed Care (FL0504) 3100 SW 145th Avenue -- 2nd Floor Miramar, FL 33027
Claims Submission Address	P.O. Box 31365 Salt Lake City, UT 84131-0362 For claims with dates of service prior to June 1, 2017, please use the previous mailing address: UnitedHealthcare of Florida P.O. Box 31362 Salt Lake City, UT 84131
Electronic Payer	Payer ID 87726

Online Resources Link and UnitedHealthcareOnline.com

Use Link – your gateway to UnitedHealthcare's online tools – to perform secure transactions for UnitedHealthcare Community Plan members:

- View patient eligibility and benefits
- Check the status of a claim
- Submit a claim reconsideration
- Submit referrals

To submit a single CMS-1500 claim form, go to UnitedHealthcareOnline.com > Claims and Payments > Claims Submission.

The following reports are also available at UnitedHealthcareOnline.com > Tools & Resources > Reports:

- PCP Panel Report
- Capitation (CAP) Reports
- Claim Trends
- Provider Profile
- Early and Periodic Screening, Diagnosis, and Treatment
- Preventive Health Measures

To access Link and reports that require secure access, sign in to UnitedHealthcareOnline.com using your Optum ID. If you don't have an Optum ID or need help remembering your ID or password, the UnitedHealthcareOnline.com sign-in screens will help guide you through the process.

To learn more about Link, please visit UnitedHealthcareOnline.com > Quick Links > Link: Learn More. Or call the UnitedHealthcare Connectivity Help Desk at **866-842-3278**, option 3, 7 a.m. – 9 p.m., Central Time, Monday through Friday.

Care Provider Services

Customer Service Department

The UnitedHealthcare Community Plan Customer Service department is available between 8 a.m. and 7 p.m. ET, Monday through Friday at **800-791-9233**.

You may call Customer Service for any questions, such as:

- Claim status
- Claim denial
- Claim submission information needed
- Claims payment address (verification or change)
- New contract status
- Provider Remittance Advice (PRA)
- Resubmission of corrected claims
- Unreconciled claims
- Enrollee eligibility

Provider Relations

Contact Provider Relations for questions regarding:

- Changes in care provider information, including name, address, telephone number or federal tax identification number
- If you open or close an office

- If you have reached capacity and are no longer accepting new enrollees. Please provide the effective date and date anticipated for accepting new enrollees.
- Contract administration/implementation issues
- Credentialing and re-credentialing
- Reimbursement, payment or coding questions
- Information about UnitedHealthcare's Community Plan's policies and procedures
- Training for billing and claim submission

Provider Relations can be reached by phone at 800-791-9233 or by email at **fl_ltc_network@uhc.com**.

Florida Abuse Hotline

Abuse, neglect, and exploitation can be reported by calling the Florida Abuse Hotline, which is a statewide, toll-free phone number at 800-96-ABUSE (800-962-2873).

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 below for a sample enrollee ID card.

This card identifies the enrollee as a UnitedHealthcare Long Term Care Managed Care Program enrollee. Medicaid will not be responsible for claims for this enrollee while they continue to be enrolled in UnitedHealthcare Community Plan. During that time, all claims need to be submitted to us.

Medicaid recipients receive a gold plastic, Medicaid ID card issued by the state of Florida. This card will allow you instant access to Medicaid recipient eligibility information.

Enrollee ID Card

Sample of UnitedHealthcare LTC Medicaid Managed Care Identification Card

Chapter 4: Benefits

Covered Services

UnitedHealthcare LTC Managed Care covers all Medicaid-covered services as well as additional benefits. New coverage decisions are communicated to participating care providers through written notification.

A general list of covered services is included below. All services must be provided in accordance with professionally recognized standards of care.

List of Covered Benefits

Services are coordinated by the care manager.

Adult Day Health Care	Home Accessibility Adaptation	Nutritional Assessment/Risk Reduction
Adult Companion Care	Home Delivered Meals	Personal Care
***Assisted Living Services	Homemaker	Personal Emergency Response System (PERS)
***Assistive Care Services (Adult Family Care Home only)	*Hospice	Physical Therapy
Attendant Nursing Care	*Intermittent and Skilled Nursing	Occupational Therapy
*Behavioral Management	**Medical Equipment and Supplies	Respite Care
Care Coordination/Case Management	Medication Administration	Respiratory Therapy
Caregiver Training	Medication Management	Speech Therapy
Comprehensive Medication Management	Nursing Facility	Transportation, Non-Emergency
**Consumable Medical Supplies		

*Behavioral Management and Intermittent – Skilled nursing care provided through contracted network. Hospice is provided through hospice provider network. Care manager will coordinate enrollee services.

**Medical equipment and consumable medical supplies coordinated by care manager through participating care providers. You bill per contract based on item and appropriate coding.

***Assisted Living Facilities and Adult Family Care Homes must meet Home Like Environment Criteria as set by AHCA. Characteristics are: Choice of private or semi-private room; Choice of roommate; Ability to lock door of living unit; Access to telephone and length of use; Flexible eating schedule and; Participate in facility and community activities, with the ability to have; Unlimited visitation and the ability to; Maintain a personal sleeping schedule and to; Prepare and have snacks as desired.

You will support the enrollee's community inclusion and integration by working with the managed care organization's case manager and the enrollee to facilitate the enrollee's personal goals and access to community activities.

List of Enhanced Benefits

Over-The-Counter (OTC) Medicines and Products	Enrollee and Caregiver Support	Dental (Preventative Care)

UnitedHealthcare LTC Medicaid-Covered Level of Benefits

UnitedHealthcare LTC 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 care provider, UnitedHealthcare Community Plan will provide an opportunity for the non-contracted 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. Please call Provider Services at 800-791-9233 for authorization-related questions. Medicare enrollees can access any Medicare-approved care provider without authorization.

Referrals

UnitedHealthcare Community Plan adheres to the "gatekeeper model" for most services, and PCPs coordinate the care for their members. They also generate referrals to network specialists. Additional information on when a referral is necessary and how to submit a referral can be found on **UnitedHealthcareOnline.com**.

Medical Necessity

"Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. To determine Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based on the information available at the time the goods or services were provided.

Exclusions

Certain services and/or service categories are excluded from coverage under UnitedHealthcare Community Plan. The UnitedHealthcare LTC Medicaid Managed Care Plan Evidence of Coverage (EOC) lists many of the excluded services. For a complete list of exclusions, contact Provider Relations at the number found on the "How to Reach Us" page of this section. In addition to the excluded services, UnitedHealthcare Community Plan may deny coverage if:

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

Emergency Service Coverage and Care Provider Responsibility

Emergency Service and Care is defined as the 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.

Comprehensive members have emergency care covered under their Medicaid plan; this is not covered under the Home and Health Connection benefit. Prior authorization is not required.

Always contact the member's assigned case manager in the event of an emergency to help ensure appropriate coordination of care.

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

Behavioral Health

Optum Health Behavioral Solutions, a subsidiary of UnitedHealth Group, provides the mental health services for UnitedHealthcare Community Plan Substance Abuse Treatment if coordinated through United Optum Health; however the services are covered through Medicaid and the Department of Children and Families (DCF).

Enrollees and/or their care managers can arrange these services by calling **800-582-8220**.

Questions or Concerns

If you have any questions, you may contact the customer service line at **800-791-9233**.

Notification Requirements

Procedures and Services	Explanation
Facility Admissions (Hospital, & SNF)	All in-patient admissions (except maternity), including acute hospital, rehabilitation facilities, and skilled nursing facilities.
Out-of-Network Services	Referrals to physicians, health care professionals and hospitals not contracted with UnitedHealthcare Community Plan.
Home and Community-Based Services	All home-based services, including nursing, respiratory therapy, IV infusion services, hospice services, physical, speech and occupational therapies and social work.
Durable Medical Equipment (DME)/ Supplies (DMS)	All DME/DMS services must be coordinated with the care manager.
Mental Health Services	Mental health services must be coordinated with the care manager.
Therapy Services	Any physical therapy (PT), occupational therapy (OT), and/or speech pathology therapy (ST) services.
This list does not signify coverage for benefits. If you have questions about an enrollee's benefit coverage, please call customer service at 800-791-9233.	

