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Chapter 1: Welcome to UnitedHealthcare Community Plan

UnitedHealthcare Community Plan is a business unit of UnitedHealth Group, a diversified health and well-being company dedicated to making health care work better. UnitedHealthcare Community Plan manages UnitedHealth Group’s Medicaid and CHIP health plans and management service organization contracts.

Several factors distinguish UnitedHealthcare Community Plan:

• UnitedHealthcare Community Plan emphasizes service to all our customers – regulators, providers and members.

• UnitedHealthcare Community Plan understands the unique needs of the populations we serve, and our health plans are designed specifically to meet those needs.

• UnitedHealthcare Community Plan has a private-sector focus on cost accounting, data analysis and fiscal discipline, coupled with sensitivity to the imperatives of public sector accountability.

• UnitedHealthcare Community Plan invests in the systems and personnel required to successfully manage our business.

Moreover, UnitedHealthcare Community Plan understands that compassion and respect are essential components of success in health care. UnitedHealthcare Community Plan employs a diverse workforce, rooted in the communities we serve, with varied backgrounds and extensive practical experience that gives us a better understanding of our members and their needs.
This Provider Manual is designed to give you and your staff a comprehensive guide for your participation with UnitedHealthcare Community Plan. It is also an integral part of your contract with UnitedHealthcare Community Plan and is specifically incorporated by reference in your provider agreement. It is imperative that you keep it in an accessible place for easy day-to-day reference.

The Provider Manual is available electronically at [UHCCommunityPlan.com](http://UHCCommunityPlan.com). Paper copies are available on request.

This Provider Manual replaces all earlier editions of Provider Manuals and provider alerts. The information contained in this manual reflects the policies of UnitedHealthcare Community Plan as of the current printing. It also reflects the policies, procedures and benefits of state and federal health programs communicated to UnitedHealthcare Community Plan as of current printing.

If it is necessary to update any information sooner, UnitedHealthcare Community Plan will send updates via provider newsletters or Provider Alerts. The Provider Manual, Newsletters and Alerts together constitute the most current information on UnitedHealthcare Community Plan programs and, along with your provider contract, outline your legal responsibilities under these programs and your contractual relationship with UnitedHealthcare Community Plan. Participating dentists, pharmacists, and vision care providers receive separate instructions, guidelines, and alerts.

If you need additional copies or have any questions about your Provider Manual, please call the Provider Services Helpline at 800-600-9007.

### UnitedHealthcare Community Plan Programs

UnitedHealthcare Community Plan of Pennsylvania currently offers the following programs:

- UnitedHealthcare Community Plan Medicaid is offered through the product name UnitedHealthcare Community Plan for Families under HealthChoices program of the Pennsylvania Department of Human Services.
- UnitedHealthcare Community Plan CHIP is offered through the product UnitedHealthcare Community Plan for Kids under State Children’s Health Insurance Program (CHIP) administered by the Pennsylvania Insurance Department.
## Chapter 3: How to Contact Us

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web portal</td>
<td>UHCCommunityPlan.com</td>
<td>As our valued health care partner, we know your time is important. So we’ve designed our website to help you save time, improve efficiency and reduce errors caused by conventional claims submission practices.</td>
</tr>
<tr>
<td>Member Services Helpline</td>
<td>800-414-9025</td>
<td>Member services helpline is available Monday through Friday from 8 a.m. to 5 p.m., and on Wednesdays until 8 p.m. 24 hour, seven day a week service is available to assist members with urgent or emergent issues/concerns.</td>
</tr>
<tr>
<td>Interactive Voice Response Line</td>
<td>800-600-9007</td>
<td>Use our toll-free Interactive Voice Response (IVR) system 24 hours a day 7 days a week to check member eligibility.</td>
</tr>
<tr>
<td>Dental Services</td>
<td>800-508-4876</td>
<td>Unitedhealthcare Specialty Dental Benefits is the Dental Provider for UnitedHealthcare Community Plan.</td>
</tr>
<tr>
<td>Provider Service Helpline</td>
<td>800-600-9007</td>
<td>Call center available to providers to answer general questions or to be able to status claims.</td>
</tr>
<tr>
<td>Network Management</td>
<td></td>
<td>For contract, demographic and network related issues.</td>
</tr>
<tr>
<td>100 Penn Square East-Suite 410</td>
<td>800-791-2067</td>
<td></td>
</tr>
<tr>
<td>Philadelphia, PA 19107</td>
<td>1001 Brinton Road</td>
<td>800-414-5349</td>
</tr>
<tr>
<td>Pittsburgh, PA 15221</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Intake (Pre-Certifications)</td>
<td>800-366-7304</td>
<td>Providers contact regarding medical, surgical, maternity and/or newborn hospitalizations, DME, home health care etc.</td>
</tr>
<tr>
<td></td>
<td>877-310-3826 (fax)</td>
<td></td>
</tr>
<tr>
<td>Specialty Units</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy First Steps</td>
<td>800-599-5985</td>
<td>Healthy First Steps is designed to assist pregnant mothers with various issues.</td>
</tr>
<tr>
<td>Sales and Marketing (CHIP)</td>
<td>877-289-1917</td>
<td>Department available to assist people in obtaining CHIP insurance.</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>800-310-6826</td>
<td>Providers contact regarding pharmacy needs, issues or concerns.</td>
</tr>
</tbody>
</table>
### Vision Services

<table>
<thead>
<tr>
<th>marchvisioncare.com</th>
</tr>
</thead>
<tbody>
<tr>
<td>March Vision Care is the Vision Provider for UnitedHealthcare Community Plan, effective January 1, 2011</td>
</tr>
</tbody>
</table>

### Special Needs Unit

<table>
<thead>
<tr>
<th>877-844-8844</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Needs Unit is designed to assist members and providers with various special needs issues</td>
</tr>
</tbody>
</table>

### Behavioral Health (Mental Health and Substance Abuse Services)

### UnitedHealthcare Community Plan – Medicaid

Behavioral health services are carved out of the agreement between UnitedHealthcare Community Plan and the Department of Human Services (DHS). Members contact the following organizations at the numbers listed based on the counties they reside in for behavioral health services.

### UnitedHealthcare Community Plan for Kids-CHIP

UnitedHealthcare Community Plan contracts with Optum Behavioral Health to provide benefits to UnitedHealthcare Community Plan – CHIP members. Outpatient therapy with a participating provider does not require prior authorization. Providers seeking authorization of services can call 866-261-7692.

### Community Behavioral Health

Philadelphia: 888-545-2600

### Community Care Behavioral Health Organization:

- Adams: 866-738-9849
- Allegheny: 800-553-7499
- Berks: 855-520-9715
- Bradford: 866-878-6046
- Cameron: 866-878-6046
- Carbon: 866-473-5862
- Centre: 866-878-6046
- Chester: 866-622-4228
- Clarion: 866-878-6046
- Clearfield: 866-878-6046
- Clinton: 855-520-9787
- Columbia: 866-878-6046
- Elk: 866-878-6046
- Erie: 855-244-1777
- Forest: 866-878-6046
- Huntington: 866-878-6046
- Jefferson: 866-878-6046
- Juniata: 866-878-6046
- Lackawanna: 866-668-4696
- Luzerne: 866-668-4696
- Lycoming: 855-520-9787
- McKean: 866-878-6046
- Mifflin: 866-878-6046
- Monroe: 866-473-5862
- Montour: 866-878-6046
- Northumberland: 866-878-6046
- Pike: 866-473-5862
- Potter: 866-878-6046
- Schuylkill: 866-878-6046
- Snyder: 866-878-6046
- Sullivan: 866-878-6046
- Susquehanna: 866-668-4696
- Tioga: 866-878-6046
- Union: 866-878-6046
- Warren: 866-878-6046
- Wayne: 866-878-6046
- Wyoming: 866-668-4696
- York: 866-542-0299

### Value Behavioral Health:

- Armstrong: 877-688-5969
- Beaver: 877-688-5970
- Butler: 877-688-5971
- Cambria: 866-404-4562
- Crawford: 866-404-4561
- Fayette: 877-688-5972
- Greene: 877-688-5973
- Indiana: 877-688-5974
- Lawrence: 877-688-5975
- Mercer: 866-404-4561
- Venango: 866-404-4561
- Washington: 877-688-5976
- Westmoreland: 877-688-5977

### Magellan Behavioral Health of Pennsylvania:

- Bucks: 877-769-9784
- Delaware: 888-207-2911
- Lehigh: 866-238-2311
- Montgomery: 877-769-9782
- Northampton: 866-238-2312

### Perform Care:

- Bedford: 866-773-7891
- Blair: 866-773-7892
- Cumberland: 888-722-8646
- Dauphin: 888-722-8646
- Franklin: 866-773-7917
- Fulton: 866-773-7917
- Lancaster: 888-722-8646
- Lebanon: 888-722-8646
- Perry: 888-722-8646
- Somerset: 866-773-7891
Chapter 4: Covered and Non-Covered Services

Each UnitedHealthcare Community Plan product has a set of covered and non-covered services. In general, all products cover comprehensive primary care, specialty care, outpatient laboratory and radiology, emergency care, hospitalization, and outpatient/ambulatory surgery and procedures.

From the care provider’s perspective, the list of covered services is important in developing treatment plans and in obtaining prior authorization when necessary.

For more detail on services given prior authorization, contact the National Intake Department at 800-366-7304.

Provider Privileges

In order 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.

<table>
<thead>
<tr>
<th>Services</th>
<th>Community Plan for Families Medical Assistance</th>
<th>UnitedHealthcare Community Plan for Kids Children’s Health Insurance Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortions</td>
<td>Covered. Must meet current federal and state guidelines and be medically necessary.</td>
<td>Covered. Must meet current federal and state guidelines and be medically necessary.</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Audiology</td>
<td>Covered.</td>
<td>Covered. One routine hearing and audiometric examination per calendar year. One hearing aid or device per ear every two calendar years. No limit on the purchase of hearing aids or devices. Co-payments apply only when services are rendered by a specialist provider.</td>
</tr>
<tr>
<td>Autism Services</td>
<td>Covered.</td>
<td>Co-pays may apply to some services. No limit.</td>
</tr>
<tr>
<td>Ambulance Services (emergency)</td>
<td>Covered.</td>
<td>Covered. Transportation outside of the service area will only be covered if medically necessary.</td>
</tr>
<tr>
<td>Ambulatory Surgical Centers (ASCs)</td>
<td>Covered. May require prior authorization. Depends on service.</td>
<td>Covered. Some services may require prior authorization.</td>
</tr>
<tr>
<td>Birth Control Services</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
</tbody>
</table>
## Chapter 4: Covered and Non-Covered Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Community Plan for Families Medical Assistance</th>
<th>UnitedHealthcare Community Plan for Kids Children’s Health Insurance Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Mass Measurement (bone density)</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>CRNP</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Crisis Support</td>
<td>Please contact your Behavioral Health MCO (see page 52)</td>
<td>Covered.</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Covered.</td>
<td>Covered; limited to 20 visits per calendar year.</td>
</tr>
<tr>
<td>Colorectal Screening Exams</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Cosmetic Services</td>
<td>NOT COVERED</td>
<td>NOT COVERED</td>
</tr>
<tr>
<td>Custodial Services</td>
<td>NOT COVERED</td>
<td>NOT COVERED</td>
</tr>
<tr>
<td>Dental Services</td>
<td>Covered. Prior authorization needed for some services.</td>
<td>Covered. Prior authorization needed for some services. Key Limitations: Dentures 1 per lifetime, Exams/prophylaxis 1 per 180 days, Crowns, Periodontics and Endodontics only via approved benefit limit exception.</td>
</tr>
<tr>
<td>Diabetic Supplies &amp; Equipment</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Covered. Prior authorization needed if over $500.</td>
<td>Covered; some services may require prior authorization. No Limit.</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Covered.</td>
<td>Covered. Co-pays may apply to some services.</td>
</tr>
<tr>
<td>EPSDT Services &amp; Immunizations (under age 21)</td>
<td>Covered.</td>
<td>Covered; Limits apply</td>
</tr>
</tbody>
</table>
## Chapter 4: Covered and Non-Covered Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Children</th>
<th>Adults</th>
<th>CHIP Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyeglasses/Contact Lenses*</td>
<td>Daily-wear contacts of standard glasses (in-plan frames). Members under age 21 are covered for 4 lenses and 2 frames per year. Regular single vision, bifocal or trifocal lenses. Polycarbonate lenses: Covered. In-plan frames are covered in full. Out-of-plan frames are covered up to $20; member must pay cost over $20. 1 pr. soft daily wear contacts or medically necessary contact covered in lieu of glasses, including contact lens exam/evaluation. Medically necessary contact lenses are covered when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: Unilateral Aphakia; or Keratoconus when vision with glasses is less than 20/40; or Corneal transplant when vision with glasses is less than 20/40; or Anisometropia that is greater than or equal to 4.00 diopter. Medically necessary exceptions can be made for children under 21.</td>
<td>Daily-wear contacts or standard glasses (in-plan frames). Members age 21 and over are covered for 2 lenses and 1 frame per year. Regular single vision, bifocal or trifocal lenses. Polycarbonate lenses: Covered for adults who are blind in one eye and +/-6.00 prescription. In-plan frames are covered in full. Out-of-plan frames are covered up to $20; member must pay cost over $20. 1 pr. soft daily wear contacts or medically necessary contact covered in lieu of glasses, including contact lens exam/evaluation. Medically necessary contact lenses are covered when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: Unilateral Aphakia; or Keratoconus when vision with glasses is less than 20/40; or Corneal transplant when vision with glasses is less than 20/40; or Anisometropia that is greater than or equal to 4.00 diopter.</td>
<td>Frames and lenses: One set of eyeglass lenses may be plastic or glass, single vision, bifocal, trifocal, lenticular lens powers and/or oversize lenses, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch resistance coating and low-vision items.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Frequency of eye exam: One routine examination and refraction every 12 months. Includes dilation, if professionally indicated. No cost to member In-Network. Out-of-Network — no coverage*.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Frequency of lens and frame replacement: One pair of eyeglasses every 12 months, when medically necessary for vision correction.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lenses: In-Network — One pair covered in full every 12 months. Out-of-Network — no coverage.*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Frames: In-plan frames are available at no cost to member. Non-plan frames: Expenses in excess of $130 allowance payable by member. Additionally, a discount of 20% is available for amounts over $130.** Out-of-Network — No coverage.*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Replacement of lost, stolen, broken frames and lenses (one original and one replacement per calendar year, when deemed medically necessary).</td>
</tr>
<tr>
<td>Services</td>
<td>Children</td>
<td>Adults</td>
<td>CHIP Plan</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------</td>
<td>--------</td>
<td>-----------</td>
</tr>
</tbody>
</table>
| **Eyeglasses/Contact Lenses**    |          |        | **Contact lenses**: One prescription every 12 months — in lieu of eyeglasses when medically necessary for vision correction. Additionally, a discount of 15% is available for amounts over $130.** In some instances, participating providers charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the contact lenses received is less than the allowance, the difference up to the $130 allowance may be applied toward the cost of evaluation, materials, fitting and follow-up care. You will be responsible for any amounts over $130.  