To request prior authorization, submit your request online, or by phone or fax:

- Online: **UnitedHealthcareOnline.com** > Notifications/Prior Authorizations > Notification/Prior Authorization Submission
- Phone: 866-604-3267
- Fax: 866-607-5975; fax form is available at **UHCCommunityPlan.com** > For Health Care Professionals > Florida > Provider Forms > Florida Prior Authorization Fax Request Form

Care Provider Education

Please review your Care Provider Manual in detail. Should you have questions, reach a Provider Relations Advocate at **800-791-9233** or by email at **fl_ltc_network@uhc.com**.

Care provider education regarding the LTC Managed Care Plan and claims submission process will be made available to all new and current care providers through monthly webcast training. The Network Provider Relations Advocate will notify you of the times and how to access the trainings during your initial on-boarding process. For current care providers, invites to ongoing webcast opportunities will be provided by mail and/or email.

Education on claims submission will also be made available onsite at designated locations and times throughout the year to assist you with claims submission issues. You will be notified in writing and provided opportunity to sign up for those sessions.

Chapter 5: Enrollment

Enrollment Eligibility

The Department of Elder Affairs' CARES Unit determines eligibility requirements, and compliance is essential. The following guidelines help determine UnitedHealthcare LTC Medicaid Managed Care enrollee eligibility:

Enrollee Eligibility Voluntary

Eligible recipients age 18 or older in any of the following programs or eligibility categories are required to enroll in a Managed Care Plan if they have been determined by CARES to meet the nursing facility level of care:

- Temporary Assistance to Needy Families (TANF);
- SSI (Aged, Blind and Disabled);
- Institutional Care;
- Hospice; and
- Aged/Disabled Adult waiver.

Individuals who age out of Children's Medical Services and meet the following criteria for the Aged/Disabled Adult waiver:

- Received care from Children's Medical Services before turning 21;
- Age 21 and older;
- Cognitively intact;
- Medically complex; and
- Technologically dependent.
- Assisted Living waiver;
- Nursing Home Diversion waiver;
- Channeling waiver;
- Low-income families and children;
- MEDS (SOBRA) for children born after 9/30/83 (age 18-20);
- MEDS AD (SOBRA) for aged and disabled;
- Protected Medicaid (aged and disabled);
- Dually Eligible (Medicare and Medicaid);
- Individuals enrolled in the Frail/Elderly Program component of UnitedHealthcare Community Plan HMO; and
- Medicaid Pending for LTC Managed Care HCBS waiver services.

Enrollee Eligibility Voluntary

Eligible recipients 18 or older in any of the following eligibility categories may, but are not required to, enroll in a Managed Care Plan if CARES determines they meet the nursing facility level of care:

A. Traumatic Brain and Spinal Cord Injury waiver;

B. Project AIDS Care (PAC) waiver;

C. Adult Cystic Fibrosis waiver;

D. Program of All-Inclusive Care for the Elderly (PACE) plan enrollees;

E. Familial Dysautonomia waiver;

F. Model waiver (age 18-20);

G. Medicaid for the Aged and Disabled (MEDS AD) – Sixth Omnibus Budget Reconciliation Act (SOBRA) for aged and disabled – enrolled in Developmental Disabilities (DD) waiver;

H. Recipients with other creditable coverage excluding Medicare; and

I. Recipients on DD HCBSWait-list.

Enrollee Eligibility Excluded

Recipients in any eligibility category not listed in subitems A.1. or A.2. above are excluded from enrollment in a Managed Care Plan. This includes, but is not limited to, recipients in the following eligibility categories:

- Supplemental Security Income (SSI) (enrolled in a DD waiver);
- Presumptive Newborns (PEN);
- Foster care;
- Institutional Care – Transfer of Assets;
- MediKids;
- MEDS (SOBRA) for children born after 9/30/83 (under age 18);
- MEDS (SOBRA) for pregnant women;
- Presumptively eligible pregnant women;
- Medically needy;
- Refugee assistance;
- Family planning waiver;
- Women enrolled through the Breast and Cervical Cancer Program;

- Emergency shelter/Department of Juvenile Justice (DJJ) residential;
- Emergency assistance for aliens;
- Qualified Individual (QI) 1;
- Qualified Medicare beneficiary (QMB);
- Special low-income beneficiaries (SLMB);
- Working disabled (19);
- Budget waiver (developmental disabilities waiver); and
- Developmental Disabilities (DD) waivers (Tiers 1-4).

In addition, regardless of eligibility category, the following recipients are excluded from enrollment in a Managed Care Plan:

- Recipients residing in residential commitment facilities operated through DJJ or mental-health facilities;
- Recipients residing in DD centers including Sunland and Tacachale;
- Children receiving services in a prescribed pediatric extended care center (PPEC);
- Children with chronic conditions enrolled in the Children's Medical Services Network; and
- Recipients in the Health Insurance Premium Payment (HIPP) program.

Enrollee Orientation

Once the UnitedHealthcare LTC Medicaid Managed Care enrollment application is processed, each new enrollee receives a letter stating the effective date of coverage and a packet of information about the program.

The following documents are provided to new enrollees:

- Welcome letter
- Enrollee handbook
- Enrollee ID card
- Provider directory
- HIPAA privacy notice

We will contact new enrollees by phone and conduct a Health Risk Assessment. Within five days of enrollment, we will help develop a plan of care.

The enrollee orientation is completed during a visit to the enrollee by the assigned care manager and includes the following topics:

- The role of the enrollee's primary care provider (PCP)
- How to access long-term care services
- Behavioral and substance-abuse services
- How to access urgent care and emergency care
- Use of non-contracted care providers and practitioners
- Filing a grievance or appeal
- Enrollee rights and responsibilities
- Enrollee right to self-determination
- The care manager's role with the enrollee and their PCP
- How to disenroll voluntarily
- Customer service number and use

Disenrollment

General Provisions

A. UnitedHealthcare LTC Medicaid Managed Care program will help ensure that it does not restrict the enrollee'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 the agency's contracted enrollment broker in the disenrollment process.

C. UnitedHealthcare Community Plan will help ensure that enrollees who are disenrolled and wish to file an appeal can do so. All enrollees will be afforded the right to file an appeal on disenrollment except for the following reasons:

    - Moving out of the region;
    - Loss of Medicaid eligibility;
    - Determination that an enrollee is in an excluded population; and
    - Enrollee death.

D. An enrollee subject to open enrollment may submit to AHCA or its agent a request to disenroll. This may be done without cause during the 90-calendar day change period following the date of the enrollee's initial enrollment with UnitedHealthcare Community Plan, or the date AHCA or its agent sends the enrollee notice of the enrollment, whichever is later. An enrollee may request disenrollment without cause every 12 months thereafter during the annual open enrollment period. Those not subject to open enrollment may disenroll at any time.

E. The effective date of an approved disenrollment will be the last calendar day of the month in which disenrollment was made effective by AHCA or its agent. In no case will disenrollment be later than the first calendar day of the second month following the month in which the enrollee or UnitedHealthcare Community Plan files the disenrollment request. If AHCA or its agent does not make a disenrollment determination within this time frame, the disenrollment is considered approved as of the date AHCA's action was required.

F. On the first day of the month after receiving notice from FMMIS that the enrollee has moved to another region, AHCA will automatically disenroll the enrollee from UnitedHealthcare Community Plan and treat the enrollee as if the enrollee is a new Medicaid-eligible enrollee able to choose another care provider pursuant to the AHCA's enrollment process.