**Out-of-Network exclusion only applies if child is in their coverage area at time of eyeglass/contact replacement. If child is unexpectedly out of the area, e.g., vacation, and they need replacement contacts or eyeglasses, their expenses can be sent to the plan for reimbursement. Expenses in excess of $600 for medically necessary contact lenses, with pre-approval. These conditions include: Aphakia, pseudophakia or keratoconus, if the patient has had cataract surgery or implant, or corneal transplant surgery, or if visual activity is not correctable to 20/40 in the worse eye by use of spectacle lenses in a frame but can be improved to 20/40 in the worse eye by use of contact lenses.**  

**Low Vision**: One comprehensive low-vision evaluation every five years, with a maximum charge of $300; maximum low-vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care — four visits in any five-year period, with a maximum charge of $100 per visit. Providers will obtain the necessary pre-authorization for these services. |          |        |           |
## Chapter 4: Covered and Non-Covered Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Community Plan for Families Medical Assistance</th>
<th>UnitedHealthcare Community Plan for Kids Children’s Health Insurance Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federally Qualified Health Center/ Rural Health Clinic</td>
<td>Covered.</td>
<td>Covered. (except for dental services as defined above)</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Hearing Exams</td>
<td>Covered.</td>
<td>One routine hearing and audiometric examination per calendar year. Copayments apply when services are rendered by a specialist provider.</td>
</tr>
<tr>
<td>Home Adaptation</td>
<td>NOT COVERED</td>
<td>NOT COVERED</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>NOT COVERED</td>
<td>NOT COVERED</td>
</tr>
<tr>
<td>Home Health Care &amp; Infusion Therapy</td>
<td>Covered. Prior authorization needed.</td>
<td>Unlimited first 28 days; 15 days per month following.</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Covered.</td>
<td>Covered. Respite care may not exceed a total of 5 days in a 60-day certification period.</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Incontinence Supplies</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Independent Clinic</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Infertility</td>
<td>NOT COVERED</td>
<td>NOT COVERED</td>
</tr>
<tr>
<td>Inpatient Drug and Alcohol</td>
<td>Please contact your Behavioral Health MCO (see page 52)</td>
<td>Covered. No Limit. No referral needed. Some services may require prior authorization, or be subject to notification and concurrent reviews.</td>
</tr>
</tbody>
</table>
## Chapter 4: Covered and Non-Covered Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Community Plan for Families Medical Assistance</th>
<th>UnitedHealthcare Community Plan for Kids Children’s Health Insurance Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Acute Hospital</strong></td>
<td>Covered. Prior authorization needed for nonemergent admission.</td>
<td>Covered. No Limit. Some services may require prior authorization, or be subject to notification and concurrent reviews.</td>
</tr>
<tr>
<td><strong>Inpatient Rehabilitation Hospital</strong></td>
<td>Covered. Prior authorization needed.</td>
<td>Covered. No Limit. Some services may require prior authorization, or be subject to notification and concurrent reviews.</td>
</tr>
<tr>
<td><strong>Inpatient Psychiatric Hospital</strong></td>
<td>Please contact your Behavioral Health MCO (see page 52)</td>
<td>Covered. No limit. No referral needed. Some services may require prior authorization, or be subject to notification and concurrent reviews.</td>
</tr>
<tr>
<td><strong>Intermediate Care Facility (IID/ORC)</strong></td>
<td>Please contact your Behavioral Health MCO (see page 52)</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Lab Tests &amp; X-rays</strong></td>
<td>Covered.</td>
<td>Covered. Some services may require prior authorization.</td>
</tr>
<tr>
<td><strong>Mammograms</strong></td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Mobile Mental Health Treatment</strong></td>
<td>Please contact your Behavioral Health MCO (see page 52)</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Medical Supplies</strong></td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Methadone Maintenance</strong></td>
<td>Please contact your Behavioral Health MCO (see page 52)</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Non-Emergency Medical Transport</strong></td>
<td>Covered. Some services provided by MATP.</td>
<td>NOT COVERED.</td>
</tr>
<tr>
<td><strong>Nutritional Supplements</strong></td>
<td>Covered.</td>
<td>Covered. Includes Medical Foods.</td>
</tr>
<tr>
<td><strong>Optometrist services</strong></td>
<td>Covered. Eyeglass or contact lens exams: two each year.</td>
<td>Covered. One every twelve months. Additional exams are covered if medically necessary.</td>
</tr>
<tr>
<td><strong>Outpatient Drug and Alcohol Services</strong></td>
<td>Please contact your Behavioral Health MCO (see page 52)</td>
<td>Covered. No Limit.</td>
</tr>
<tr>
<td><strong>Outpatient Hospital Clinic</strong></td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
</tbody>
</table>
## Chapter 4: Covered and Non-Covered Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Community Plan for Families Medical Assistance</th>
<th>UnitedHealthcare Community Plan for Kids Children’s Health Insurance Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Psychiatric Clinic</td>
<td>Please contact your Behavioral Health MCO (see page 52)</td>
<td>Covered.</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Covered. Prior authorization needed.</td>
<td>NOT COVERED</td>
</tr>
<tr>
<td>Orthopedic Shoes</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Pain Clinic Services</td>
<td>Covered. May require prior authorization.</td>
<td>Covered. May require prior authorization.</td>
</tr>
<tr>
<td>Pap Smears &amp; Pelvic Exams</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Personal Emergency Response Systems</td>
<td>NOT COVERED</td>
<td>NOT COVERED</td>
</tr>
<tr>
<td>Peer Support</td>
<td>Please contact your Behavioral Health MCO (see page 52)</td>
<td>NOT COVERED</td>
</tr>
<tr>
<td>Care Provider Office Visits (including medical/surgical services provided by a dentist)</td>
<td>Covered.</td>
<td>Covered. No limit.</td>
</tr>
<tr>
<td>Podiatrist Services: Medically Necessary, Routine &amp; Preventive</td>
<td>Covered. May require prior authorization.</td>
<td>Excluded, except as necessary for the treatment of diabetes or medically necessary due to severe peripheral vascular disease.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Covered.</td>
<td>Covered, copays may apply.</td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>Covered.</td>
<td>Covered. No copay required for Well Child visits.</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
</tbody>
</table>
## Chapter 4: Covered and Non-Covered Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Community Plan for Families Medical Assistance</th>
<th>Community Plan for Kids Children’s Health Insurance Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate Cancer Screenings</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Prosthetics and Orthotics</td>
<td>Covered. Prior authorization needed for items with a value greater than $500.00.</td>
<td>Covered. Limits may apply</td>
</tr>
<tr>
<td>Psychiatric Partial Hospital</td>
<td>Please contact your Behavioral Health MCO (see page 52)</td>
<td>Covered.</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Renal Dialysis (Kidney Treatment)</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Residential Treatment Facility (Non-Hospital Residential D&amp;A)</td>
<td>Please contact your Behavioral Health MCO (see page 52)</td>
<td>Covered. No limit. Some services may require prior authorization, or be subject to notification and concurrent reviews.</td>
</tr>
<tr>
<td>Second Opinions (Medical &amp; Surgical)</td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Short Procedure Unit (SPU)</td>
<td>Covered. May require prior authorization. Depends on service.</td>
<td>Covered.</td>
</tr>
</tbody>
</table>

*Note: Coverage and limitations vary depending on the specific plan and service.*
## Chapter 4: Covered and Non-Covered Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Community Plan for Families Medical Assistance</th>
<th>UnitedHealthcare Community Plan for Kids Children’s Health Insurance Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skilled Nursing Care (Home Visits)</strong></td>
<td>Covered. Prior authorization needed.</td>
<td>Covered. Limits may apply.</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>Covered. Prior authorization needed.</td>
<td>Covered. Some services may require prior authorization, or be subject to notification and concurrent reviews.</td>
</tr>
<tr>
<td><strong>Targeted Case Management – Behavioral Health</strong></td>
<td>Please contact your Behavioral Health MCO (see page 52). Limited to individuals identified in the target group.</td>
<td>Limited to individuals identified in the target group.</td>
</tr>
<tr>
<td><strong>Targeted Case Management – Other than Behavioral Health</strong></td>
<td>Covered. Limited to individuals identified in the target group.</td>
<td>Limited to individuals identified in the target group.</td>
</tr>
<tr>
<td><strong>Transportation Help</strong></td>
<td>Available to and from MA covered services. See information under MATRA.</td>
<td>NOT COVERED</td>
</tr>
<tr>
<td><strong>Tobacco cessation counseling</strong></td>
<td>Covered.</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Therapy (physical, occupational, speech (PT, OT, ST)) (includes rehabilitative and habilitative)</strong></td>
<td>Covered.</td>
<td>Covered. Only when provided by a hospital, outpatient clinic, or home health provider. <strong>Physical Therapy</strong> — limited to 30 visits per year combined rehabilitative and habilitative. <strong>Speech Therapy</strong> — limited to 30 visits per year combined rehabilitative and habilitative. <strong>Occupational Therapy</strong> — limited to 30 visits per year combined rehabilitative and habilitative.</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>Covered.</td>
<td>Covered. Copays may vary depending on the facility where services are being provided.</td>
</tr>
</tbody>
</table>
UnitedHealthcare, through March Vision Care, provides vision care services based upon standard exams and materials. Member may choose some specialty items, such as tinted lenses, but may incur some out-of-pocket expense for such extras.

** UnitedHealthcare Community Plan requires the use of CLIA – certified providers for laboratory services.

**** The CHIP limit of 50 outpatient physical health visits does not apply to well baby, well child, or prenatal visits

NOTE: The list above is not all-inclusive, but represents a sample of some of the covered services of the plan.

For additional information please call Provider Services at 800-600-9007.

Please see the note at the end of this section regarding Behavioral Health and Substance Abuse Services.

Limitations and most exclusions do not apply to children younger than age 21, but some services do require a referral or prior authorization.

If you have questions about the benefit chart, call Provider Services at 800-600-9907.

Eligibility can change any time, and care providers are encouraged to verify eligibility at the time of each service. If changes in eligibility cause a member to move to a different benefit package, co-pay amounts may also change. Please take the time to verify co-pays when you check eligibility.

Copayments for Medicaid recipients:
The following services are exempt from copayments: laboratory services, family planning services and supplies, services provided in emergency situations, home health agency services, psychiatric partial hospitalization services, renal dialysis services, blood and blood products, oxygen, ostomy supplies, rental of durable medical equipment, screenings provided under the EPSDT program, targeted case management services, tobacco cessation counseling services.

Co-payments do not apply to members younger than 18, pregnant or in a nursing home, women in the Breast and Cervical Cancer Prevention and Treatment (BCCPT) coverage group, terminally ill individuals who are receiving hospice care, individuals of any age eligible under Titles IV-B and IV-E Foster Care and Adoption Assistance. Also, most Medicaid limits do not apply to pregnant women, residents of nursing homes or intermediate care facilities.

Exceptions to the Medical Assistance adult benefit limits, can be granted if the following criteria are met:

• The member has a serious chronic illness or health condition and without the additional service, their life would be in danger; or
• The member has a serious chronic illness or health condition and without the additional service, their health would get much worse; or
• The member would need more expensive services if the exception was not granted; or,
• It would be against state or federal law for UnitedHealthcare Community Plan to deny the service

For details on submitting benefit limit exception requests for Dental benefits, please call the benefit manager directly. Find the benefit manager information under How To Contact Us.

Automatic exceptions to Medical benefit limits will be granted based upon the guidance provided by DHS in Medical Assistance Bulletin 99-14-10.
You can make pre-service exception requests to Medical benefit limits through the same channels as a prior authorization, but it should clearly be identified as a request for benefit limit exception.

**Behavioral Health and Substance Abuse Services**

All Medicaid members receive their mental health and substance abuse services through a contracted behavioral health managed care organization for their county. See [How To Contact Us](#).

CHIP members receive mental health and substance abuse services through Optum Behavioral Health.

Members may call our Member Services line at **800-414-9025** for information on accessing these services.

When referring for Behavioral Health or Substance Abuse services, please share this information with your patient who is a UnitedHealthcare member.

You may call Optum Care Management at **866-261-7692**.
Chapter 5: Prior Authorization

Primary Care Provider Responsibility for Prior Authorization and Notification

The Primary Care Provider or Specialist referring a patient who is a UnitedHealthcare member for an elective admission or same day surgery is responsible for contacting UnitedHealthcare Community Plan for prior authorization. UnitedHealthcare Community Plan recommends calling at least five days in advance of the admission or surgery. Requests for prior authorization are prioritized according to level of medical necessity. Certain cases are reviewed under emergency guidelines. Requests for program exceptions and exceptions to benefit limits should follow the same process.

For prior authorizations, you should call 800-366-7304, fax 877-310-3826 or enter request into I-Exchange, a web-based authorization system, Monday through Friday, 8 a.m. to 5 p.m. Eastern Time. For any discharge or urgent needs, call 800-366-7304.

Prior Authorization Grid – See Covered and Non-Covered Grid (above)

Prior Authorization Requirements

Inpatient Acute, Sub-Acute, Rehab and SNF admissions require prior notification. All non-par service require prior authorization. Prior notification not required for emergency services, but hospitals must provide notification within two business days of inpatient admission.

Authorization Requirements

Provider Services Helpline and IVR
800-600-9007

Prior Authorization
800-366-7304
877-310-3826(Fax)

Inpatient - Authorization Requirements

<table>
<thead>
<tr>
<th>Services and Procedures Requiring Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions</td>
</tr>
<tr>
<td>Rehabilitation Admissions</td>
</tr>
<tr>
<td>Skilled Nursing Facility Admissions</td>
</tr>
<tr>
<td>Abortion - Medicaid - Proper completion of consent and MA forms required (MA-3, MA-366)</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
</tr>
<tr>
<td>Bone Growth Stimulator</td>
</tr>
<tr>
<td>BRCA Genetic Testing</td>
</tr>
<tr>
<td>Breast Reconstruction (Non Mastectomy)</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
</tr>
<tr>
<td>Cochlear &amp; Auditory Implants</td>
</tr>
<tr>
<td>Cosmetic &amp; Reconstructive</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) &gt; $500</td>
</tr>
<tr>
<td>Enteral/Parenteral Services</td>
</tr>
<tr>
<td>Experimental &amp; Investigational</td>
</tr>
<tr>
<td>Home Healthcare</td>
</tr>
<tr>
<td>IMRT</td>
</tr>
<tr>
<td>Injectable Medications: Botulinum Toxins (Botox, Dysport, Myobloc, Xeomin), H.P. Acthar Gel, Immune Globulins, 17-P, Makena</td>
</tr>
<tr>
<td>Joint Replacement</td>
</tr>
</tbody>
</table>
Chapter 5: Prior Authorizations

<table>
<thead>
<tr>
<th>Services and Procedures Requiring Prior Authorization (Continued)</th>
<th>Non-emergent air transportation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Orthognathic</td>
</tr>
<tr>
<td></td>
<td>Orthotics &gt; $500</td>
</tr>
<tr>
<td></td>
<td>Out of Network Services</td>
</tr>
<tr>
<td></td>
<td>Prosthetics &gt; $500</td>
</tr>
<tr>
<td></td>
<td>Proton Beam</td>
</tr>
<tr>
<td></td>
<td>Septoplasty/Rhinoplasty</td>
</tr>
<tr>
<td></td>
<td>Sleep Apnea Procedures &amp; Surgeries</td>
</tr>
<tr>
<td></td>
<td>Spinal Stimulator</td>
</tr>
<tr>
<td></td>
<td>Spine Surgeries</td>
</tr>
<tr>
<td></td>
<td>Vagus Nerve Stimulation</td>
</tr>
<tr>
<td></td>
<td>Vein Procedures</td>
</tr>
<tr>
<td></td>
<td>Ventricular Assist Devices</td>
</tr>
<tr>
<td></td>
<td>Transplants</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Radiology Services Requiring Prior Authorization</th>
<th>PET Scans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MRI/MRA</td>
</tr>
<tr>
<td></td>
<td>CT Scans</td>
</tr>
<tr>
<td></td>
<td>Nuclear Medicine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Paper Claims Submission Address</th>
<th>United Healthcare Community Plan Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P.O. Box 8207</td>
</tr>
<tr>
<td></td>
<td>Kingston, NY 12402-8207</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Timely Filing Limits</th>
<th>COB submissions after primary payment – 365 days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Initial Claims – 180 days</td>
</tr>
<tr>
<td></td>
<td>Resubmission/Corrections – 365 days</td>
</tr>
<tr>
<td></td>
<td>COB resubmissions – 365 days</td>
</tr>
</tbody>
</table>

| Peer to Peer Hotline | You may access the Peer to Peer Reconsideration Line at 800-514-4910. |

This line is dedicated to care providers to discuss a determination for a service that may not have been approved at the level of care originally requested.

| Special Needs Unit | If you have a member who may need extra help, please call or have your patient call our Special Needs Unit at 877-844-8844. |

<table>
<thead>
<tr>
<th>Healthy First Steps Program</th>
<th>First Steps is UnitedHealthcare Community Plan’s perinatal case management and support services to UnitedHealthcare Community Plan pregnant women.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Contact the Healthy First Steps case managers at 800-599-5985</td>
</tr>
<tr>
<td></td>
<td>• Healthy First Steps fax number is 877-353-6913</td>
</tr>
<tr>
<td></td>
<td>• Healthy First Steps email address is <a href="mailto:hfs@uhc.com">hfs@uhc.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Appeals</th>
<th>UnitedHealthcare Community Plan of Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P. O. Box 31364</td>
</tr>
<tr>
<td></td>
<td>Salt Lake City, UT 84131-0364</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Electronic Claims Submission</th>
<th>Optum Insight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ingenix.com/connectivity</td>
</tr>
<tr>
<td></td>
<td>800-341-6141</td>
</tr>
<tr>
<td></td>
<td>Claims Payer ID: 87726</td>
</tr>
<tr>
<td></td>
<td>Electronic Remittance Advice Payer ID: 04567</td>
</tr>
</tbody>
</table>
Chapter 5: Prior Authorization

Electronic Funds Transfer (EFT)
- To enroll for EFT, visit the Pennsylvania home page of UHCCommunityPlan.com, and go to the EDI section.
- Download and complete the EFT enrollment form.
- EFT will be available within six to eight weeks of our receipt of the signed form.
- You may also call UnitedHealthcare Community Plan EDI Support for assistance at 800-210-8315.

Access the On-Line Provider Portal, UnitedHealthcareOnline.com
- Verify Member Eligibility
- Submit Claims
- Check Claim Status
- Access Provider Member Rosters
- Access Provider Manual and Forms
- Billing Guidance/Reimbursement Policies
- Provider Newsletters

UnitedHealthcare Community Plan Medicaid is offered through the product name UnitedHealthcare Community Plan for Families under HealthChoices program of the Pennsylvania Department of Human Services.

Care Provider Privileges
In order 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.

Provider’s Responsibility to Verify Prior Authorization

Prior Authorization Criteria and Guidelines
Once the Prior Authorization Department receives the complete information to review the request according to industry accepted standards, the Pre-Certification Department makes a determination.

If approved, UnitedHealthcare Community Plan assigns a notification number to the requested service and enters the notification number into UnitedHealthcare Community Plan’s information system. UnitedHealthcare Community Plan then informs the requesting care provider’s office of the notification number. This notification number references the admission or procedure.

Prior authorization examines only the medical necessity of proposed services. Authorization does not guarantee payment, which is affected by other factors, such as eligibility, benefit limitations, exclusions and other coverage issues.

Hospital Utilization Management
Prior authorization for an inpatient stay is not a guarantee of approval. UnitedHealthcare conducts concurrent reviews to confirm prior requested procedure/service was performed and was the reason for the admission.

UnitedHealthcare approves or denies all inpatient stays in accordance with the clinical guidelines described in this section. If clinical information does not support the level of care requested the case will be forwarded to the Medical Director for Medical Necessity determination.

In accordance with UnitedHealthcare policy, all initial clinical reviews must be received by the Health Plan within one business day of notification of the admission. Failure to provide clinical review within one business day of notification may result in an administrative denial.

In the case of a denial, UnitedHealthcare will notify the facility by phone or fax within one business day after all clinical information has been received to render a determination. A written notification of the denial will be sent to you within two business days of the final determination.

You may request a Peer to Peer review by calling 800-514-4910 to discuss the case with the UnitedHealthcare Medical Director within two business days of the decision or within two business days of discharge.

The Primary Care Provider, Specialist, attending care provider, or the facility may appeal any adverse decision, according to the procedures outlined in Provider Appeals Section and/or may request a copy of the criteria used to render a determination.
A prospective UM decision shall be communicated by the plan, to enrollee and you within two business days of the receipt of all supporting information reasonably necessary to complete the review. The plan shall give the enrollee and you or electronic confirmation of the decision within two business days of communicating the decision.

A concurrent UM decision shall be communicated by the plan, to you within one business day of the receipt of all supporting information reasonably necessary to complete the review. The plan shall give you written or electronic confirmation of the decision within two business days of communicating the decision.

A retrospective UM decision shall be communicated by the plan, to you within 30 days of the receipt of all supporting information reasonably necessary to complete the review. The plan shall give the enrollee and you written or electronic confirmation of its decision within 15-business days of communicating the decision.

A grievance review decision shall comply with the requirements and time frames set out in §§ 9.705 and 9.707 (relating to internal grievance process; and external grievance process) of the Pennsylvania Department of Health Managed Care Organization regulations. Utilization Management Staff and Medical Directors do not receive incentives for any utilization management determinations.

Determination of Medical Necessity

A service or benefit is Medically Necessary if it is compensable under the Medical Assistance (MA) Program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition, or disability;
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability;
- The service or benefit will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.

UnitedHealthcare Community Plan gives written determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, post-utilization, or exception basis. The determination is based on medical information provided by the Healthcare Practitioner that has evaluated the member. UnitedHealthcare Community Plan uses industry accepted standards for determinations of appropriateness of care. UnitedHealthcare Community Plan has written policies and procedures specifying responsibilities and qualifications of staff that authorize admissions, services, procedures, or extensions of stay. UnitedHealthcare Community Plan makes determinations on a timely basis, as required by the urgency of the situation.

A UnitedHealthcare Community Plan Care Manager can authorize, but not deny, an admission, service, procedure, or extension of stay. If the Care Manager is unable to determine by chart documentation, documentation from the facility utilization review department, or discussion with you or the attending care provider, the need for admission, surgical or diagnostic procedure, or continued stay, the case is then referred to the Medical Director or his/ her designee.

If, after reviewing all documentation of clinical information, the Medical Director or his/her designee determines the admission, service, procedure, or extension of stay is medically necessary, the Care Manager notifies you by phone or fax, assigns an authorization number, and sets the next review date.

If the Medical Director or his/her designee makes a determination to deny or limit an admission, service, procedure, or extension of stay, UnitedHealthcare Community Plan notifies you, facility’s utilization review department or vendor, either by phone or fax. UnitedHealthcare Community Plan employees are not compensated for denial of services. Information on how to obtain criteria used to make the decision is included in all denial letters.

You may contact the Medical Director or his/her designee to have the decision reconsidered, based on medical information. You may make a written request for a copy of the criteria applied and a description of the process for making determinations to deny or limit care. The Medical Director or his/her designee is available immediately in urgent or emergency cases and on a timely basis for all other cases.
If, after discussion with you, the attending physician or designee, the Medical Director or his/her designee determines the admission, service, procedure, or extension of stay is reasonable, the Medical Director or his/her designee notifies the Case Manager, who notifies the facility’s utilization review department by phone or fax.

UnitedHealthcare Community Plan will not retroactively deny reimbursement for a provided member covered service if you relied upon the written or oral authorization of UnitedHealthcare Community Plan prior to providing the service to the member, except in cases where there was material misrepresentation or fraud.

**Exceptions to Medicaid Benefit Limits**

An exception to benefit limits for adult Medicaid members can be granted if:

- The member has a serious chronic illness or health condition and without the additional service, their life would be in danger; or
- The member has a serious chronic illness or health condition and without the additional service, their health would get much worse; or
- The member would need more expensive services if the exception was not granted; or,
- It would be against state or federal law for UnitedHealthcare Community Plan to deny the service.

**Continuity of Care When Provider Leaves Network**

Upon termination of your provider agreement, UnitedHealthcare Community Plan shall use its best efforts to persuade members assigned you to choose an alternative participating care provider. However, you shall continue to furnish covered services to any member under your care who, at the time of termination of the provider Agreement, is a registered bed patient at a hospital or other institution until the member’s discharge.

Upon termination of the provider agreement, a member may continue an ongoing course of treatment with you at the member’s option, for a transitional period of up to 90 days from the date the member was notified by UnitedHealthcare Community Plan of the termination of the provider Agreement. UnitedHealthcare Community Plan, in consultation with you and member, may extend the transitional period if clinically appropriate. Continued care will be provided under the same terms and conditions.

**Continuity of Care During a Pregnancy**

In the case of a member who is pregnant at the time of notice of the termination, or is pregnant at the time, the member transfers to UnitedHealthcare Community Plan from a different delivery system, the transitional period shall extend through post-partum care related to delivery. Any health service provided during the transitional period shall be covered by UnitedHealthcare Community Plan under the same terms and conditions as applicable to participating care providers.

**Continuity of Care for Primary Care Providers**

Should you terminate the provider agreement, you shall provide services to members assigned through the end of the month in which termination becomes effective. In the event of UnitedHealthcare Community Plan’s insolvency or other cessation of operations, you shall continue to provide benefits to members through the period for which the premium has been paid, including benefits to members in an inpatient facility.

Despite the above provisions, if UnitedHealthcare Community Plan terminates the provider agreement for cause, UnitedHealthcare Community Plan shall not be responsible for health care services provided to members following the effective date of termination.

**Authorization of Care for New Members**

For adult members (ages 21 or older), UnitedHealthcare Community Plan will honor plans of care (including DME, medical supplies, prosthetic and orthotic appliances, and any other on-going services) initiated prior to a new member’s enrollment for a period of up to 60 days, or until the Primary Care Provider evaluates the member and establishes a new plan of care. For any member younger than the age of 21, rules concerning continuation of an ongoing course of treatment when transferring between MCOs or between the Fee For Service program and an MCO can be found in Medical Assistance Bulletins 99-96-01 and 99-03-13.

**Medical Assistance Bulletins**

Authorsizations to Non-Participating Providers

All services referred to non-participating care providers must receive prior authorization from UnitedHealthcare Community Plan.

You may obtain prior authorization by calling 800-366-7304. If you need to verify a care provider’s participation, please call 800-600-9007.
Chapter 6: Claims Policies and Procedures

Time Frame for Claims Submission

You must submit claims within 180 days of the date of service (or discharge for inpatient services).

FAILURE TO MEET THE ABOVE TIME FRAMES WILL RESULT IN THE DENIAL OF CLAIMS FOR TIMELY FILING. YOU ACKNOWLEDGE THAT YOU WILL NOT BE PAID FOR ANY LATE CLAIMS FOR SERVICES PROVIDED TO UNITEDHEALTHCARE COMMUNITY PLAN MEMBERS REGARDLESS OF THE MERITS OF THE UNDERLYING CLAIM.

ANY LATE CLAIMS WHICH ARE PAID IN ERROR SHALL NOT SERVE AS A WAIVER OF UNITEDHEALTHCARE COMMUNITY PLAN’S RIGHT TO DENY ANY OTHER LATE CLAIM.

You must submit claims within 180 days of the date of service (or discharge for inpatient services), or in accordance with submission timelines outlined in your provider agreement. If you originally sent the claims to the wrong payer, these days count against you. There is no extension of the 180-day limit/time requirement.

You are responsible for verifying members’ eligibility for all coverages. When UnitedHealthcare Community Plan is the secondary payer under Coordination of Benefits (COB), the 180-day timeframe for submitting claims begins on the date of payment from the primary payer.

Electronic Claims Submission

You should submit claims electronically, unless the claim requires invoice documentation, or other contingencies apply as described in Paper Claims Submission. UnitedHealthcare Community Plan accepts Medical, Professional Service and Hospital claims in electronic format through several clearinghouses. Please contact your clearinghouse for their payer list to verify if UnitedHealthcare Community Plan of Pennsylvania (Payer ID 87726) is supported by them. Below is our preferred clearinghouse:

- Optum Insight
  ingenix.com/connectivity
  800-341-6141

If you are using another clearinghouse, please call UnitedHealthcare Community Plan Client Support Center at 800-249-3114, option 1, so that we may accommodate you through other arrangements for electronic claims submission.

Claim submissions of professional service claims is also available at UnitedHealthcareOnline.com under the UnitedHealthcare Community Plan Online link.

For more information on EDI transactions, call the UnitedHealthcare Community Plan EDI support line at 800-210-8315, option 1.

To Become an Electronic Claims Submitter

If you have never submitted claims electronically, call the sales office for the clearinghouse supported by your patient accounting computer software. If the vendor of your software acts as a clearinghouse, call your vendor. If you are using a third-party billing agent, call your billing agent and request that UnitedHealthcare Community Plan claims be submitted electronically.

Call UnitedHealthcare Community Plan at 800-210-8315 for assistance, option 1.

If you already submit claims electronically, contact your clearinghouse or vendor Help Desk to obtain a current copy of the procedures to submit claims, or if you have any questions regarding your submissions to UnitedHealthcare Community Plan.

Acknowledgment of Claims Received

- Accepted industry practice is the organization that first receives the electronic claims is responsible for notifying the sender of the success or failure of claim receipt. Therefore, if you submit to a clearinghouse, that clearinghouse is responsible for notifying you the claims were successfully received.
- UnitedHealthcare Community Plan then notifies the clearinghouse if the claims were received at UnitedHealthcare Community Plan’s claims processing center.
• Individual clearinghouse policy determines whether the acknowledgments from UnitedHealthcare Community Plan are passed back to the original submitter.

• It is your responsibility to confirm that the claims have passed the clearinghouse and have been submitted to UnitedHealthcare Community Plan for claims processing.

ID Numbers for Electronic Claims Submission

To submit your claims through the above clearinghouses, you must submit UnitedHealthcare Community Plan claims with the Payer ID number indicated above. The Payer ID number is a required field. Claims missing the Payer ID number will be rejected. This may also apply to claims submitted via a software vendor if that vendor uses one of the above clearinghouses.
Chapter 7: Provider ID Numbers

NPI (National Practitioner Identifier) Number

- NPI is the new National Provider Identifier that replaces the provider number as the primary identifiable number to process electronically submitted claims.
- All providers and provider types must use this unique provider identifier to submit their electronic claims.
- This federally mandated numbering process eliminates the use of personalized identifiers.
- The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers, as well as standard unique identifiers for health plans.
- The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health care information.
- The Centers of Medicare and Medicaid Services (CMS) developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers.
- All health care providers must use the NPI as their standard unique identifier. However, this does not eliminate the need for participating providers to maintain their DHS Promise Medicaid ID number.
- Other numbers may be used in conjunction with the NPI. They include the UPIN, Medicare, Medicaid state identification number, medical license number or health plan assigned provider identification number.
- These numbers are no longer valid in and of themselves to receive payment for electronically submitted claims.

Who Must Obtain the NPI:

- Care providers, CRNP, Chiropractors, Dentists etc.
- Ancillary providers: DME, Ambulance providers, medical supply companies etc.
- Counselors, educators, social workers
- Pharmacists, optometrists, laboratories
- Hospitals, SPUs, SNFs, Home Health
- Other facility providers (mental health providers) and all other health care providers that provide medical type services Taxonomy Codes are structured into three distinct levels including:
  1. Level I – Provider Type
  2. Level II – Classification
  3. Level III – Areas of Specialization

Taxonomy codes allow a single provider (individual, group or institution) to identify their various areas of specialization so that claims may be paid according to that area of specialization.