When Disenrollment Can Occur

An enrollee may request disenrollment at any time. AHCA or the enrollment broker performs disenrollment as follows:

- For cause, at any time
- Without cause, for enrollees subject to open enrollment, at the following times:
  - During the 90 days following the enrollee's initial enrollment, or the date AHCA or its agent sends the enrollee notice of the enrollment, whichever is later;
  - At least every 12 months;
  - If the temporary loss of Medicaid eligibility has caused the enrollee to miss the open enrollment period;
  - When AHCA or its agent grants the enrollee the right to terminate enrollment without cause (done on a case-by-case basis); or
  - During the 30 days after the enrollee is referred for hospice services to enroll in another managed care plan to access the enrollee's choice of hospice care provider.
- Without cause, for enrollees not subject to open enrollment, at any time.

Cause for Disenrollment

A. A mandatory enrollee may request disenrollment from UnitedHealthcare Community Plan for cause at any time. Such request will be submitted to AHCA or its agent.

B. The following reasons constitute cause for disenrollment from our plan.
   - The enrollee does not live in a region where we are authorized to provide services, as indicated in FMMIS.
   - The care provider is no longer with UnitedHealthcare Community Plan.
   - The enrollee is excluded from enrollment.
   - A substantiated marketing or community outreach violation has occurred.
   - The enrollee is prevented from participating in the development of his or her treatment plan/plan of care. The enrollee has an active relationship with a care provider who is not on UnitedHealthcare Community Plan's panel, but is on the panel of another managed care plan. "Active relationship" is defined as having received services from the care provider within the six months preceding the disenrollment request.
   - The enrollee is in the wrong managed care plan as determined by AHCA.
   - The managed care plan no longer participates in the region.
   - The state has imposed intermediate sanction upon UnitedHealthcare Community Plan.
   - The enrollee needs related services to be performed concurrently, but not all related services are available within our network, or the enrollee's PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.
   - UnitedHealthcare Community Plan does not, because of moral or religious objections, cover the service the enrollee seeks.
   - The enrollee missed open enrollment due to a temporary loss of eligibility, defined as 60 days or less for long-term care enrollees and 180 days or less for MMA enrollees.
   - Other reasons per 42 CFR 438.56(d)(2) and s. 409.969(2), F.S., 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 enrollee's health care needs; or fraudulent enrollment.

C. Voluntary enrollees may disenroll from UnitedHealthcare Community Plan at any time.

Involuntary Disenrollment Requests

A. With proper written documentation, the following are acceptable reasons for which UnitedHealthcare Community Plan may submit involuntary disenrollment requests to AHCA or its agent:

- Fraudulent use of the enrollee ID card. In such cases, we will report the event to MPI.
- The enrollee's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the UnitedHealthcare Community Plan seriously impairs our ability to furnish services to either the enrollee or other enrollees.
  - This section does not apply to enrollees with medical or mental health diagnoses if the enrollee's behavior is attributable to the diagnoses.
- An involuntary disenrollment request related to enrollee behavior must include documentation that we:
  - Provided the enrollee at least one (a) oral warning and at least one (b) written warning of the full implications of the enrollee's actions;
  - Attempted to educate the enrollee regarding rights and responsibilities;
  - Offered assistance through care coordination/case management that would enable the enrollee to comply; and
  - Determined that the enrollee's behavior is not related to the enrollee's medical or mental health condition.
- Falsification of prescriptions by an enrollee. In such cases the managed care plan will report the event to MPI.

B. We will promptly submit such disenrollment requests to AHCA. In no event will UnitedHealthcare Community Plan submit a disenrollment request at such a date as would cause the disenrollment to be effective later than 45 calendar days after the plan's receipt of the reason for involuntary disenrollment. We will help ensure that involuntary disenrollment documents are maintained in an identifiable enrollee record.

C. All requests will be reviewed on a case-by-case basis and subject to the sole discretion of AHCA. 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 an enrollee due to:

- Health diagnosis;
- Adverse changes in an enrollee's health status;
- Use of medical services;
- Diminished mental capacity;
- Pre-existing medical condition;
- Uncooperative or disruptive behavior resulting from the enrollee'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 enrollee in writing UnitedHealthcare Community Plan is requesting disenrollment, the reason for the request, and an explanation that UnitedHealthcare Community Plan is requesting that the enrollee be disenrolled in the next contract month, or earlier if necessary. Until the enrollee is disenrolled, the managed care plan will be responsible for the provision of services to that enrollee.

Chapter 6: Credentialing and Re-Credentialing

Credentialing

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

Requirements include all of the below: (Compliance with all credentialing rules is required every three years unless indicated with **. The ** documents are required annually.)

- Completed care provider application;
- W9;
- **A copy of your current medical license for medical care providers, or occupational or facility license as applicable to care provider type, or authority to do business;
- No revocation, moratorium or suspension of your state license by AHCA or the Department of Health, if applicable;
- **No sanctions imposed on the care provider by Medicare or Medicaid (validated by OIG and/or EPLS report);
- No record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.;
- A satisfactory level II background check pursuant to s. 409.907, F.S., for all treating care providers not currently enrolled in Medicaid's fee-for-service program;
  - AHCA-approved attestation to compliance
  - As defined by UnitedHealthcare Community Plan, you will need to submit a roster listing of all staff who qualify as direct care providers (face-to-face contact and have access to enrollee information) as it relates to UnitedHealthcare LTC Medicaid Managed Care Plan enrollees. The roster will be used to confirm staff compliance by accessing the AHCA background screening portal.
- Professional liability claims history (requires loss/run report);
- Liability insurance;
- **Occupational License or Tax Receipt;
- Medicaid ID number; (You do not have to participate in the Florida Medicaid program; however, you must be eligible for participation. If AHCA determines you are not eligible to participate in the Medicaid program, you are considered ineligible to participate in the LTC Medicaid Managed Care Plan. The Medicaid number is assigned for encounter data reporting purposes only. If you do not have a Medicaid number, the plan can apply for one on your behalf).
- Tax ID number;
- NPI number (transportation, emergency response system, environmental adaptation and pest control providers are excluded);
- Disclosure of ownership;
- Debarment letter;
- Work history; and
- Attestation to abuse/neglect/exploitation training.

The credentialing process is complete when the credentialing committee approves the credentialing application. You will be issued a UnitedHealthcare Community Plan number at that time.

Adverse Credentialing Determination Appeals

You must meet our protocols for continued participation in UnitedHealthcare Community Plan. You receive written notice of such protocols in the contract between yourself and us (provider contract), in UnitedHealthcare Community Plan's 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.

Termination

You must give us notice to terminate as outlined in your contract with us, and your active enrollees will be notified of that termination.We will also notify AHCA of the termination. In addition to all termination procedures listed in your contract, AHCA or UnitedHealthcare Community Plan may request immediate termination of your contract if, after notice of non-compliance, you do not come into compliance with the contract. You will have no additional right to appeal this termination outside the standard rights on termination.

Care Provider Complaint Process

If you have a concern, complaint, or inquiry, call the Provider Toll-Free line at **800-791-9233** or email at **fl_ltc_network@uhc.com**.

UnitedHealthcare Community Plan has established a care provider complaint system that permits you to dispute the policies, procedures, or administrative functions, including proposed actions, claims, billing disputes, and service authorizations which have been established. UnitedHealthcare Community Plan's process for care provider complaints concerning claims issues has been developed in accordance with s. 641.3155, F.S. These policies and procedures, including claims issues, are available to you upon request at no charge.

As a part of the care provider complaint system, you may contact us by phone, email, mail, or in person, to ask questions, file a complaint and resolve problems. You have 45 calendar days to file a written complaint for issues that are not about claims.

Within three business days of receipt of a complaint, we provide notification (verbally or in writing) the complaint has been received and the expected date of resolution. A Provider Relations representative will look into your issue and try to resolve it through informal discussions. Each complaint is investigated using applicable statutory, regulatory, contractual and care provider contract provisions, collecting all pertinent facts from all parties and applying UnitedHealthcare Community Plan's written policies and procedures. The Provider Relations representative will document why a complaint is unresolved after 15 days of receipt and provide written notice of the status every 15 days thereafter. UnitedHealthcare Community Plan will resolve all complaints within 90 days of receipt and provide written notice of the disposition and the basis of the resolution within three business days of resolution.

If you disagree with the outcome, an arbitration proceeding may be filed as described below and in your contract agreement. If your concern or complaint relates to a matter, which is generally administered by certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, we will follow the procedures set forth in those departments to resolve the concern or complaint. After following those procedures, if one of us remains dissatisfied, an arbitration proceeding may be filed as described below and in your agreement. If we have a concern or complaint about our agreement with you, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions with you, an arbitration proceeding may be filed as described below and in our agreement.

These processes may also be found at **UnitedHealthcareOnline.com** and **UHCCommunityPlan.com**.

Care Provider Privileges

To help our members get access to appropriate care and to help minimize out-of-pocket costs, you must have privileges at applicable participating facilities or arrangements with a participating practitioner to admit and provide facility services. This includes but is not limited to, full admitting hospital privileges, ambulatory surgery center privileges, and/or dialysis center privileges.

Arbitration

UnitedHealthcare Community Plan will conduct any arbitration proceeding under your agreement under the auspices of the American Arbitration Association, as further described in our agreement. For more information on the American Arbitration Association guidelines, visit their website at www.adr.org. In the event that a customer has authorized you to appeal coverage determination on their behalf, that appeal will follow the appropriate government regulatory process governing customer appeals outlined in this manual.

Data Collection

We are required to maintain a health information system that collects, analyzes and integrates all data necessary to compile, evaluate and report certain statistical data related to costs, utilization and quality, and such other matters as AHCA may require from time to time. As a UnitedHealthcare Community Plan participating care provider, you are required to submit all data necessary to fulfill these obligations in a timely manner. You must certify in writing at the time of submission to UnitedHealthcare Community Plan or its designee, that all data including, but not limited to, encounter data and other information that AHCA may specify, is truthful, reliable, accurate and complete.

We are authorized to take whatever steps are necessary to help ensure that the care provider is recognized by the state Medicaid program, including choosing counseling/enrollment broker contractor(s) as a participating care provider of the health plan and that the provider's submission of encounter data is accepted by the Florida MMIS and/or the state's encounter data warehouse.

Protect Confidentiality of Enrollee Data

UnitedHealthcare Community Plan enrollees have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates that need that information to fulfill our obligations and to facilitate improvements to our enrollees' health care experience. We require our affiliates and business partners to protect privacy and abide by privacy law. If an enrollee requests specific medical record information, we will refer the enrollee to you as the holder of the medical records. UnitedHealthcare Community Plan requires you to comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for privacy and protection of enrollee data.

County Services Contact Phone Numbers

- To report domestic violence, call 800-500-1119
- To reach the statewide consumer call center, call 888-419-3456
- To report health care fraud, call 866-966-7226 or 850-414-3990.
- To reach your local Medicaid office, call 305-593-3000
- Healthy Mothers-Healthy Babies, call 954-765-0550
- Pregnancy Prevention Education, call 305-324-2400

Toll-Free Care Provider Help Line

- Care Provider Toll-Free Help Line, 800-791-9233

Chapter 7: 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.
- Care and services should be provided 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) interface with the PCP, specialist, enrollee, and authorized representative on an ongoing basis. The CM develops and implements 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 must comply with all sections of the contract agreement between UnitedHealthcare Community Plan and the subcontractor. Requirements include but are not limited to:

- Care provider credentialing requirements;
- Make available to all authorized state and federal oversight agencies and their agents to any and all administrative, financial, documentation records and data relating to the delivery of items or services for which Medicaid monies are expended. Access will be during normal business hours except under special circumstances when AHCA and the Florida attorney general will have after-hours admission;
- Adherence to the False Claim Act;
- Eligible for participation in the Medicaid Program, however, you are not required to participate in the Medicaid program as a care provider. You will be assigned a Medicaid ID number for the purpose of reporting encounter data to AHCA;
- 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 LTC Medicaid Managed Care enrollees will receive initial and ongoing face-to-face care management assessments.

The CM 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 that the enrollee continues to receive an appropriate level of care. The CM documents all the orientation; health assessments, reassessment, and care plan findings in UnitedHealthcare Community Plan's care management system software program.

Inpatient Concurrent Review: Clinical Information

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

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

You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide all requested and complete clinical information and/or documents as required within 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 Community Plan 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.

Enrollee Records

We will make use of the usual and customary protocols within the care provider community by using the enrollee records you maintain. These records you will include enrollee's diagnoses, medical conditions, medications, scheduled appointments, progress notes and services/treatments provided on behalf of the enrollee.

Confidentiality and accuracy of an enrollee's record must be maintained at all times. UnitedHealthcare Community Plan requires you comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for privacy and protection of enrollee data. The privacy of any information that identifies a particular enrollee must be safeguarded. Information from or copies of an enrollee's record may only be released to authorized individuals.

You must help ensure that unauthorized individuals cannot gain access to or alter an enrollee's record. Original records may only be released in accordance with state laws, court orders or subpoenas, and timely access by enrollees to the information that pertains to them must be promised. Additionally, you and UnitedHealthcare Community Plan must abide by all federal and state laws regarding confidentiality and disclosure of all enrollee records and information.

All records must be maintained for six years. Additionally, the record must include must be prominent documentation demonstrating whether an enrollee has executed an advance directive.

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

We help ensure the hours of operation of participating care providers do not discriminate against the enrollee, and that 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 that may have a limited English proficiency or reading skills. If you cannot accommodate the enrollee, you must call our Customer Service number in the 'How to Reach Us' 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 care providers, UnitedHealthcare Community Plan initiates a Letter of Agreement (LOA) with a care provider so that service requirements can be met by out-of-network resources.

Short-Term Intervention: If a participating care provider cannot 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 your licensure status and good standing with the state.

Long-Term Intervention: If you meet credentialing requirements, you can become a participating care provider (e.g., in-network), thereby expanding network options for services.

Clinical Practice Guideline References

All services provided to enrollees must be medically necessary.

For services unique to long-term care, UnitedHealthcare LTC Medicaid Managed Care uses a person-centered care plan to help determine medical necessity. If a service request cannot be approved as medically necessary, the request is forwarded to a physician advisor who determines medical necessity using their clinical judgment, acceptable standards of care, state and federal laws, and the Agency for Healthcare Administration's medical necessity definition.

For mixed services, which are available under both the Managed Medical Assistance program and the LTC program, UnitedHealthcare Community Plan uses the same criteria for Medicaid Managed Care and LTC Medicaid Managed Care.

For services unique to the Managed Medical Assistance program, please see the MMA Provider Administrative Manual at **UHCCommunityPlan.com**.

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 care providers related to their continued participation in the network;
- Approval of policies and procedures;
- Define and implement process improvements that enhance clinical efficiency, provide effective utilization and focus on improved outcome management achieving the highest level of success; and
- Define interventions that will best help manage the care and enrollee outcomes.

Enrollee Bill of Rights

The state must help ensure that each enrollee is free to exercise their rights, and that the exercise of those rights does not adversely affect the way the LTC Medicaid Managed Care plan and its care providers or AHCA treat the enrollee.

We tell our customers they have the following rights and responsibilities, all of which 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 us, our services and network care providers in accordance with federal and state regulations;
- To be treated with respect and with due consideration for his or her dignity and privacy by our 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 care provider 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 that the care provider they receive service from is in the UnitedHealthcare LTC network;
- If applicable, pay any necessary copayment at the time they receive treatment;
- Provide information needed for their care;
- Follow the agreed upon instructions and guidelines of physicians and health care professionals; and
- Notify Customer Service of a change in address, family status or other coverage information.