They are used with dental, professional and institutional health care provider claims.

The provider type field is necessary for providers applying for the NPI.

There are two types of provider types:

- **Type 1** – individuals who render health care or provide typical services, or furnish health care supplies to patients; dentists, care providers, nurses, chiropractors, pharmacists, physical therapists
- **Type 2** – organizations that render health care services, or furnish health care supplies to patients. (e.g. hospitals, home health agencies, ambulance companies, health maintenance org., durable medical equipment suppliers, and pharmacies)

Provide full legal name which matches name on file with the Social Security Administration. Such as:

- First, last, middle with credentials (e.g. Doctor)
- Provide DOB
- Social Security Number (SSN) for purposes of unique identification
- State, county of birth
- Gender
- Sole proprietor or group
The Individual Category Includes:
- Care providers
- Behavioral Health and Social Service Providers
- Chiropractic Providers
- Dental Providers
- Dietary and Nutritional Service Providers
- Emergency Medical Service Providers
- Eye and Vision Service Providers
- Nursing Service Providers
- Nursing Service Related Providers
- Other Service Providers
- Pharmacy Service Providers
- Physician Assistants and Advanced Practice Nursing Providers
- Podiatric Medicine and Surgery Providers
- Respiratory, Rehabilitative and Restorative Providers
- Speech, Language and Hearing Providers
- Technologist, Technician, and Other Technical Service Providers

The Group (of Individuals) Category Includes:
- Multi-Specialty
- Single Specialty

Non-individual Category Includes:
- Agencies
- Ambulatory Health Care Facilities
- Hospital Units
- Hospitals
- Laboratories
- Managed Care Organizations
- Nursing and Custodial Care Facilities
- Residential Treatment Facilities
- Respite Care Facilities
- Suppliers
- Transportation

The CMS have contracted with Fox Systems Incorporated to serve as the NPI Enumerator, and the NPI Enumerator is responsible for servicing the health plans and providers on issues relating to the unique identifier information.

Providers may contact:
- By Phone: 800-465-3203
- TTY Users: 800-692-2326
- Correspondence:
  NPI Enumerator
  P.O. Box 6059 Fargo, ND 58108-6059

Paper Claims Submission

In the event a care provider is unable to submit medical, professional or facility claims electronically, or is submitting a claim requiring invoice documentation, or as a contingency when the electronic system is not available, paper claims may be submitted to the following address for UnitedHealthcare Community Plan Medical Assistance and UnitedHealthcare Community Plan CHIP:

UnitedHealthcare Community Plan
Claims P.O. Box 8207
Kingston, New York 12402-8207

- Claims must be separated from all other claims
- Claims sent to the wrong lock box will be returned
- Do not send claims to UnitedHealthcare Community Plan offices in Pennsylvania
- Do not send claims to any Pennsylvania P.O. Box

Coding Standards

Uses the most recent versions of the following codes:
- Health Care Common Procedure Coding System (HCPCS).
- International Classification of Diseases, 9th revision, Clinical Modifications (ICD-10-CM).
- Pennsylvania Medical Assistance (MA) codes where applicable.
- Submission of claims without the most current set of codes will result in delayed payment or denial.
- The U.S. Department of Health and Human Services (DHHS) and the American Medical Association (AMA) annually publish industry standard codes that are essential for prompt and accurate payment of provider claims.
- Providers must use codes for data items with a schedule of codes. No narratives are accepted for data items where codes are available.
Chapter 7: Provider ID Numbers

- Providers must state ICD-10-CM codes to the highest level of specificity stated in the current version.
- Provider must add whatever modifier is stated in the current version.
- Providers should not rely on the index, which only lists family of codes and not the highest level of specificity.
- Claims lacking codes with the highest level of specificity will be denied.
- Federal and State regulations require hospitals to submit Present on Admission (POA) information for all primary and secondary diagnoses for inpatient discharges on all Medicaid and Medicare claims.

Additional information regarding the POA indicator reporting requirements and hospital acquired conditions can be found on the CMS website at [cms.gov/HospitalAcqCond](https://cms.gov/HospitalAcqCond).

**Encounter Data**

- UnitedHealthcare Community Plan is contractually obligated to submit accurate, detailed, and complete encounter information to CMS and the Pennsylvania Department of Human Services and the Pennsylvania Insurance Department.
- UnitedHealthcare Community Plan participating providers are required to submit accurate, detailed, and complete encounter information to UnitedHealthcare Community Plan.
- Claims submission constitutes the provider’s certification of the submitted data.

**Our Claims Process**

We want you to be paid for the services you provide. Here’s what you can do to help ensure prompt payment:

- Register at UnitedHealthcareOnline.com, our free website for network care providers and health care professionals.
- Once you’ve registered, you may review the patient’s eligibility on the website at UnitedHealthcareOnline.com.
- To check patient eligibility by phone, by calling the Interactive Voice Response line at 800-600-9007.
- Notify us of planned procedures and services on our prior authorization list.
- Prepare a complete and accurate claim form (see “Complete Claims”).

- Submit a claim online at UnitedHealthcareOnline.com or
- Optum Insight or another clearinghouse vendor – If you currently use Optum Insight or another vendor to submit claims electronically, be sure to use our electronic payer ID 87726 to submit claims to us.

**Mail paper claims to:**

UnitedHealthcare Community Plan P.O. Box 8207
Kingston, New York 12402-8207

**IMPORTANT NOTE:** Claims must be submitted within 180 days of date of service. Claims received after 180 days will be denied for timely filing.

**Complete Claims**

Whether you use an electronic or a paper form, complete a revised CMS 1500 or UB-04 form. A complete claim includes the following information; additional information may be required by us for particular types of services or based on particular circumstances or state requirements.

- Patient’s name, sex, date of birth and UnitedHealthcare Community Plan ID number
- Name, signature, ‘remit to’ address and phone number of care providers or provider performing the service, as in your contract document
- Care provider’s federal tax ID number
- Care provider’s NPI and your UnitedHealthcare Community Plan Provider ID number
- Date of service(s), place of service(s) and number of services (units) rendered
- Current CPT and HCPCS procedure codes with modifiers where appropriate
- Current ICD-9 diagnostic codes documented to the highest level of specificity (e.g. 493.11)
- Referring care provider’s name and NPI number (if applicable)
- Charges per service and total charges, including presence-on-admission (POA)
- Information about other insurance coverage, including job-related, auto or accident information, if available, including subscriber name, subscriber ID and relationship to patient, including presence on admission
- Attach a detailed description of the procedure or service provided for claims submitted with unlisted medical or surgical CPT or “other” revenue codes as well as experimental or reconstructive services
Chapter 7: Provider ID Numbers

- If you need to correct and re-submit a claim, submit a new CMS 1500 or UB-04 indicating the correction being made. Hand corrected claim re-submissions will not be accepted.

**Additional Information Needed for a Complete UB-04 Form:**
- Date and hour of admission and discharge as well as patient status-at-discharge code
- Type of bill code
- Type of admission (e.g. emergency, urgent, elective, newborn)
- Current revenue code and description
- Current principal diagnosis code (highest level of specificity, e.g. 493.11)
- Current other diagnosis codes, if applicable (highest level of specificity, e.g. 493.11)
- Attending care provider’s name and ID
- For outpatient surgeries, include the appropriate revenue and CPT code
- Submit claims according to any special billing instructions that may be indicated in your agreement (or letter of contract)
- Present-on-admission indicators are required for inpatient claims

If you have questions about submitting claims to us, please contact Provider Services.

**Claim Editing**

**Clearinghouse Care Provider Claim Editing**

UnitedHealthcare Community Plan uses iCES Clearinghouse. iCES CH is a clinical edit system application that analyzes care provider health care claims based on business rules designed to automate UnitedHealthcare Community Plan reimbursement policy and industry standard coding practices. ICES CH is interfaced with the claims application and claims are analyzed prior to payment to validate billings in order to minimize inaccurate claim payments.

The UnitedHealthcare Community Plan website outlines the reimbursement policies which are applied in ICES CH as clinical edits. In addition ICES CH applies the following edits:

1. Basic field validity screens for patient demographic and clinical data elements on each claim
2. Effective-dated ICD-10-CM, CPT and HCPCS Level II code validation, based on service dates and patient clinical data

**Facility Claim Editing**

UnitedHealthcare Community Plan utilizes Facility Editor® for claims for outpatient services. The Facility Editor is a rules-based software application that evaluates outpatient claims data for validity and reasonableness. These reasonableness tests incorporate the Outpatient Code Edits (OCE) developed by the CMS for hospital outpatient claims. The Facility Editor will be used to examine outpatient facility-based claims prior to payment to validate billings in order to minimize inaccurate claim payments.

The UnitedHealthcare Community Plan website outlines the reimbursement policies which are applied in Facility Editor as clinical edits. The CMS OCE edits that will be applied by the Facility Editor include:

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

**Other Claim Edits – Generic Claim Edits**

Generic Claim Edits:
- Member active in system on date of service
Chapter 7: Provider ID Numbers

- Provider active in system on date of service, for contract to be paid upon
- Timely filing checks by type of provider or line of business
- Check for authorization, if required for service on claim
- Diagnosis, procedure, HCPCS, revenue code or modifier valid in system
- Paperwork missing when required for claim processing (e.g. EOB for coordination of benefits)
- Duplicate payment
- Dates of services validity

Facility- Specific Claim Edits

- Incomplete or invalid patient status, admission date, admission type, or discharge information
- Date of service precedes date of death

Denied Claims

Reimbursement is likely to be denied for services determined not to be medically necessary, or services that have not been properly authorized. Providers will receive a remittance advice for all claims submitted to UnitedHealthcare Community Plan. If a claim is denied, a reason for the denial will be included in the remittance advice.

If a provider feels that a claim was processed incorrectly or denied in error, the provider should contact Provider Services at 800-600-9007.

Claims Resubmission: If provider receives notice from UnitedHealthcare Community Plan that a claim was denied due to incorrect or missing information, the provider may resubmit the claim to UnitedHealthcare Community Plan within 60 days of the date of the remittance advice (**note that this timeframe may differ depending upon your contract).

For professional and institutional paper claim forms, the only mechanism accepted to indicate the claim is a correction or a void of a previous processed claim will be the following:

Claim Form: CMS 1500
Box Number: 22
Title: Medicaid Resubmission and/or Original Reference Number
Instructions: When resubmitting a claim, enter the appropriate claim frequency code left justified in the left-hand side of the field. (7- replacement of prior claim, or 8- Void-cancel of prior claim).

Claims Form: UB-04
Box Number: 4
Title: Type of Bill
Instructions: When resubmitting a claim, enter the appropriate claim frequency code in the 3rd position of the Type of Bill (7- replacement of prior claim, or 8- Void-cancel of prior claim).

For professional or institutional EDI claims, the only mechanism accepted to indicate the claim is a correction or a void of a previous processed claim will be the following:

Loop: 2300
Segment: CLM05-3
Name: Claims Frequency Type Code
Instructions: When resubmitting a claim, enter the appropriate claim frequency code (7- replacement of prior claim, or 8- Void-cancel of prior claim).

Claims Reconsiderations/Adjustments

A Claim Reconsideration request is typically the quickest way to address any concern you have with how we processed your claim. With a Claim Reconsideration request, we review whether a claim was paid correctly, including if your provider information and/or contract are set up incorrectly in our system, which could result in the original claim being denied or reduced.

There are several ways to submit a Claim Reconsideration Request:

1. Submit an electronic Claim Reconsideration Request with attachments on Optum Cloud Dashboard. For information on registering for access to the Optum Cloud Dashboard, see uhccommunityplan.com/health-professionals/pa/claim-reconsideration-appeals1 and click link for: Administrator Registration and Importing Users Quick Reference Guide.

By using this method, you can:
- Reduce the overall turnaround time for the request.
- Receive immediate confirmation and a unique tracking number to show we received your request.
- Check submission status throughout the process

To learn more, go to: uhccommunityplan.com/health-professionals/pa/claim-reconsideration-appeals1 and click link for: Optum Cloud Dashboard Claim Reconsideration with Attachments Quick Reference Guide.
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2. Submit a Claim Reconsideration without attachments via the Claim Reconsideration function on UnitedHealthcareOnline.com. You’ll be notified that your request was received. Go to: uhccommunityplan.com/health-professionals/pa/claim-reconsideration-appeals1 and click link for: Claim Reconsideration Quick Reference Guide for more information.

3. Paper Claim Reconsideration Request forms can be downloaded from: UnitedHealthcareOnline.com at uhccommunityplan.com/health-professionals/pa/claim-reconsideration-appeals1 and click on the link for Community Plan Claim Reconsideration Request Form and Guide.

Where to send the paper Claim Reconsideration Requests:

- If your request for a claim reconsideration is for a Medicaid/Chip member, go to: www.uhccommunityplan.com/health-professionals/pa/claim-reconsideration-appeals1 and click link for: Claim Reconsideration Quick Reference Guide for more information.

UnitedHealthcare Community Plan provides notification of the decision on a future remittance advice within 30 days of receipt of the request. UnitedHealthcare Community Plan will accept subsequent reconsideration requests if there is additional supporting documentation not yet submitted. Providers still disputing the reimbursement determination after submitting all supporting information may file an appeal. If a correction on a claim is being submitted, please be sure to have the claim clearly marked as a corrected claim. Otherwise, this may result in the claim denying as a duplicate claim.

Coordination of Benefits

Our benefits contracts are subject to coordination of benefits (COB) rules. COB - Coordination of benefits is administered according to the member’s benefit contract and in accordance with applicable statutes and regulations. Medicaid is the payor of last resort. Coordination of Benefits is a shared responsibility. If UnitedHealthcare Community Plan is aware of other coverage when we receive a claim from you, we will deny that claim and instruct you to bill the primary carrier first and then bill UnitedHealthcare Community Plan for any secondary liability. If UnitedHealthcare Community Plan becomes aware of other coverage after we have paid your claim, we will make every effort to identify the carrier for you when we seek recoveries. Your responsibility is to verify that the member does not have other insurance with another carrier at the time service is rendered.

Members With Medicare

Providers should bill UnitedHealthcare for any Medicare coinsurance or deductible amounts, and include the Medicare Explanation of Benefits with their claim, so these benefits can be appropriately coordinated.

Casualty Related Third Party Liability

When an provider receives payment from a third party payer involving a casualty related auto or accident injury(s), the provider is required to reimburse the MCO the funds, including the related details.

In order for MCO to process the payments/checks sent in by an provider, the following DHS-prescribed information must be included for each client/claim:

- First and last name of injured party (Member Name)
- CIS/RID number of injured party
- Social Security number
- Date of incident
- Date of service
- Claim number
- Provider’s Medical Assistance (MA) number
- Insurance carrier name
- PROMISe ICN
- Dollar amount of claim being returned (Refund Amount)

Submission format: The preferred submission format is an Excel spreadsheet.

Submission process: The provider must submit the EXCEL spreadsheet along with the check payable to “UnitedHealthcare Community Plan of Pennsylvania” containing no more than twelve cases to the following address:

UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374

UnitedHealthcare will deposit the funds and return the amount to the Pennsylvania Department of Human Services TPL unit as contractually required.
Retroactive Eligibility Changes

Eligibility under a benefit contract may change retroactively if:

• we receive information that an individual is no longer a member;
• the individual’s policy/benefit contract has been terminated;
• the eligibility information we receive is later determined to be false.