UnitedHealthcare LTC enrollees receive a complete list of their enrollee rights and responsibilities in their Enrollee Information Guide.

Sanctions

Upon written notification from AHCA – by letter or the lists published by the OIG and GAO – of a care provider's exclusion from original Medicare or Medicaid, UnitedHealthcare Community Plan will send a letter to the care provider stating they will be removed from the UnitedHealthcare Community Plan list of participating care providers as of a given date. Except for post-stabilization, emergency and urgently needed care, no payments will be made to the care provider after the exclusionary effective date. Enrollees are notified that the care provider is no longer contracted and are advised to select a new care provider.

Enrollees with claims pending for items or services from an excluded care provider, or enrollees submitting claims for items or services from an excluded physician or care provider for the first time will receive a letter notifying the enrollee of the following:

- The enrollee is accessing a sanctioned care provider.
- Payments to a Medicare-Medicaid-excluded care provider are prohibited.
- Payments will not be made for items or services rendered after the date of exclusion or after notification to the enrollee (whichever date is later).

Care providers are also prohibited from employing or contracting with an individual who is excluded from participation in Medicaid, 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 AHCA, you are responsible for notifying UnitedHealthcare Community Plan and applying for reinstatement.

Surveys

AHCA 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 that are non-English speaking, or have physical disabilities, or are part of a minority ethnic group.

Chapter 8: Billing and Payment

Billing and Claims

When presenting a claim for payment to UnitedHealthcare Community Plan, you are indicating that you have an affirmative duty to supervise the provision of, and be responsible for, the covered services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for UnitedHealthcare LTC covered services determined medically necessary and that have actually been furnished to the recipient prior to submitting your claim.

At **UnitedHealthcareOnline.com**, you can:

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

This website is a service provided free to participating care providers.

Electronic Claim Submission

In addition to **UnitedHealthcareOnline.com**, you can 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**.

Another option that is free for care providers to use for the purpose of submitting claims is 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 claims submitted via standard mail, claims should be completed on either a HCFA 1500 or UB-04 claim form.

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

Detailed directions for completing the HCFA 1500 and UB-04 can be found in the Claims Submission 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 31365
Salt Lake City, UT 84131-0362

Please do not bill Medicaid directly.

Claims Processing Rules and Resources

Automated Claims Adjudication and PRAs
The process to correct claims that require additional information or that had missing information will be automated to reduce the need to retroactively correct claims. When a claim needs correction, you'll no longer receive letters when claims can't be paid due to missing or inaccurate information. The PRA will include a description of the information needed to pay the claim, eliminating the need for a separate letter.

Facility and Professional Claim Types
For UnitedHealthcare Community Plan, we will process claims according to coverage and billing rules for Facility and Professional claim types.

To access our policies for these claim processing rules, please use the following resources:

- **UHCCommunityPlan.com** > Health Professionals > Florida > Bulletins
- **UHCCommunityPlan.com** > Health Professionals> Florida > Provider Administrative Manual
- **UHCCommunityPlan.com** > Health Professionals > Florida > Reimbursement Policy

Payment Information

Please 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 90 days from the date of discharge from a facility; or 90 days from the date the services are rendered to the enrollee. Any claims received after this time period may be rejected for payment at our discretion.

We 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 do not submit a claim. The enrollee cannot be balance billed for services covered under the contractual agreement at a pre-determined contracted rate.

If a claim is filed within the time period allowed under Medicaid the service is our liability, we will pay the claim even if the contract between AHCA and UnitedHealthcare is no longer in effect; or if the enrollee has disenrolled from UnitedHealthcare Community Plan, provided that the enrollee was enrolled and effective at the time that the service(s) were rendered and that the service was a covered benefit through the UnitedHealthcare LTC Plan.

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."

The correct UnitedHealthcare Community Plan enrollee ID number should be legible and included on the claim.

For HCFA 1500 claims, only valid procedure codes should be used. Consult your contract agreement payment appendix for approved codes to be provided for submitting claims for services provided.

For UB-04 claims, only valid revenue codes must be used. Consult your contract agreement payment appendix for approved codes to be provided for submitting claims for services provided.

- HCFA 1500 claim forms may be obtained by contacting the American Medical Association at 312-464-5000 or toll free at 800-621-8335.
- UB-04 claim forms may be obtained by contacting the American Medical Association at 312-464-5000 or 800-621-8335.

Claim Completion Requirements

Patient information required for each claim:

- Enrollee's 16-digit UnitedHealthcare Community Plan 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 Community Plan 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 on each claim:

- Name of care provider delivering service;
- If applicable, must include care provider DBA name;
- Seven-digit UnitedHealthcare Community Plan number for care provider who renders the service (unique for each care provider);
- If applicable, name of the referring physician;
- Federal Tax ID Number; and
- Care provider signature/date – for HCFA 1500 claims.

Service information required on 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 HCFA 1500 claims; and
- Standard CMS site codes are required to indicate where services were rendered.

Guidelines for submitting claims:

- Claims should be submitted for only one enrollee and one care provider per claim form.
- For HCFA 1500 claims, multiple visits rendered by a care provider over several days should be itemized, by date of service. (See section on – How to Bill HCFA 1500.)
- For UB-04 see section on – How to Bill UB-04

- Modifiers are located at the beginning of each major section of CPT. The modifiers provide a means by which the definition of a particular service can be modified to better describe the circumstances of the service. When appropriate, the two-digit modifier should be used immediately following the five-digit procedure code. (Do not insert a space or a dash.)
- We follow NDC coding guidelines.

Examples of reasons why claims would be returned:
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 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., HCFA 1500 or UB-04)
- Date span for services requiring authorization does not match dates authorized

Taxonomy Codes

Taxonomy codes are required with claim submissions. This 10-digit alphanumeric code indicates the type, classification and specialty of the care provider. The taxonomy code submitted on claims should match one of the taxonomy codes you registered with Medicaid included in their Provider Registration data.

You can verify the taxonomy code(s) you registered with Medicaid:

Online: Referring to the Florida Provider Master List (PML) spreadsheet at **mymedicaid-florida.com** > Managed Care

Phone: Florida Medicaid Provider Enrollment Call Center at **800-289-7799**, Option 4. **Contact** your Provider Advocate or Provider Services at **877-842-3210**.

Taxonomy codes only apply to providers who directly render health care services to our members.

NPI Number Required on Claims

Starting June 1, 2017, if you're a care provider who renders direct health care services to members, you will need to add your national provider identifier (NPI) number to claims. Be sure to:

- Use the NPI you registered with Florida Medicaid
- Bill for services as you are registered on the Florida PML.

NPI information can be faxed to 866-943-0517, emailed to **americhoice_dbm_npi@uhc.com** or mailed to UnitedHealthcare DBM Claims, P.O. Box 16900, Phoenix, AZ 85011.

Claims may be rejected or denied when submitted without an NPI or with an invalid NPI, depending on the method of submission. If you have not yet applied for and received your NPI, please do so immediately by visiting **nppes.cms.hhs.gov**. If you have not yet provided your NPI to UnitedHealthcare or any of the UnitedHealthcare government programs health plans, you must do so immediately.

National Correct Coding Initiative Guidelines

UnitedHealthcare Community Plan follows National Correct Coding Initiative (NCCI) guidelines and other applicable coding guidance from the Centers for Medicare & Medicaid Services including but not limited to the Official ICD-10-CM Guidelines for Coding and Reporting.

Claims Paid and/or Denied in Error

Claims receiving partial/incorrect payments or inappropriate denials must be resubmitted using the Adjustment Request Form. Not using the Adjustment Request Form may cause a delay in adjusting the claim.