If you have submitted a claim(s) that is impacted by a retroactive eligibility change, a claim adjustment may be necessary. The reason for the claim adjustment will be reflected on the EOB or Provider Remittance Advice.

Access to Records

With respect to Medicaid members, the provider shall maintain and make available to UnitedHealthcare Community Plan records reflecting collection of benefits by the provider and amounts paid directly to Medicaid members by other payers. UnitedHealthcare Community Plan shall maintain or have immediate access to records concerning collection of benefits.

Hold Harmless Language

UnitedHealthcare Community Plan members must NEVER receive a bill or a balance bill for covered services. Sending bills or balance bills to UnitedHealthcare Community Plan members for covered services is a violation of your Participating Provider Agreement with UnitedHealthcare Community Plan and violates Pennsylvania State law and regulation.

Provider offices should instruct office staff to ask for appropriate documentation of a patient’s insurance coverage and accurately maintain this information in all billing systems.

If your office has not received payment for covered services provided to a UnitedHealthcare Community Plan member, call 800-600-9007.

Subrogation and Tort Policy

• To the extent permitted by applicable law, the provider shall cooperate with subrogation procedures in instances where the member is covered by automobile insurance or worker’s compensation.

• In the event that UnitedHealthcare Community Plan is notified of a legal action being taken by, or on behalf of, a member in connection with an illness or injury, UnitedHealthcare Community Plan may contact the provider to make available information related to the services provided in connection with the illness or injury. For Medicaid members, this information will be shared with DHS since they do the subrogation in all Medicaid cases except workers compensation. UnitedHealthcare performs any required subrogation functions for CHIP members.

• With respect to Medicaid members, the provider shall maintain and make available to UnitedHealthcare Community Plan records reflecting collection of benefits by the provider and amounts paid directly to Medicaid members by other payers. UnitedHealthcare Community Plan shall maintain or have immediate access to records concerning collection of benefits.

• All providers are required to notify UnitedHealthcare Community Plan when an UnitedHealthcare Community Plan member presents with an illness or injury that is related to an automobile accident or employment. Notification can be made on a standard claim form.

• Providers are also required to notify UnitedHealthcare Community Plan if they become aware of any litigation on behalf of the member resulting from the member’s injuries.

• Providers should call 800-600-9007.

Provider, Billing, Address or Tax ID Number Changes and Updates

Providers must notify UnitedHealthcare Community Plan when there are any changes to the provider office, billing, office addresses, Tax identification number etc.

Please contact Provider Services at 800-600-9007.

Fee Schedules

Providers should refer to their individual contracts for fee schedule information.
Chapter 8: The Primary Care Provider – The Entry Point of Care

The Primary Care Provider is the designated Medical Home for all members roster. The Primary Care Provider’s role is to ensure that members receive appropriate care and follow-up services.

The Primary Care Provider is the member’s point of entry into the health care delivery system.

UnitedHealthcare Community Plan Primary Care Providers are to communicate with specialists and should document the communication in their patient’s medical record. UnitedHealthcare Community Plan also expects specialists to communicate back to the Primary Care Provider any care provided to the member such as:

- Outcome/Significant Findings
- Recommendations for Continued Care
- Other Specialty Referrals
- Medication Changes.

A specialist may refer the patient directly to another specialist.

Referral Guidelines

Providers are to utilize UnitedHealthcare Community Plan’s Participating Network when making referrals for services. Submission of a paper referral is no longer required for claims payment under UnitedHealthcare Community Plan.

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

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

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

Referring Guidelines

- Refer only to UnitedHealthcare Community Plan participating providers
- Record the referral in your patient’s medical record
- Refer patients to a specialist by calling, sending a letter, fax or prescription to the specialist’s office
- Include the following information in the referral to the specialist:
  - Patient’s name,
  - Reason for the referral,
  - Any medical records, lab and test results relevant to the reason for the referral
  - Specialists name and National Provider Identifier (if known).
- The request for non-network providers must be obtained prior to service by contacting the Prior Authorization Department at 800-366-7304.
- Failure to obtain a prior authorization will result in the denial of the claim.

Members may be assessed a co-pay for some services depending on coverage limits.

Self-referred Services

Members may self-refer in-network for dental, vision, OB/GYN, and chiropractic care. Information on how to access network information for dental and vision care can be found in the contact information on page 3 of this Guide.

Family planning services and Emergency care can be self-referred to any qualified provider or facility.

Out-of-Network Referrals

Special circumstances including coordination of care will be considered for out-of-network providers. When referring to non-participating specialists you must obtain Prior Authorization.
All Out-of-Network requests requires the following information:

• Justification for use of Out-of-Network Provider

If you have questions, please contact the Prior Authorization Department at 800-366-7304.

Specialists Acting as Primary Care Providers

A specialist can be designated as a member’s primary care provider following approval by the credentialing committee. The specialist would need to submit the request to act as the primary provider.

For more information you may contact the Provider HelpLine at 800-600-9007.

Primary Care Providers Acting as Specialists

If a care provider is credentialed as a specialist as well as a Primary Care Provider, the care provider can accept referrals from other Primary Care Providers.

• If the Primary Care Provider wants to provide specialty services to members on his or her own panel, the Primary Care Provider can contact the Medical Director or his/her designee to discuss arrangements for providing these services.

• The Primary Care Provider should call 800-600-9007, and explain what services he/she wants to provide his/her patients and ask to speak with the Medical Director or his/her designee.

Second Opinions

UnitedHealthcare Community Plan does not require a second opinion for any specific services or procedures. However, all UnitedHealthcare Community Plan members are entitled to a second opinion from a UnitedHealthcare Community Plan participating provider prior to initiating any recommended treatment plan.

The Primary Care Provider will initiate a referral for a second opinion to a participating care provider.

If the referral is for an out-of-network provider the Primary Care Provider should contact the Provider Help Line at 800-366-7304 to request authorization.

UnitedHealthcare Community Plan will contact the Primary Care Provider, Member and Specialist within 72 hours of the request with the determination of the request.

School-based Services

School districts sometimes provide some basic health services or offer programs to promote healthy behaviors. These programs vary from district to district, are too many state-wide to successfully list here.

Our Special Needs Unit is available to assist if you need help finding services in your area.

You can contact the SNU at 877-844-8844.
Chapter 9: Hospital and Hospitalizations

General Requirements
The standards, policies and procedures described in this section apply to participating hospitals unless they specifically address another type of provider, e.g. Primary Care Practitioners.

For additional information about the medical management process see the Prior Authorization section.

Peer to Peer
In order to facilitate a professional clinical discussion UnitedHealthcare Community Plan Community and Plan has established a Peer to Peer Reconsideration Line.

This line is dedicated to care providers to discuss a determination for a service that may not have been approved at the level of care originally requested.

You may access the Peer to Peer Reconsideration Line at 800-514-4910.

Elective Procedures and Same Day Surgery
The Primary Care Provider or Specialist referring a patient for an elective procedure or same day surgery is responsible for obtaining prior authorization, as required (refer to prior authorization list in Prior Authorization Section).

UnitedHealthcare Community Plan recommends calling at least five days in advance of the elective procedure in order to ensure a timely determination of the request.

Requests for prior authorization are prioritized according to level of medical necessity.

You may access the Peer to Peer Reconsideration Line at 800-514-4910.

Certain cases are reviewed according to UnitedHealthcare Community Plan’s Guidelines at UHCCommunityPlan.com/health-professionals.

Other guidelines utilized to make determinations are InterQual and/or Milliman, Local and Federal Guidelines and Medical Necessity.

All cases that do not meet review guidelines as referenced above are referred to the Medical Director for review and determination. Only Medical Directors have the authority to deny a service request that is reviewed for medical necessity.

Determinations will be notified according to the State regulated timeframes.

All Admissions are subject to concurrent review for medical necessity on the first day of admission.

The Primary Care Provider, specialist, attending care provider, or facility may appeal any adverse decision made by UnitedHealthcare Community Plan. See the section on Provider Appeals.

Emergency Admissions
Notification by the hospital must be presented to the National Intake Department at 800-366-7304 by 5 p.m. the next business day.

Nurses in the Health Services Department will review emergency admissions within one business day of receipt of all clinical information. UnitedHealthcare Community Plan uses industry accepted standards, to determine appropriateness of care.

Post-Stabilization Services
UnitedHealthcare Community Plan members should not be billed or balance billed for any post-stabilization services. The only liability a UnitedHealthcare Community Plan member should accrue for post-stabilization services is any applicable co-pay amount.

UnitedHealthcare Community Plan will cover post-stabilization services without requiring authorization, if any of the following situations exist, regardless of whether the Member obtains the services within or outside the UnitedHealthcare Community Plan Provider Network:

A. The post-stabilization services were pre-approved by UnitedHealthcare Community Plan.
Emergency Defined

An emergency is defined as the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain such that a prudent layperson would believe that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the person in serious jeopardy
- Serious impairment to such person’s bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Active labor is an emergency.

Obstetrical Admissions

Hospital facilities are required to contact the National Intake Department when members are admitted to a facility for delivery or other inpatient services related to the pregnancy.

Newborn Admissions

If the baby is detained in the hospital following the mother’s discharge it is the hospital responsibility to notify UnitedHealthcare Community Plan’s National Intake Department at 800-366-7304.

This information is important to ensure accurate claim adjudication. Furthermore, the detained baby medical condition must be reviewed for medical necessity for approval of ongoing stay.

The following information is required at time of notification:

- Date of birth
- Birth weight
- Gestational age
- APGAR score
- Mother’s full name and date of birth
- Clinical information related to detained status

Emergency Room Care

Emergency Room services qualify under the provision of prudent layperson and no referral or prior authorization is required for these services. There are certain contractual agreements that require clinical documentation to support prudent layperson standard.

Emergency services furnished by a licensed care provider are a covered benefit for participating, non-participating emergency room service and urgent care centers.
Concurrent Review

Initial review must be received within two business days of notification of the admission. If no review is received within two business days, an administrative denial may be issued for the entire admission.

- A concurrent Utilization Review decision shall be communicated within two business days after the receipt of all clinical supporting information reasonably necessary to render a determination.

Discharge Planning and Continuing Care

UnitedHealthcare Community Plan teams coordinate with the facility, member and provider to ensure a safe and effective discharge plan.
Chapter 10: Special Needs

Special Needs Unit

UnitedHealthcare Community Plan’s Community Plan wants to inform you that our Special Needs Unit is available to assist your special needs members who may be experiencing difficulty accessing care:

Our Special Needs Staff is able to assist with:

- Finding a Specialist or Dentist
- Identifying and Connecting with Community and State Resources
- Connecting with Behavioral Health Providers/Case Management
- Accessing the Transportation Benefit
- Coordinating Benefits

The above are examples of how we can assist.

If you have a member who may need extra help, please call or have your member call our Special Needs Unit at 877-844-8844, hearing impaired can call TTY 711.

Case Management and Disease Management

UnitedHealthcare Community Plan’s Case Management Program is a holistic approach to helping our members live healthier. Our primary focus is to work with you to keep members healthy and independent in the community by decreasing barriers to care. Our program encourages and promotes member self-management, active decision-making, and participation in health care interventions and outcomes.

Our Case Managers and field-based Community Health Workers will assist to coordinate services, educate and encourage the member on your established plan of care. In addition, we will work with you and the member to ensure timely access to the right provider, at the right time, at the right place of service.

UnitedHealthcare Community Plan’s Case Management Program is inclusive of Case and Disease Management. The following disease specific case management programs are available to adult and pediatric members:

- Asthma/COPD
- Diabetes
- HIV/AIDS
- Cardiac/CHF

If you identify a member who may need Case and/or Disease Case Management services please contact Member Services or the Special Needs Unit.

Interpreter Services

UnitedHealthcare Community Plan provides members with access to interpreter services including the deaf or hard of hearing or those who have need of interpreter services due to language barriers. Providers have an independent obligation under Title VI of the Civil Rights Act of 1964 to provide interpreter services for languages found in the communities they serve. Language services can be provided over the telephone or in person. The AT&T Language Line can provide extensive interpretation services for many languages.

To arrange for AT&T Language Line services go to languageline.com/page/industry_healthcare/ or call 800-752-6096.

Family members, especially children, should not be used as interpreters in assessments, therapy or other situations where impartiality is critical.

For additional information or to arrange for services call:

Member Helplines:
Phone TTY/TTD: 800-414-9025 (Member Services)
800-654-5984 (Voice Relay)

Instructions on how to Access Interpreter Services for Plan and Provider

UnitedHealthcare of Pennsylvania Hearing Impaired Access
Languages Unlimited: 800-864-0372
ALS International: 800-322-0284
UnitedHealthcare of Pennsylvania Language Line Access
Language Line is utilized to ensure communication with non-English speaking Health Plan members.

To Access language interpreter do the following:
- dial a toll-free number,
- provide your account information, extension and,
- request the language you need.

Instructions for Providers to set up an Account with Language Line
- dial a toll-free number 800-752-6096
- open an account online: languageline.com/page/open_account/

How Language Line Works
Instructions accessed from Language Line website at http://www.languageline.com/page/how_it_works/
- Place the Limited English Speaker on conference hold.
- Dial the Language Line Services designated toll-free number you have been provided at sign-up.
- Request the language your caller speaks through our easy-to-use interactive voice response (IVR) system.
- When the interpreter is connected, explain the situation.
- Conference in your limited English-speaking caller.

You Need to Make a Call to a Limited English Speaker
- Dial the Language Line Services designated toll-free number.
- Request the language your client speaks through our easy-to-use interactive voice response (IVR) system.
- When the interpreter is connected...
- Call your limited English-speaking client...
- Or the interpreter can place the call for you within the U.S. or Canada.
- Dial the Language Line Services designated toll-free number.
- Request the language your client speaks through our easy-to-use IVR system.
- When the interpreter is connected, use the Language Line® Phone, or your speakerphone, or pass your handset back and forth.

Healthy First Steps™ Program
Healthy First Steps is UnitedHealthcare Community Plan’s perinatal case management and support services to UnitedHealthcare Community Plan pregnant women. The Perinatal Case Managers facilitate linkages between the member, obstetrician and Primary Care Provider, especially for high risk pregnancies. The perinatal case managers authorize services such as:
- Helping the patient find a participating provider
- Helping the member make prenatal appointments
- Arranging for home health care if the doctor requests the service
- Coordinating well baby visits
- Coordinating transportation services
- Ordering any special supplies that the OB/GYN requests
- Monitoring the health during and after pregnancy
- Skilled nursing visits and DME.
- Coordinating transportation for any pregnant woman who needs this service to help her keep her prenatal appointments.

Healthy First Steps also helps in managing psychosocial and substance abuse issues.

Providers can contact the Healthy First Steps Program at 800-599-5985. Healthy First Steps fax number is 877-353-6913. Healthy First Steps email address is hfsescalation@optum.com.

We appreciate your efforts to improve pregnancy outcomes and your willingness to partner with HFS.

If you would like additional information about Healthy First Steps or have questions please call your provider advocate at 800-600-9007.

UnitedHealthcare Community Plan requires you to complete the MA-552 Obstetrical Needs Assessment Form and fax it to Healthy First Steps within five days of the first OB visit. The fax number is 877-353-6913.

The form may be downloaded from our website at uhccommunityplan.com/healthprofessionals/PA/provider-information.
This assessment information allows our care management department to:

1. Identify pregnant members
2. Conduct outreach to these members
3. Assess any identified needs
4. Work with the members who miss appointments to schedule additional ones
5. If necessary, arrange transportation.