Submit the Adjustment Request Form with required documentation to:

UnitedHealthcare Community Plan
P.O. Box 31365
Salt Lake City, Utah 84131

If you are submitting corrected claims online, complete the required UnitedHealthcare Claim Reconsideration Request Form. Check the appropriate reason for submission, and attach required documents.

Go to **UnitedHealthcareOnline.com**. Click on Claims and Payments > Claim Reconsideration. Log in to complete the process.

Claim Denials

Claims denied for inaccurate or missing information will be noted on the Provider Remittance Advice, see section for Remittance Advice included in this manual. The denied claims will be listed with a denial code. The denial code will identify the error that must be corrected prior to resubmitting the claim. The claim must be resubmitted noting – Corrected Claim in the comments section to assure the claim will be reprocessed appropriately. For questions concerning claims resubmission, contact your local Provider Relations Advocate. Reference the "How to Reach Us" page for information on how to reach the Provider Relations Advocate.

Care Provider Claims Dispute

If you disagree with a claim payment determination, send a letter to the claim office at:

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

Your dispute must be submitted to us within 12 months from the date of payment shown on the EOB or PRA. If you are appealing a claim that was denied because filing was not timely, for:

- **Electronic claims:** include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim.
- **Paper claims:** include a copy of a screen print from your accounting software to show the date you submitted the claim.

You are reimbursed according to your LTC-contracted rates. If you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed as described in your agreement.

Overpayment

- If you receive an overpayment from UnitedHealthcare Community Plan, you can return the original check by mailing it to the local UnitedHealthcare Community Plan office c/o Operations Manager with the reason for the return (See "How to Reach Us" section).
- To properly credit any returned check or refund check please include a copy of the PRA with your correspondence.
- If you wish to mail a refund check to UnitedHealthcare Community Plan on your own check stock paper, please mail it to:

  UnitedHealth Group Recovery Services
  P.O. Box 740804
  Atlanta, GA 30374-0804

Durable Medical Equipment (DME) Billing

Prior authorization is required for all DME products. If you are a supplier of DME products, please verify the appropriate billing source for your products. You must identify the skill level of the enrollee before the provision of services. This knowledge of the level of care provided will assure the appropriate party is billed for the services.

Filing Corrected Claims

1. If you are submitting corrected claims by mail: Complete the Adjustment Request Form below and submit it along with required documentation to:

   UnitedHealthcare Community Plan
   P.O. Box 31365
   Salt Lake City, UT 84131-0362

2. If you are submitting corrected claims online: Complete the required Claim Reconsideration Request Form. Check the appropriate reason for submission and attach required documents.

Go to **UnitedHealthcareOnline.com**. Click on Claims and Payments > Choose *'Claim Reconsideration' > Log in to complete the process.*

UnitedHealthcare®

Single Paper Claim Reconsideration Request Form

This form is to be completed by physicians, hospitals or other health care professionals for paper Claim Reconsideration Requests for our members.

NOTE

- **Please submit a separate Claim Reconsideration Request form for each request.**
- **No new claims should be submitted with this form.**
- **Do not use this form for formal appeals or disputes. Continue to use your standard appeals process for formal appeals or disputes.**

Please refer to the attached Claim Reconsideration Reference Guide, your care provider manual or our care provider website for additional details including where to send paper ClaimReconsideration Requests. You may verify the member's address using the eligibility search function on the website listed on the member's health care ID card.

☐ Physician ☐ Hospital ☐ Other Health Care Professional (Lab, Durable Medical Equipment (DME), etc.)

Member information **Date form completed**

Member ID	Control / Claim #	Date of Service	Billed Amount
Member Last Name		First Name	MI
Street Address		State	Zip
Patient: Last Name		First Name	MI

Physician/Health care professional information

Tax Identification Number (TIN):_____ Phone Number (with area code): _____

Email Address: _____

Physician or other Health Care Professional Name(as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB)

Last Name First MI

Street Address City State Zip

Facility/Group Name_____Contact Person _____

Expected amount owed _____ Contact Fax Number (with area code) _____

Reason for request: ***(More information on the definition reasons listed below and what documentation needs to be submitted can be found on the Claim Reconsideration Request definition sheet on UnitedHealthcareOnline.com)***

☐ 1. Previously denied / closed as "Exceeds Filing Time"
☐ 2. Previously denied / closed for "Additional Information"
☐ 3. Previously denied / closed for "Coordination of Benefits" information
☐ 4. Resubmission of a corrected claim
☐ 5. Previously processed but rate applied incorrectly resulting in over/underpayment (Network Care Providers - Check your fee schedules)
☐ 6. Resubmission of "Prior Notification Information"
☐ 7. Resubmission of a claim with "Bundled" services
☐ 8. Other *(explain below)*

Please include what you are expecting from UnitedHealthcare regarding this Claim Reconsideration Request to close this out in your practice management system, including dollar amount if possible.

Comments

Required attachments

- Copy of PRA or EOB
- Claim Form is **ONLY** required for Corrected Claims Submissions
- Other required attachments as listed above

You may have additional rights under individual state laws. Please review the care provider website, your care provider manual or your provider agreement/contract if you need more information.

Doc#: PCA11850_20140312

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 the claim not being paid. Claim information must match authorization information.

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

How to Bill a HCFA 1500

This list contains the minimum amount of information required to process a claim on a HCFA 1500. Any missing/invalid data will result in the claim not being paid. Claim information must match authorization information.

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

Claim Submission Address

All paper claims mmust be submitted to:

UnitedHealthcare Community Plan
P.O. BOX 31365
Salt Lake City, UT 84131-0362

Do not submit claims to Medicaid:
Claims submitted to Medicaid 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**. (HCFA 1500 claims only)

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

Claims Forms Used

Physician claims.....HCFA1500
Ancillary claims.....HCFA1500
Facility claims.....UB-04

Electronic Remittance Advice and Paper Remittance Advice

As of June 1, 2017, the Electronic Remittance Advice (ERA) Payer ID number will be 04567. For dates of service prior to June 1, 2017, please use the previous ERA Payer ID number 87726.

If you are signed up to receive ERAs, you'll receive both paper and electronic remittance advices for 31 days after your first payment. For example, if your first payment is June 15, you'll receive ERAs and paper remittance advices until July 16. You will only receive ERAs thereafter. You can still view, save and print the paper version at **UnitedHealthcareOnline.com** > Claims & Payments > Electronic Payments & Statements (EPS).

Electronic Payments & Statements

Electronic Payments & Statements (EPS) is UnitedHealthcare's solution for electronic funds transfers (EFT) and ERAs. Your posting method does not change, and you do not need special software. By enrolling in EPS, you can:

- Receive claims payments by direct deposit.
- Access your explanations of benefits (EOBs) online or via 835 ERA files.

Care providers who are enrolled in EPS are automatically enrolled with the new ERA Payer ID 04567.

Provider Remittance Advice

A PRA is a summary of payments made on all claims processed. This statement is called an Explanation of Benefits (EOB) when it is sent to the UnitedHealthcare Long Term Care 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 which a claim was paid/denied.

A PRA is included with each check sent to a care provider.

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

See the PRA sample that follows in the next three pages.

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: notcovered benefits or amounts over the fee maximum.)

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

We send payment to the address listed in our claim processing system. The claim form address must match either the place of service or the billing address listed in our claims processing system for the claim to be processed in a timely manner.

Remittance Advice Key

1. **CHECK DATE:** The date the check was issued
2. **CHECK NO:** The number of the check that was generated
3. **AMOUNT:** The total amount of the check
4. **TAX ID NO:** Care provider's Federal Tax Identification number
5. **CARE PROVIDER/ALT PAYEE:** The mailing name and address for the care provider of alternate payee
6. **PROV NO:** 7-digit number identifying the care provider
7. **NAME:** The name of the care provider who performed the services
8. **MEMBER:** The name of the member receiving services
9. **NUMBER:** The 16-digit number for the member receiving services
10. **ACCOUNT NO:** Member's account number assigned by the provider and submitted on the claim

11. **ADJUSTMENT:** The word “Adjustment” is displayed on a separate line above the claim number if the claim was modified from the original. In addition to the word “Adjustment”, the original payment date is displayed if the claim was paid on a previous check write
12. **PCP NAME/NO:** The member’s PCP name and number displays when applicable
13. **CLAIM NO:** The audit number assigned to the claim
14. **DOS:** Date of service - date the service was performed
15. **PROC:** The code identifying the procedure/service provided
16. **U:** The number of units for each detail line
17. **CLAIMED:** The total amount claimed for the procedure performed
18. **COPAY:** Amount that the member is required to pay for services
19. **DEDUCT:** Amount of deductible specified under the member’s contract
20. **INELIG MEM:** Services that are not covered by the member’s policy and are member responsibility **(These are generally services not covered by Medicare.)**
21. **INELIG PROV:** Services that are not covered and are your responsibility
22. **CODES:** Reason codes that define any claim adjustments, disallows or denials. **The code explanations are listed on the last page or end of the PRA**.
23. **DISCOUNT:** Amount of discount defined within a care provider’s contract **(Difference between claimed amount and contract rate – YOU MUST WRITE THIS OFF)**
24. **AMOUNT PAID:** Net amount paid to the care provider for services after all deductions have been taken
25. **CLAIM TOTAL:** The total dollars paid on the claim

Patient Responsibility

Patient responsibility is the cost of Medicaid LTC residential services not paid for by the Medicaid program, for which the enrollee is responsible. Patient responsibility is the amount enrollees must contribute toward the cost of their care. This is amount is determined by DCF and is based on income and type of placement.

Payment to care providers is governed by the Medicaid State Plan and the Florida Medicaid promulgated handbooks.

While the Managed Care Plan is responsible for collecting patient responsibility as determined by DCF, the Managed Care Plan may transfer the responsibility for collecting its enrollees’ patient responsibility to residential care providers and compensate these care providers net of the patient responsibility amount. If the Managed Care Plan transfers collection of patient responsibility to the care provider, the care provider contract will specify complete details of both parties’ obligations in the collection of patient responsibility. If the Managed Care Plan transfers the responsibility for collecting its enrollees’ patient responsibility to residential care providers the Managed Care Plan will compensate these care providers net of the patient responsibility amount. The Managed Care Plan must either collect patient responsibility from all of its residential care providers or transfer collection to all of its residential providers. Some enrollees have no patient responsibility either because of their limited income or the methodology used to determine patient responsibility.

The Managed Care Plan must have a system in place to track the receipt of patient responsibility at the enrollee level irrespective of which entity collects the patient responsibility. This data must be available upon request by the Agency. The Managed Care Plan or its care providers will not assess late fees for the collection of patient responsibility from enrollees.

Provider Remittance Advice

UNITEDHEALTHCAREINSURANCECOMPANY
P.O. Box 1459
Minneapolis, MN 55440-1459

a member of the United HealthCare Corporation family of services

1 CHECK DATE 05/13/1997

Ref # 0858
MSP B10 001

2 CHECK NO. 7779295

3 AMOUNT $34.63

4 TAX ID NO. 460789999

5
Sample Provider Medical Clinic
123 Main Street
Anytown, MN 55555

EverCare: a product of
UnitedHealthCare Insurance Company

6 PROV NO. 01-99999

7 NAME Sample Provider Medical Clinic

UPIN NO.

Plz Submit

8 MEMBER Doe, Jane

9 **NUMBER** 10003-300030003-00

ACCOUNT NO.

403 10

11

13 CLAIM No. 20222222-00

12 PCP NAME GERIATRIC PHYSICIANS ASSOCIATION, INC.

ICD-10 DIAG.
43401 PCP NO.
0000099

14 DOS	15 PROC	16 U	17 CLAIMED	COPAY	DEDUCT	18 Inelig-mem	19 Inelig-prov	20 Code	21 Discount	22 Withhold	23 Amount Paid
3/17/97	99312	01	100.00		20.00		35.73	32	9.64		34.63
CLAIM TOTAL			100.00		20.00		35.73			25	34.63

DOS	PROC	U	CLAIMED	COPAY	DEDUCT	Inelig-mem	Inelig-prov	Code	Discount	Withhold	Amount Paid
PROVIDER TOTAL			100.00		20.00		35.73		9.64		34.63

The Above Totals are included in Check #7779299 34.63

PROVIDER REMITTANCE ADVICE

CODE DESCRIPTIONS

CHECK DATE	REF # 1126
01/23/1997	MSP BR1 500

PROVNO. 01-99999 NAME GERIATRIC PHYSICIANS ASSOCIATES, Inc.

INELIGIBLE EXPLANATION CODES

32 CHARGES EXCEED FEE SCHEDULE

Care Provider Risk Arrangements

We are required to disclose our care provider incentive arrangements to AHCA on request. The purpose of this disclosure is to allow AHCA to monitor those entities that hold their care providers at "substantial financial risk."

In addition, we must 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 us to comply with these AHCA requirements. Please respond promptly to our requests for information as required.

Mid-Level Claims Reimbursement

As of June 1, 2017, UnitedHealthcare Community Plan has updated how mid-level claims are reimbursed for the following care providers:

- Nurse practitioners
- Physician assistants
- Registered nurse first assistants

In accordance with your provider agreement, you will be reimbursed using the Florida Medicaid fee schedule. The affected services and codes may be found at **ahca.myflorida.com**.

Anesthesia Unit Billing Guidelines

As of June 1, 2017, UnitedHealthcare Community Plan has moved to a new enrollment and claims payment system. Given this transition, we ask that you:

- Submit claims with the number of units based on the total anesthesia service time. Any portion of a 15-minute increment equals one unit.
- Include the appropriate HCPCS modifiers. These modifiers identify monitored anesthesia and whether a procedure was:
    - Personally performed,
    - Medically directed, or
    - Medically supervised.

We validate this information for reimbursement. In addition, bill according to Florida Medicaid guidelines to avoid a payment reduction.

To review the reimbursement guidelines and anesthesia policies, go to: **UHCCommunityPlan.com** > Health Care Professionals > Florida > Reimbursement Policy.

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

We may send an enrollee a request for information about other insurance they may have. If the enrollee has other insurance, we may require that 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% of billed charges or possible amount required by state regulation, after the primary carrier and UnitedHealthcare Community Plan have reached final claim disposition.

Chapter 9: Appeals and Grievances

Enrollee Appeals and Grievances

Grievance Process

If an enrollee has a concern or question regarding care or coverage under the plan, they should contact the Customer Service department at the toll-free number on the back of their identification card, Monday through Friday. A customer service representative will answer questions or concerns. The representative will try to resolve the problem. If the customer service representative does not resolve the problem to the enrollee's satisfaction, they have the right to file a grievance.

The enrollee may file a grievance in writing or by phone. Members may file a grievance at any time. It may be filed by you, with the enrollee's written consent. A grievance may be filed about such things as the quality of the care the enrollee receives from the plan or a care provider, rudeness from a plan employee or a care provider's employee, a lack of respect for their rights by the plan or a care provider or anything else the enrollee may be dissatisfied with.

To file, you or the enrollee may call Customer Service at **800-791-9233** or TDD 771

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

Or fax to: 800-757-2617 (Office Hours: 7 a.m. – 8 p.m., Monday – Friday)

The plan will send the enrollee a letter when the plan receives the grievance. The plan will send a decision letter usually within 60 days of receiving the request. In some cases, the plan may need to ask for more information. Then it may take up to 90 days to issue a resolution letter.