The document should contain the following information:

- Care provider name and plan provider ID number
- Current pregnancy information, e.g. gestational diabetes, preterm labor, PROM
- Prior OB history e.g. delivery of a baby with a birth weight of less than 4 pounds, Cerclage, etc.
- Current Medical conditions e.g. Sickle Cell Disease, bleeding
- Hospitalizations related to pregnancy complications

If you would like additional information related to HFS or have any questions please call your provider advocate at 800-600-9007.

Prenatal Care Includes the Normal Assessment and Physical Examination as well as the Following Tests:

- Hemoglobin and hematocrit
- Complete blood count with differential
- Urinalysis
- Blood group and Rh type determination
- Antibody screen
- Rubella antibody titer measurements
- Syphilis screen (VDRL)
- Pap smear
- Gonorrhea test
- Hepatitis B virus screen
- Maternal serum alpha-fetaprotein (AFP)
- Diabetes screening
- Testing for sexually transmitted disease
- Repeat antibody test for sensitized Rh-negative
- Ultrasound (up to two), including level 2
- Amniocentesis
- Chorionic villi sampling (if indicated)
- Non-stress test (NST)
- Biophysical profile
- Genetic consults
- HIV testing
- Vaccinations when appropriate
- Smoking Cessation Counseling and Medication

Post-Partum Visit Program

UnitedHealthcare Community Plan offers post-partum in-home nursing visits to new mothers and infants within 48-72 hours of discharge from the hospital. Each new mother is contacted in the hospital prior to discharge by a
hospital discharge planner who explains the purpose of the visit and sets up the appointment. The purpose of the postpartum visit is fourfold:

1. To perform follow-up examinations on both the new mother and the infant, with copies sent to the Primary Care Provider to promote continuity of care.
2. To provide or reinforce education about care of the newborn, including the importance of selecting Primary Care Provider for both mother and baby.
3. To assist the member in selecting a Primary Care Provider if one has not been selected and to arrange an appointment with the Primary Care Provider for a newborn checkup if it has not been arranged.
4. To provide support and linkage to community social services and health care providers.

If your UnitedHealthcare Community Plan member is not offered a home visit while she is in the hospital, have her contact the UnitedHealthcare Community Plan Healthy First Steps program at 800-599-5985 to arrange for services.

Other Women’s Health Services Include:

- Post partum care visit between the 21st and 56th day after delivery
- Birth control services and counseling
- Annual Pap Smear beginning at the age of 21 or at the onset of sexual intercourse
- Annual pelvic exam beginning at the age of 18 or earlier if sexually active
- Sexually transmitted disease testing beginning at the age of 16, or at the onset of sexual intercourse
- Mammogram Screening
- Family Planning Services
- Birth Control

Drug and Alcohol Rehabilitation Services for Pregnant Women

The Healthy First Steps program can help coordinate behavioral health services during pregnancy.

If a member needs these services, call 800-599-5985.

Termination of Pregnancy

Termination of pregnancy is a covered benefit in specific cases when the abortion is necessary to avert the death of the woman or when the pregnancy resulted from rape or incest.

The care provider requesting authorization of coverage for a pregnancy termination must complete the Medical Assistance Physician Certification for an Abortion Consent Form (MA3) prior to performing the procedure. This form must be completed for both Medical Assistance and CHIP Program members.

UnitedHealthcare Community Plan determines the coverage and payment of termination on a case by case basis.

| Refer all questions to the Inpatient National Intake Department at 800-366-7304. |

Voluntary Sterilization

UnitedHealthcare Community Plan covers voluntary sterilization when performed at the request of the member. Federal and state regulations require a 30-day waiting period between the time the patient requests the procedure and the time it is performed to allow the patient time to reconsider the decision.

The care provider performing the procedure is responsible for assisting the member in completing the Medical Assistance Sterilization Consent Form (MA 31) for the procedure and for obtaining prior authorization from National Intake at 800-366-7304.

UnitedHealthcare Community Plan does not cover reversal of sterilization procedures.

Hysterectomy

UnitedHealthcare Community Plan covers hysterectomy if it is medically necessary, and the care provider performing the procedure must obtain prior authorization from UnitedHealthcare Community Plan. Because hysterectomy results in sterilization, the care provider performing the procedure is responsible for assisting the member in completing the Medical Assistance Patient Acknowledgment Form for Hysterectomy (MA30) prior to surgery.

Fertility Treatments

UnitedHealthcare Community Plan does not cover any costs, drugs, procedures or devices associated with fertility treatment and/or reversal of sterilization procedures.
Chapter 11: Pharmacy

Pharmacy Benefit Management

Medicaid and CHIP members receive their outpatient prescription drugs through UnitedHealthcare Community Plan.

The pharmacist can call for an override by calling either the Pharmacy Help Desk at 888-306-3243 or the Prior Notification Service at 800-310-6826.

<table>
<thead>
<tr>
<th>Anti-anginal Drug</th>
<th>Asthma and COPD Drugs</th>
<th>Immunosuppressant Drugs</th>
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<tr>
<td>Anti-arrhythmic Drugs</td>
<td>Cancer Medications</td>
<td>Mood Stabilizers</td>
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<tr>
<td>Anti-coagulant Drugs</td>
<td>Chronic Kidney Disease Drugs</td>
<td>Multiple Sclerosis Drugs</td>
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<td>Anti-convulsant Drugs</td>
<td>Diabetes Drugs</td>
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<td>Anti-depressant Drugs</td>
<td>Enzyme Deficiency Agents</td>
<td>Opiate Dependency Agents</td>
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<td>Anti-emetic Drugs</td>
<td>Epinephrine</td>
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<td>Anti-hepatitis Drug</td>
<td>Family Planning Drugs</td>
<td>PPI Drugs</td>
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<td>Anti-hypertensive Drugs</td>
<td>Glaucoma Drugs</td>
<td>Pulmonary Hypertension</td>
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<td>Anti-infective Drugs</td>
<td>Gout Medications</td>
<td>Thyroid Drugs</td>
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<td>Anti-neoplastic Drugs</td>
<td>Hemophilia Agents</td>
<td>Triptans</td>
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<tr>
<td>Anti-Parkinson’s Drugs</td>
<td>HIV/AIDS Drugs</td>
<td>Statins</td>
</tr>
<tr>
<td>Anti-psychotic Drugs</td>
<td>Immune Deficiency Agents</td>
<td>Vaccines-Flu Only</td>
</tr>
</tbody>
</table>

The benefit limit does not apply to members who are under 21 years of age or are pregnant (through the postpartum period) or who live in a nursing home or an intermediate care facility. In an emergency, the pharmacist may dispense a 5 day temporary supply. Drugs dispensed as an emergency supply, or temporary coverage override, will not count toward the six prescription limit.

There are some exceptions to the limit that will not require prior plan approval. The pharmacy can override the limit at point of sale for those drugs in the classes listed below. To override the limit, a clarification code of ‘05’ or ‘10’ can be entered in the Field ID 42Ø-DK. A benefit limit exception request is not needed for these drugs.
Chapter 11: Pharmacy

In some instances, UnitedHealthcare can approve more than 6 prescriptions through the benefit limit exception process. A benefit limit exception can be granted if:

- The member has a serious chronic illness or health condition and without the additional service, their life would be in danger; or
- The member has a serious chronic illness or health condition and without the additional service, their health would get much worse; or
- The member would need more expensive services if the exception was not granted; or,
- It would be against federal law for UnitedHealthcare to deny the service.

A benefit limit exception can be requested by the prescribing provider by contacting the UnitedHealthcare pharmacy prior notification service at 800-310-6826.

Or a fax can be sent to 866-940-7328, using the PNS Pennsylvania Prescription Limit form.

This form is posted on the provider website under Pharmacy Program.

- The member’s name, address, date of birth, and UnitedHealthcare ID number
- Provider name, address, telephone and fax number, medical license number and National Provider Identifier number
- Information about the drug being prescribed, the diagnosis and why the exception is being requested

Once UnitedHealthcare has the needed information, a written notice of the decision will be sent to the requesting care provider and member within 24 to 72 hours.

Member ID Cards for Prescription Benefits

A member with prescription benefits should always use the UnitedHealthcare Community Plan member ID card at a network pharmacy to obtain prescription drugs. A member with Medicaid coverage should use the UnitedHealthcare Community Plan ID card AND the Pennsylvania ACCESS card. Dual eligibles, members covered by both Medicaid and Medicare, should use their Medicare card for prescriptions.

![If a pharmacist calls the care provider’s office because an error message has appeared when trying to process a prescription for a member, refer the pharmacist to Pharmacy Help Desk at 888-306-3243.]

Prescriptions Requiring Prior Authorization

UnitedHealthcare Community Plan periodically updates the UnitedHealthcare Community Plan Preferred Drug List (PDL). Care providers should consult the drug formulary to identify the drugs that require prior authorization. The most current version of the PDL is also available for viewing or printing at UHCCommunityPlan.com.

Care providers should obtain prior authorization before giving a member a prescription for a medication that requires prior authorization. This will avoid delays for the member at the pharmacy and additional phone calls to the care provider’s office. Once UnitedHealthcare has the needed information, a written notice of the decision will be sent to the requesting care provider and member within 24 to 72 hours.

Emergency Supplies of Medication

To ensure the use of PDL drugs, all non-PDL drugs require authorization review. Prescribing care providers should request the prior authorization before prescribing. If a member brings a prescription for non-PDL drug to the pharmacy, that has not been authorized for payment, and there is an immediate need for the medication, the pharmacist can use an override code to permit a one-time dispensing of a 5-day supply of the newly prescribed non-PDL drug.

Pharmacy Department Prior Authorization Phone and Fax Numbers

Requests for non-preferred drugs or drugs that require prior authorization should be submitted through the phone/ fax numbers listed below. Phone requests are preferred.

Pharmacy Network: 800-940-7328 (fax)

Most chain pharmacies and many independent pharmacies fill prescriptions for UnitedHealthcare Community Plan members. To locate a pharmacy that is convenient for a member, please reference a listing of participating pharmacies in the UnitedHealthcare Community Plan of Pennsylvania provider directory, or go to “Find a Pharmacy” at UHCCommunityPlan.com.
Generic drugs are preferred when available. Generic drugs are approved by the Food and Drug Administration (FDA) to be therapeutically equivalent to their brand name counterparts. If a generic drug is available, the brand name drug will not be provided to the member, unless the care provider provides information that documents why the brand drug is medically necessary.

Care providers should contact the Pharmacy Prior Notification Service at 800-310-6826 to present the information regarding the medical necessity for the brand drug.

Over the Counter (OTC) Medications

Many OTC medications are covered for UnitedHealthcare Community Plan members, with a prescription.

Please consult the Preferred Drug List for each program at UHCCommunityPlan.com.

Pharmacy Benefit Exclusions

Certain drugs are not covered by the pharmacy benefit. Drugs that are not covered include:

- Drugs that are used for weight loss or appetite suppression
- Drugs that are used for cosmetic purposes
- Drugs used to treat infertility
- Drugs used to stimulate hair growth or prevent hair loss
- Investigational and experimental drugs, unless a Medical Director or his/her designee gives prior authorization
- DESI drugs
- Erectile Dysfunction (ED) drugs
Chapter 12: Member Information

Member ID Card

UnitedHealthcare Community Plan issues a member identification (ID) card to each member enrolled in the plan. When more than one member of a family enrolls, UnitedHealthcare Community Plan issues a separate ID card to each family member.

The member ID card displays the UnitedHealthcare Community Plan logo and the UnitedHealthcare Community Plan toll-free Member Services number.

The member ID card also displays:

• The member’s Primary Care Provider’s name and telephone number
• The member’s name and UnitedHealthcare Community Plan ID number
• Co-payment requirements for members, if applicable.

The back of the member ID card has the following information:

• Telephone number for providers to verify eligibility and obtain prior authorization
• Mailing address for claims
• Pharmacy Help Desk phone number for pharmacy claim issues

The member should present his or her member ID card whenever seeking UnitedHealthcare Community Plan covered services. Medicaid members should also present their Pennsylvania ACCESS card. No member should be denied services because of failure to have a member ID card at the time of service.

Member Eligibility Verification

To verify a member’s enrollment in UnitedHealthcare Community Plan and the member’s Primary Care Provider, providers can:

• Call 800-600-9007;
• Use the On-Line Provider Portal, uhconline.com; or
• Check the Primary Care Provider Member Roster for appropriate UnitedHealthcare Community Plan program

Do NOT call the Member Helpline for this service.

Medicaid members are responsible for presenting their current Medical Assistance ACCESS card or Electronic Benefits Transfer (EBT) card when services are rendered.

For Medicaid members, providers can obtain eligibility status information through the Pennsylvania Department of Human Services (DHS) Eligibility Verification System (EVS). The EVS may be accessed using a:

• Touch-Tone Telephone
• Point of Sale (POS) Device
• Personal Computer (PC)
• Mainframe Computer

The toll-free number for the EVS is 800-766-5387.

The care provider enters the member’s 10-digit recipient number and two-digit card issue number. When members state they are eligible for Medical Assistance but are unable to present a valid card, the provider should access the EVS with the Social Security Number and birth day (Month/Day/Year) of the patient.

Care providers may request EVS software through the DHS Provider Assistance Center by calling 800-248-2152.

There is a shipping and handling charge for the EVS PC software. The software is shipped once payment is received.

Care providers may also download a document containing the specifications for customizing a computer system to access EVS after completing and submitting the form available at click here to access the form.
**Primary Care Provider Selection**

Every member enrolling in UnitedHealthcare Community Plan is required to select a participating Primary Care Provider. Members may change their Primary Care Provider at any time. UnitedHealthcare Community Plan encourages members to select a Primary Care Provider they intend to remain with for an extended period of time.

If a new member does not select a Primary Care Provider, UnitedHealthcare Community Plan will assign the member to a Primary Care Provider, based on geographic location. The member may change this selection later for any reason.

**Member-Initiated Transfers**

A member may change his or her Primary Care Provider by calling the Member Helpline. Member requests for Primary Care Provider changes are effective on the day of the request. It typically takes two to three weeks for the member to receive a new ID card. UnitedHealthcare Community Plan monitors the member transfer rates for each Primary Care Provider and Primary Care Provider site by recording the member’s reason for requesting the transfer. The Quality Management Department investigates quality-related transfer requests.

**Primary Care Provider-initiated Transfers**

A Primary Care Provider may wish to transfer a member due to an inability to establish or maintain a professional relationship. To initiate a transfer of the member, the Primary Care Provider must send a request in writing to the Medical Director or his/her designee identifying the member and describing the circumstances supporting the request. The request should not be made unless interventions have been attempted and documented. These interventions should include contact between the Primary Care Provider office and UnitedHealthcare Community Plan to provide education to the member concerning his/her rights and responsibilities.

A Primary Care Provider may not request a change because of the patient’s physical condition, degree of illness, or amount of services required, unless the Primary Care Provider can justify he or she is unable to deliver quality care to the member. If the Medical Director or his/her designee approves the transfer, the Primary Care Provider is obligated to provide services to the member for 30 days beginning with the date of the letter. For more information, providers should contact their care provider or Hospital and Facility Advocate.

UnitedHealthcare Community Plan trends Primary Care Provider-initiated transfer requests to ensure that Primary Care Provider are not inappropriately removing patients from their panels. UnitedHealthcare Community Plan will notify the member about the transfer.

**Membership Roster Report**

UnitedHealthcare Community Plan sends a Membership Roster Report to Primary Care Provider with the monthly roster statement. This roster report contains the list of members on the Primary Care Provider’s panel, and a fee amount per member and other pertinent member information.

If the member appears on the monthly roster, UnitedHealthcare Community Plan expects the care provider to render services to the member.

Any questions regarding the Member Eligibility rosters, providers may contact Provider Services at 800-600-9007.