If the enrollee wants a Grievance Committee Hearing, they or their care provider, with the enrollee's written permission, may ask for it within 90 days after they receive the plan's decision.

If the enrollee needs assistance in filing their grievance or need the help of an interpreter, they may call the Customer Service number: **800-791-9233 or the TDD 771**.

Interpreter services are free.

If the enrollee needs more time to get information, they may get up to 14 more days. If the plan needs more time, we will tell the enrollee why in writing.

Appeals Process

If we deny, reduce, put on hold or stop a service the enrollee is receiving, they will get a written "Notice of Action" at least 10 days before the action takes place. If the enrollee does not agree, they may file an appeal. Or, they may have you file with their written consent.

Standard Appeal

A Standard Appeal asks UnitedHealthcare Medicaid LTC Plan to review a decision about the enrollee's care. An enrollee, authorized representative, or legal representative of the estate may file a plan appeal orally or in writing within 60 calendar days from the date on the notice of adverse benefit determination. If the enrollee does not get a written notice from UnitedHealthcare Community Plan, the enrollee has one year to file an appeal.

The enrollee can ask their doctor, a family enrollee or friend to file the appeal for them. If someone helps the enrollee file an appeal, that person must be the enrollee's "authorized representative."

To file an appeal, the enrollee or representative may fax a letter to: 800-757-2617 (Office Hours: 7 a.m. – 8 p.m., Monday – Friday)

Or mail to:

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

Or call 800-791-9233 or TDD 888-685-8480

If the enrollee calls, they must also send the appeal in writing. The review begins the day the plan receives the request. The plan will send a written notice to the enrollee within five days. UnitedHealthcare Community Plan has 30 days to look at the case. We will send the enrollee a letter with the decision, explaining how we made our decision.

The plan indicates the laws or health plan policies reviewed to decide the case. Before we make a decision, the enrollee and/or the person helping the enrollee with the appeal can give information to UnitedHealthcare Community Plan. The new information can be in writing or in person. The enrollee and their representative may look at the case file. The enrollee's estate representative may review the file after the enrollee's death. The file may have medical records or other papers. The enrollee can review their file any time while we are reviewing the appeal.

If the enrollee needs more time to get information, they may have it. The enrollee or the plan can request up to 14 calendar days. If we ask for more time, we will send a letter informing the enrollee why.

Medicaid Fair Hearings

Any enrollees not satisfied with the outcome of their appeal after completion of the process may file for a Fair Hearing within 120 calendar days of receiving the appeal resolution.

To request a Medicaid Fair Hearing, the enrollee should send a letter to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906
(877) 254-1055 (toll-free)
(239) 338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

Continuation of Benefits

An enrollee may continue to receive services while waiting for the plan's decision if all of the following apply:

- The appeal is filed within 60 calendar days from the date on the adverse benefit determination notice;
- The appeal is related to reduction, suspension or termination of previously authorized services;
- The services were ordered by an authorized care provider;
- The authorization has not ended, and
- The enrollee requested the services to continue.

The enrollee's services may continue until one of the following happens:

- The enrollee decides not to continue the appeal.
- The enrollee did not request a fair hearing and continuation of benefits within 10 days after we sent the notice of plan appeal resolution.

The enrollee may have to pay for the continued services if the final decision from the Medicaid Fair Hearing is against them.

If the Medicaid Fair Hearing agrees with the enrollee, we will pay for the services received while waiting for the decision.

If the Medicaid Fair Hearing decision agrees with the enrollee and they did not continue to get the services while waiting for the decision, we will issue an authorization for the services to restart as soon as possible, and we will pay for the services.

Subscriber Assistance Program (SAP)

Medicaid members have the right to appeal to the Subscriber Assistance Program (SAP) as an additional level of appeal. The member can access the SAP after exhausting UnitedHealthcare Community Plan's Grievance and Appeals process, except when the member has requested or is participating in a Medicaid Fair Hearing for the matter. The SAP must receive the request for review from the member (or their designee with appropriate documentation for representation) within one year of the receipt of the final decision letter from us. Members can either:

Call **850-412-4502** or **888-419-3456 (toll-free)**

Or write to:

Agency for Health Care Administration
Subscriber Assistance Program
Building 3, MS #45
2727 Mahan Drive
Tallahassee, Florida 32308

If the decision from UnitedHealthcare Community Plan, the Medicaid Fair Hearing or the Subscriber Panel is in the enrollee's favor and the services were not continued during the reviews, UnitedHealthcare Community Plan will start the services and pay for them.

Expedited Appeal

An enrollee or their representative, with the enrollee's written consent, can request an Expedited Appeal. Expedited Appeals are for health care services, not denied claims.

To ask for an expedited appeal, the enrollee or their representative may call **800-595-9532**.

The new information can be in writing or in person. The plan will send a written decision within 72 hours.

If the enrollee needs more time to get information, they may ask for up to 14 more days. If the plan asks for more time, the plan will let the enrollee know why in writing.

If the plan determines that taking more time to decide an appeal will be harmful to the enrollee, the plan will notify the enrollee of the decision by phone and in writing within two days.

Chapter 10: Fraud and Abuse

Fraud and Abuse Reporting

To support suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hot-line toll-free at **888-419-3456** or complete a Medicaid Fraud and Abuse Complaint Form. The form is available at **apps.ahca.myflorida.com/Inspector General/fraud_complaintform.aspx**

If you report suspected fraud, and your report results in a fine, penalty or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Award Program (866-866-7226 or 850-414-3990). The reward may be up to 25 percent of the amount recovered, or a maximum of $500,000 per case (Florida Statutes Chapter 409.9203). You can talk to the Attorney General's office about keeping your identity confidential and protected.

HCBS Critical Incident Reporting and Management

All UnitedHealthcare Community Plan employees, including HCBS providers, are responsible for reporting all adverse/critical incidents in an appropriate and thorough manner, **not more than 24 hours** after becoming aware of the incident. Such reporting includes:

a. Any allegation of abuse – physical, sexual or mental

b. Any allegation of exploitation, including financial exploitation

c. Any allegation of neglect

d. Any allegation of injury, serious illness or death of an individual that occurs within the agency's programs when abuse or neglect is suspected

e. Alleged involvement with law enforcement

f. Potential elopement/missing person

g. Major medication incidents

h. Any of the Code 15 Reportable events defined above.

1. If a UnitedHealthcare Community Plan employee including HCBS providers, is told of, or suspects an incident of physical abuse, sexual abuse, mental abuse, financial exploitation, neglect, injury or death has occurred, the employee must report the allegation to Quality Management immediately. Quality Management provides Critical Incident reporting coverage, to include weekends and holidays, 365 days per year, to comply with the Contract, Section XIV, Reporting Requirements; reporting of a Critical Incident within 24 hours of detection or notification.
2. Upon identification of an adverse/critical incident as defined above, the UnitedHealthcare Community Plan employee, including HCBS providers, completes a Critical Incident Reporting Form (**Attachment A**) and submits the completed form to Quality Management **not more than 24 hours** after becoming aware of the incident.
3. Failure to report adverse/critical incidents is subject to disciplinary action in accordance to established UnitedHealthcare Community Plan policy.
4. Members' quality of care issues (QOC), including those related to adverse events/critical incidents must be reported to and a resolution coordinated with UnitedHealthcare Community Plan's Quality Management Department, according to the established policy (QM-006).

Chapter 11: Comments

Comments

UnitedHealthcare Community Plan welcomes your comments and suggestions about this manual. If you need information about the material covered in this manual or expansion on topics not addressed or if you find incorrect or inaccurate information, please complete this form. Then mail to:

UnitedHealthcare Community Plan
Provider Relations
3100 SW 145th Avenue -- 2nd Floor
Miramar, FL 33027

Comments and Recommendations

Please provide the following information so we can contact you if we need to clarify your request.

Name: _____

Address: _____

Phone: _____