**Member Rights and Responsibilities**

UnitedHealthcare Community Plan members have certain rights related to health care, and they also have certain responsibilities to the health care professionals who are providing their care. The following is the Member’s Rights and Responsibilities for Medicaid and CHIP. The Member Rights and Responsibilities are also in the member guides.

As a Member of UnitedHealthcare Community Plan Community Plan, Members Have the Right to:

- Receive information about UnitedHealthcare Community Plan Community Plan, its services and benefits, network health care providers, how to file complaints and grievances and other information about UnitedHealthcare Community Plan Community Plan and the member’s rights and responsibilities
- Receive readable materials and information and in an alternative format or language
- Have personal and health information kept private
- Request an accounting of disclosures of protected health information
- Request UnitedHealthcare Community Plan Community Plan amends certain protected health information
• Be treated with courtesy, consideration, respect and dignity
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
• Expect records and anything said to the doctor will be treated confidentially and will not be released without consent
• Receive information they understand about available treatment options and alternatives
• Participate in decision making regarding health care. This includes open discussion of appropriate or medically necessary treatment options and alternatives suitable for your condition, regardless of cost or benefit coverage. This includes the right to refuse treatment
• Know what treatment they receive, what the expected outcome is, what risks there are and the side effects
• Ask for a second opinion about any medical treatment or procedure offered
• Voice a complaint or grievance with or about UnitedHealthcare Community Plan Community Plan or care provided and to receive timely response
• File a fair hearing appeal with the Department of Human Services
• Offer suggestions for changes in UnitedHealthcare Community Plan Community Plan’s member rights and responsibilities
• Receive health care services without discrimination based on race, color, ethnicity, age, mental or physical disability, religion, gender, sexual orientation, national origin or income
• Choose their own Primary Care Provider within the limits of the UnitedHealthcare Community Plan Community Plan network, including the right to refuse the care of specific care providers
• Request and receive a copy of your medical records according to applicable federal and state laws
• Expect written permission will be obtained before we give out medical information to anyone except those directly providing care except for purpose specifically permitted by state and federal laws, such as to make sure UnitedHealthcare Community Plan Community Plan members are getting quality care.
• Make an advance directive that tells others about the types of health care they want to receive when they are unable to speak for themselves
• Receive information on the cost of your care
• Exercise your rights freely, without it adversely affecting the way UnitedHealthcare Community Plan Community Plan, its providers and state agencies treat you

As a Member of UnitedHealthcare Community Plan Community Plan, Members Have a Responsibility to:

• Carry the UnitedHealthcare Community Plan Community Plan card at all times
• Learn and follow UnitedHealthcare Community Plan Community Plan rules
• Supply information to UnitedHealthcare Community Plan Community Plan and provider as well as let UnitedHealthcare Community Plan Community Plan, the case worker and provider know about important changes such as changes in a name, address and telephone number needed in order to provide care
• Get medical services from UnitedHealthcare Community Plan Community Plan care providers
• Get an authorization from the Primary Care Provider before seeing a consultant or specialist except for dental, family planning, vision care, chiropractic services or OB/GYN services
• Use the emergency room only in cases of an emergency
• Treat health care providers with courtesy, consideration, respect and dignity. This includes scheduling appointments, arriving on time for scheduled appointments and canceling appointments when they cannot keep them
• Request protected health information by calling the UnitedHealthcare Community Plan Community Plan Member Helpline at 800-414-9025
• Ask questions to understand health problems and work with the care provider and UnitedHealthcare Community Plan Community Plan to develop agreed upon treatment goals
• Follow treatment plans and instructions for care agreed on with provider
• Learn about any procedure or treatment and to think about it before it is done
• Learn about any procedure or treatment and to think about the outcome of refusing treatment that is suggested
• Consider health care choices carefully
• State complaints and concerns in a polite and appropriate way
• Report your symptoms, problems and related health information to the Primary Care Provider
• Tell the Primary Care Provider about themselves and to sign consent forms so the Primary Care Provider can get a copy of old records
Chapter 13: Participating Provider Responsibilities

General Requirements

In contracting with UnitedHealthcare Community Plan, all care providers (physicians, other health professionals, hospitals, facilities, and agencies) agree to:

- **NEVER** bill or balance bill UnitedHealthcare Community Plan members for covered services. Sending bills or balance bills to UnitedHealthcare Community Plan members for covered services is a violation of your Participating Provider Agreement with UnitedHealthcare Community Plan and violates Pennsylvania law and regulation.
- Instruct office staff to ask for appropriate documentation of a patient’s insurance coverage and accurately maintain this information in all billing systems. If your office has not received payment for covered services provided to an UnitedHealthcare Community Plan member, call UnitedHealthcare Community Plan’s Provider Services Helpline at 800-600-9007.
- Advise members of services not covered by their UnitedHealthcare Community Plan plan and their financial obligation for those services prior to rendering the service.
- Bill Medicaid members only for services not covered by either their UnitedHealthcare Community Plan plan or Medicaid fee-for-service.
- Collect copayments as indicated on the member’s UnitedHealthcare Community Plan ID card.
- Bill other insurance carriers which are primary to UnitedHealthcare Community Plan Medicaid prior to billing UnitedHealthcare Community Plan.
- Maintain medical records according to UnitedHealthcare Community Plan Medical Records Documentation Standards and maintain patient confidentiality.
- Maintain all licenses and certifications required to practice and render services without any encumbrances, limitations, or restrictions and provide copies of such licenses and certifications to UnitedHealthcare Community Plan for verification and (re)credentialing purposes.
- Provide covered benefits in a manner consistent with professionally recognized standards of health care and in accordance with standards established by UnitedHealthcare Community Plan.
- Respect the rights of UnitedHealthcare Community Plan members.
- Notify UnitedHealthcare Community Plan of any change in office location, office hours, or additional office location at least 30 days prior to the date when services will be rendered at the new location(s).
- Notify UnitedHealthcare Community Plan promptly of any changes in the information originally submitted in the application to participate in UnitedHealthcare Community Plan.
- Submit to UnitedHealthcare Community Plan all data necessary to characterize the content and purpose of each member encounter. The submission of a claim or encounter information by a provider is the provider’s certification that the data are accurate, complete, and truthful.
- Never employ or contract with individuals who are excluded from participation in any federal health care program or with entities that employ or contract with such individuals.

Timeliness and Availability Standards

Providers shall comply with the following appointment availability standards:

**Primary Care Providers**

Primary Care-Primary Care Providers should arrange appointments for:

- Urgent care within 24 hours of request.
- Routine care within 10 business days
- Health assessments and general physical examinations and first examinations within 3 weeks of enrollment
- EPSDT screens for new enrollees under the age of 21 within 45 days of enrollment unless the child is under the care of a Primary Care Providers and the child is current with screenings and immunizations
- Appointment for new enrollees known to be HIV positive or diagnosed with AIDS within 7 days of enrollment unless the member is under the active care of the Primary Care Provider
- Appointment for new Supplemental Security Income (SSI) enrollees within 45 days of enrollment unless the member is under the active care of the Primary Care Provider
Chapter 13: Participating Provider Responsibilities

- Emergency Care immediately upon the member’s presentation at a service delivery site or referral to an emergency facility.

Specialty Care
Specialists and specialty clinics should arrange appointments for:
- Urgent care within 24 hours of request.
- Routine care within 10 days of referral.
- Appointment for new enrollees known to be HIV positive or diagnosed with AIDS within 7 days of enrollment unless the member is under the active care of the specialist.
- Appointment for new SSI enrollee within 45 days of enrollment unless the member is under the active care of the specialist.

Prenatal Care
UnitedHealthcare Community Plan conducts proactive identification of pregnant women. Providers of prenatal care should arrange appointments for the initial prenatal visit after confirmation of pregnancy:
- High risk pregnancies – within 24 hours of identification of high risk status or immediately if an emergency exists.
- First trimester – within 10 business days.
- Second trimester – within 5 business days.
- Third trimester – within 4 business days.

Allowable Office Waiting Times
Members with appointments should not routinely be made to wait longer than 20 minutes, or no more than one hour when the provider must address an unanticipated urgent medical condition of another patient.

UnitedHealthcare Community Plan tracks and follows up on all instances of Primary Care Provider unavailability. UnitedHealthcare Community Plan also conducts periodic access surveys to ensure that all access and availability standards are met. Primary Care Provider are required to participate in all activities related to these surveys.

Medicaid Marketing Regulations
The Pennsylvania Office of Medical Assistance Programs (OMAP) prohibits MCOs from conducting direct mail, door-to-door, telephone or other cold-call marketing activities. MCOs are prohibited from distributing outreach materials without advance written approval of OMAP. All MCO outreach materials must be approved by OMAP.

Medicaid Recipient Restriction Program

If a provider suspects that a member is misusing or abusing the Medicaid benefit by obtaining prescriptions from multiple providers or requesting controlled substances for questionable indications, the provider should call the Fraud and Abuse Hotline at 844-347-8477 and (844-DHS-TIPS).

Additionally, UnitedHealthcare Community Plan monitors non-compliant members through the Recipient Restriction Program. The Recipient Restriction Program restricts a member to a single pharmacy and/or care provider for obtaining prescriptions. Stolen prescription pads and suspected forged prescriptions should be reported immediately to UnitedHealthcare Community Plan, using the phone number listed above.

UnitedHealthcare Community Plan will investigate the issue and take the appropriate action, which may include, but is not limited to:
1. Reporting the member to the state.
2. Enrolling the member in the UnitedHealthcare Community Plan Pharmacy Recipient Restriction Program.
3. Informing the appropriate provider network of the member’s activity.
4. Informing the Department of Human Services of member’s activity.

Provider Office Standards
UnitedHealthcare Community Plan requires a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities Act (ADA) standards. UnitedHealthcare Community Plan representatives conduct periodic site visits to ensure that each Primary Care Provider office meets ADA standards.

Advance Directives
The member has the right to make health care decisions and to execute advance directives. An advance directive is a formal document, completed by the member in advance of an incapacitating illness or injury.
- The provider should be aware of and maintain in the patient’s medical record a copy of the member’s completed advance directive.
- The provider should not send a copy to UnitedHealthcare Community Plan.
Members are not required to initiate an advance directive or proxy and cannot be denied care if they do not have an advance directive.

If a member believes that a provider has not complied with an advance directive, he or she may file a complaint with a Medical Director or his/her designee or UnitedHealthcare Community Plan.

Primary Care Provider Termination Process

Either the Primary Care Provider or the Health Plan may terminate the Provider Agreement according to contractual guidelines.

Medical Records and Documentation Standards

Providers must maintain medical records in a detailed and comprehensive manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Medical records must be legible, signed, and dated.

Providers must maintain medical records in paper form for at least 2 years before they are converted to any other form, and all forms must be readily available for review. Providers must maintain and preserve medical records for a minimum of 7 years from the termination of their provider agreement.

The provider will make medical records or copies of medical records available to UnitedHealthcare Community Plan, agents of the Pennsylvania Department of Human Services, the CMS, and any external quality review organization for purposes of assessing the quality of care rendered.

The following are basic requirements for an acceptable medical records system:

- Records are stored in a central file in locked, fireproof cabinets.
- If a computerized medical records system is utilized, the provider has established and enforces policies and procedures for saving, storing, securing, protecting, and retrieving medical records.
- Records are organized in a logical manner, by individual patient or family, or other acceptable medical records filing system.
The Role of the Primary Care Provider (PCP)

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

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

The Primary Care Provider is responsible for the provision of initial and basic care to a member who has selected the Primary Care Provider. The Primary Care Provider makes referrals for specialty and ancillary care, and coordinates all care delivered to members. The Primary Care Provider must provide 24-hour/7-day coverage and backup coverage when he or she is not available.

The Primary Care Provider is the point of entry into the delivery system, except for services allowing self-referral, emergencies, and out-of-area urgent care. UnitedHealthcare Community Plan expects:

- Primary Care Provider to communicate with specialists the reason for referral to the specialist by use of the prescription or letter
- Referral is to be notated to the patient's medical record
- The Specialist needs to communicate to the Primary Care Provider any significant findings and recommendations for continuing care (A specialist may refer the patient directly to another specialist)

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

Responsibilities of the Primary Care Provider

In addition to the requirements applicable to all providers, Primary Care Provider must:

- Conduct a baseline examination during the member’s first appointment. The Primary Care Provider should attempt to schedule this appointment if the new member fails to do so.
- Treat general health care needs of members listed on the Primary Care Provider’s panel roster
- Provide all EPSDT services to Medicaid members up to 21 years (including structured screenings for developmental delays and dental referrals where appropriate).
- Screen all children ages 9 months to 19 months and before their third birthday for lead toxicity
- Contact members identified as non-compliant with the EPSDT periodicity schedule and notify ACPA when they come into compliance. Document reasons for continued non-compliance.
- Refer to participating specialists for health problems not managed by the Primary Care Provider
- Complete the referral prescription form and assist the member in making an appointment.
- Document the reason for a specialist ‘referral’ and the outcome of the specialist intervention in the member’s medical record
- Coordinate each member’s overall course or plan of care
- Be available personally to accept UnitedHealthcare Community Plan members at each office location at least 20 hours a week
- Be available to members by telephone 24 hours a day, 7 days a week, or have on-call service or make arrangements with another UnitedHealthcare Community Plan participating Primary Care Provider (Recorded messages are NOT permitted)
- Respond to after-hour patient calls within 30–45 minutes for non-emergent symptomatic conditions and within 15 minutes for emergency situations
- Contact new members identified as not having an encounter during the first six months of enrollment, and all members identified as not having an encounter during the previous 12 months
- Identify and reschedule broken and no-show appointments
- Document procedures for monitoring patients’ missed appointments as well as outreach attempts to reschedule missed appointments
- Triage for medical and dental conditions and special behavioral needs for non-compliant individuals who are mentally deficient
• Educate members about appropriate use of emergency services
• Discuss available treatment options and alternative courses of care with members
• Refer services requiring prior authorization to the Pre-Certification Department, Behavioral Health Unit, or Pharmacy as appropriate. (UnitedHealthcare Community Plan recommends calling at least 5 days, but not later than 48 hours, in advance of the admission or surgery. The Primary Care Provider, Specialist, attending care provider, or the facility may appeal any adverse decision made by UnitedHealthcare Community Plan. Procedures for filing an appeal are in Provider Appeals)
• Inform UnitedHealthcare Community Plan Case Management at 800-366-7304 of any member showing signs of End Stage Renal Disease.
• Inform UnitedHealthcare Community Plan Case Management at 800-366-7304 of any member who requires a referral to a certified hospice
• Admit UnitedHealthcare Community Plan members to the hospital when necessary and coordinate the medical care of the member while hospitalized
• Assist the UnitedHealthcare Community Plan Case Manager in assessing a member’s needs and developing a plan for continuing care beyond discharge, if medically necessary
• Respect the Advance Directives of the member and document in a prominent place in the medical record whether or not a member has executed an advance directive form
• Provide covered benefits in a manner consistent with professionally recognized standards of health care and in accordance with standards established by UnitedHealthcare Community Plan
• Transfer medical records upon request. (Copies of members’ medical records must be provided to members upon request at no charge)
• Maintain staff privileges at a minimum of one UnitedHealthcare Community Plan participating hospital

**Pediatric Primary Care Medical Records Documentation Standards**

In addition to the requirements displayed in Appendix B, pediatric medical records documentation must include:

• Documentation of health and developmental history (mental and physical)
• Growth and development chart
• Documentation of physical exam
• Documentation of anticipatory guidance and health education
• Flow chart for immunizations
• Documentation of compliance with EPSDT guidelines for Medicaid members younger than 21 years old

**Primary Care Provider as Specialist**

If a care provider is credentialed as a specialist as well as a Primary Care Provider, the care provider can accept referrals from members whose Primary Care Provider is a different provider. If the Primary Care Provider wants to provide specialty services to members on his or her own panel, UnitedHealthcare Community Plan must give prior authorization for the specialty services in order for the care provider to receive payment.

The Primary Care Provider should call **800-366-7304**.
Responsibilities of Specialist Providers

In addition to the requirements applicable to all care providers; Specialist care providers must:

• Offer access to office visits on a timely basis, in conformance with the standards outlined in Timeliness Standards for Appointment Scheduling

• Provide specialty care medical services to UnitedHealthcare Community Plan members referred by the member’s Provider or who self-refer (for services not requiring a referral)

• Refer services requiring prior authorization to the Pre-Certification Department, Behavioral Health Unit, or Pharmacy as appropriate. UnitedHealthcare Community Plan recommends calling at least five days in advance of the admission or surgery. Refer to the Behavioral Health information in How To Contact Us.

• The care provider may appeal any adverse decision made by UnitedHealthcare Community Plan. Procedures for filing an appeal are in the section for Provider Appeals

• Provide the Primary Care Provider copies of all medical information, reports, and discharge summaries resulting from the specialist’s care

• Communicate in writing to the Primary Care Provider all findings and recommendations for continuing patient care and note them in the patient’s medical record

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

Specialists as Primary Care Providers

If a member has a life-threatening or degenerative and disabling condition or disease that requires prolonged specialized care, UnitedHealthcare Community Plan may authorize the member’s specialist to also serve as the Primary Care Provider. In these cases, a Medical Director or his/her designee must approve a treatment plan, in consultation with the Primary Care Provider, the specialist, and the member (or the member’s designee). UnitedHealthcare Community Plan will approve only specialists who are participating in UnitedHealthcare Community Plan’s network, unless no qualified specialist can be identified in the UnitedHealthcare Community Plan network.

After-Hours Coverage

Obstetricians must be available to members by telephone 24 hours a day, 7 days a week, or have arrangements for telephone coverage by another UnitedHealthcare Community Plan participating obstetrician. A Medical Director or his/her designee must approve coverage arrangements that vary from this requirement. Obstetricians are expected to respond to after-hour patient calls within 30-45 minutes for non-emergent symptomatic conditions and within 15 minutes for crisis situations.

UnitedHealthcare Community Plan tracks and follows up on all instances of specialist unavailability. UnitedHealthcare Community Plan also conducts periodic access surveys to ensure that all access and availability standards are met. Specialists are required to participate in all activities related to these surveys.
Chapter 16: Reporting Communicable Disease

You must ensure that all cases of reportable communicable disease that are detected or suspected in an enrollee by either a clinician or a laboratory are reported to the Pennsylvania Department of Health (DOH) as required by 28 PA Code, Chapter 27.

Any health care provider with reason to suspect that an enrollee has a reportable communicable disease or condition that endangers public health, or that an outbreak of a reportable communicable disease or public health-endangering condition has occurred, must submit a report to the Local morbidity reporting office (typically located within the Nearest DOH office) for the jurisdiction where the provider cares for the member.

The following diseases, infections and conditions are reportable by health care providers and health care facilities within 24 hours after being identified by symptoms, appearance or diagnosis:

- Animal bite.
- Anthrax.
- Arboviruses.
- Botulism.
- Cholera.
- Diphtheria.
- Enterohemorrhagic E. coli.
- Food poisoning outbreak.
- Haemophilus influenzae invasive disease.
- Hantavirus pulmonary syndrome.
- Hemorrhagic fever.
- Lead poisoning.
- Legionellosis.
- Measles (rubeola).
- Meningococcal invasive disease.
- Plague.
- Poliomyelitis.
- Rabies.
- Smallpox.
- Typhoid fever.

The following diseases, infections and conditions are reportable by health care providers and health care facilities within 5 work days after being identified by symptoms, appearance or diagnosis:

- AIDS.
- Amebiasis.
- Brucellosis.
- CD4 T-lymphocyte test result with a count of less than 200 cells/µL or a CD4 T-lymphocyte percentage of less than 14% of total lymphocytes (effective October 18, 2002).
- Campylobacteriosis.
- Cancer.
- Chancroid.
- Chickenpox (varicella) (effective January 26, 2005).
- Chlamydia trachomatis infections.
- Congential adrenal hyperplasia (CAH) in children under 5 years of age.
- Creutzfeldt-Jakob Disease.
- Cryptosporidiosis.
- Encephalitis.
- Galactosemia in children under 5 years of age.
- Giardiasis.
- Gonococcal infections.
- Granuloma inguinale.
- Guillain-Barre syndrome.
- HIV (Human Immunodeficiency Virus) (effective October 18, 2002).
- Hepatitis, viral, acute and chronic cases.
- Histoplasmosis.
- Influenza.
- Leprosy (Hansen’s disease).
- Leptospirosis.
- Listeriosis.
- Lyme disease.
- Lymphogranuloma venereum.
- Malaria.
Chapter 16: Reporting Communicable Disease

- Maple syrup urine disease (MSUD) in children under 5 years of age.
- Meningitis (All types not caused by invasive Haemophilus influenza or Neisseria meningitis).
- Mumps.
- Perinatal exposure of a newborn to HIV (effective October 18, 2002).
- Pertussis (whooping cough).
- Phenylketonuria (PKU) in children under 5 years of age.
- Primary congenital hypothyroidism in children under 5 years of age.
- Psittacosis (ornithosis).
- Rickettsial diseases.
- Rubella (German measles) and congenital rubella syndrome.
- Salmonellosis.
- Shigellosis.
- Sickle cell disease in children under 5 years of age.
- Staphylococcus aureus, Vancomycin-resistant (or intermediate) invasive disease.
- Streptococcal invasive disease (group A).
- Streptococcus pneumoniae, drug-resistant invasive disease.
- Syphilis (all stages).
- Tetanus.
- Toxic shock syndrome.
- Toxoplasmosis.
- Trichinosis.
- Tuberculosis, suspected or confirmed active disease (all sites).
- Tularemia.

A person who is in charge of a clinical laboratory in which a laboratory test of a specimen derived from a human body yields microscopical, cultural, immunological, serological, chemical, virologic, nucleic acid (DNA or RNA) or other evidence significant from a public health standpoint of the presence of a disease, infection or condition listed below must promptly report the findings, in most cases no later than the next work day after the close of business on the day on which the test was completed:

- Amebiasis.
- Anthrax.
- An unusual cluster of isolates.
- Arboviruses.
- Botulism – all forms.
- Brucellosis.
- CD4 T-lymphocyte test result with a count of less than 200 cells/µL or less than 14% of total lymphocytes (effective October 18, 2002).
- Campylobacteriosis.
- Cancer.
- Chancroid.
- Chickenpox (varicella).
- Chlamydia trachomatis infections.
- Cholera.
- Congenital adrenal hyperplasia (CAH) in children under 5 years of age.
- Creutzfeldt-Jakob disease.
- Cryptosporidiosis.
- Diphtheria infections.
- Enterohemorrhagic E. coli 0157 infections, or infections caused by other subtypes producing shiga-like toxin.
- Galactosemia in children under 5 years of age.
- Giardiasis.
- Gonococcal infections.
- Granuloma inguinale.
- HIV (Human Immunodeficiency Virus) (effective October 18, 2002).
- Haemophilus influenzae infections – invasive from sterile sites.
- Hantavirus.
- Hepatitis, viral, acute and chronic cases.
- Histoplasmosis.
- Influenza.
- Lead poisoning.
- Legionellosis.
- Leprosy (Hansen’s disease).
- Leptospirosis.
- Listeriosis.
- Lyme disease.
- Lymphogranuloma venereum.
- Malaria.
- Maple syrup urine disease (MSUD) in children under 5 years of age.
- Measles (rubeola).
Chapter 16: Reporting Communicable Disease

- Meningococcal infections – invasive from sterile sites.
- Mumps.
- Pertussis.
- Phenylketonuria (PKU) in children under 5 years of age.
- Primary congenital hypothyroidism in children under 5 years of age.
- Plague.
- Poliomyelitis.
- Psittacosis (ornithosis).
- Rabies.
- Respiratory syncytial virus.
- Rickettsial infections.
- Rubella.
- Salmonella.
- Shigella.
- Sickle cell disease in children under 5 years of age.
- Staphylococcus aureus Vancomycin-resistant (or intermediate) invasive disease.
- Streptococcus pneumoniae, drug-resistant invasive disease.
- Syphilis.
- Tetanus.
- Toxoplasmosis.
- Trichinosis.
- Tuberculosis, confirmation of positive smears or cultures, including results of drug susceptibility testing.
- Tularemia.
- Typhoid.

UnitedHealthcare Community Plan supports, and will assist, the Department of Health’s reporting requirements and efforts. In addition to the general information supplied here, all providers are urged to be familiar and complaint with the Department’s rules regarding such reporting.

The full text of these rules can be found at: http://www.pacode.com/secure/data/028/chapter27/subchapBtoc.html.

Providers with questions related to this requirement may contact UnitedHealthcare Community Plan via the Special Needs Unit hotline, 877-844-8844.
Preventive Health Care Standards

UnitedHealthcare Community Plan’s goal is to partner with providers to ensure that members receive preventive care. UnitedHealthcare Community Plan endorses the practice of preventive health standards recommended by recognized medical and professional organizations and monitors the provision of these services through chart reviews and analysis of encounter data. UnitedHealthcare Community Plan periodically reviews and updates these guidelines and distributes them to providers.

EPSDT at a Glance

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program provides comprehensive, periodic preventive, acute, and chronic care services for children under 21 who are eligible for Medical Assistance. The program attempts to discover and treat health problems before they become disabling and, therefore, more costly to treat.

The program examines all aspects of a child’s wellbeing and addresses any problems that are discovered. Age appropriate assessments, known as “screens,” must be provided at intervals following defined periodicity schedules. Additional examinations are also required whenever a health care provider suspects the child may have a health problem. Treatment for all Medically Necessary services discovered during an EPSDT screening is also covered. All Medically Necessary immunizations are required.

EPSDT services will be accomplished following the regulations and guidelines of all applicable state, federal and contractual requirements; Centers for Medicare and Medicaid; Department of Insurance (DOI) and Department of Human Services (DHS) and the guidelines of the National Committee for Quality Assurance (NCQA).

Provider Responsibilities in the EPSDT Program

All UnitedHealthcare Community Plan of Pennsylvania providers must comply with the following responsibilities:

• Provide primary and preventive care to eligible plan members
• Coordinate and monitor the member’s physical and behavioral health care needs
• Perform and report all EPSDT screens in the appropriate format, including all applicable procedure codes and modifiers
• Provide childhood blood lead poisoning prevention services in accordance with the DHS’s EPSDT program requirements and guidelines established by the Centers for Disease Control (CDC)
• Medical Record Documentation - All services submitted on the EPSDT claim must be reflected in the medical record for that child as well as referrals to specialists
• In cases of suspected developmental delay or elevated blood lead levels, the PCP must contact CONNECT at 800-692-7288 to refer the child for early intervention services
• Arrange all medically necessary follow-up care
• If necessary, provide the member’s parent (or guardian) with information on how to access mental health services, or inform the appropriate county children and youth agency in cases of neglect or abuse

EPSDT Screenings Must Include the Following

Under Pennsylvania and federal laws, the EPSDT program must provide the following services according to a periodicity schedule developed by the DHS as recommended by the American Academy of Pediatrics.

• Screening services, including a comprehensive health and developmental history, including both physical and mental development, nutritional assessment, and all appropriate immunizations according to age and health history
• An unclothed physical exam
• Laboratory tests, including hemoglobin and hematocrit, urinalysis, iron levels, TB skin testing, sickle cell anemia screening, blood lead level testing and HIV Screening
• Health education including anticipatory guidance
• Vision services, including diagnosis and treatment for defects in vision, and eye exams for the provision of glasses
• Hearing services, including diagnosis and treatment for defects in hearing, and testing or the provision of hearing aids
• Dental risk assessment for 6-8 months and 9-11 months of age
• Dental screening, including diagnosis and treatment of dental disease (First Exam recommended at the time of the eruption of the 1st tooth and no later than 12 mo.)
• Dental screening, including diagnosis and treatment of dental disease (oral exam beginning at the eruption of the first tooth)
• Dental Care (referral to dentist for dental screening is required annually for all children aged 3 years and older as part of a complete EPSDT screen)
• Autism Screening
• Developmental Screening
• Mental health services, including counseling. Referral to behavioral health or medical providers to correct or ameliorate any problems discovered upon the screen, including those not covered on the Medical Assistance fee for-service program
• Teenage pregnancy services or referral for those services
• All other medically necessary health care, diagnostic services, and treatment measures
• Depression Screening

For screening eligibility information and services required for a complete EPSDT screen, please consult the:
• EPSDT Program Periodicity Schedule and Coding Matrix
• Recommended Childhood Immunization Schedule

You may direct EPSDT program specific questions to UnitedHealthcare Community Plan Provider Services Department at 800-600-9007 or access our EPSDT Quick Reference Guide on our website at http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/Bulletins/PA-Bulletins/PA%20DHS_Bulletin_EPSDT.pdf

Dental Periodicity Schedule per the American Academy of Pediatric Dentistry: apd.org/media/Policies_Guidelines/G_Periodicity.pdf

Additional information is available at: Bright Futures/American Academy of Pediatrics: Periodicity Schedule aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf


In cases of suspected developmental delay or elevated blood lead levels (lead level >10), the PCP must contact CONNECT at 800-692-7288 to refer the child for early intervention services.

EPSDT Billing Guidelines
(Refer to current EPSDT Periodicity Schedule and coding matrix)

Claim must have a diagnosis code of Z76.1, Z76.2, of Z00.129 as the primary diagnosis code.
### CPT Codes

<table>
<thead>
<tr>
<th>New Patient</th>
<th>Established Patient</th>
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<td>99381 Age &lt; 1 year</td>
<td>99391 Age &lt; 1 year</td>
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<tr>
<td>99382 Age 1-4 years</td>
<td>99392 Age 1-4 years</td>
</tr>
<tr>
<td>99383 Age 5-11 years</td>
<td>99393 Age 5-11 years</td>
</tr>
<tr>
<td>99384 Age 12-17 years</td>
<td>99394 Age 12-17 years</td>
</tr>
<tr>
<td>99385 Age 18-20 years</td>
<td>99385 Age 18-20 years</td>
</tr>
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### EPSDT Modifiers

(Must be included on the claims line for all EPSDT Services)

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Definition</th>
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<tr>
<td>EP</td>
<td>Complete EPSDT Screen</td>
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<tr>
<td>52</td>
<td>Incomplete Screening</td>
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<tr>
<td>90</td>
<td>Outpatient Lab</td>
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<td>Autism</td>
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### Referral Codes

(Must be included on the claim Block 10d)

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<td>YD</td>
<td>Dental Referral</td>
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<tr>
<td>YM</td>
<td>Medical Referral</td>
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<tr>
<td>YV</td>
<td>Vision Referral</td>
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<td>YH</td>
<td>Hearing Referral</td>
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<tr>
<td>YB</td>
<td>Behavioral Health Referral</td>
</tr>
<tr>
<td>YO</td>
<td>Other Referral</td>
</tr>
</tbody>
</table>

**Billing Notes**

- If you detect an illness during the well visit, do not change the coding from a well visit to a sick visit. Use Z76.1 as the primary diagnosis code. The second diagnosis is then determined by the detected illness.
- Claim should include the customary fee for the EPSDT E&M codes. Payment of EPSDT claims will be subject to the lower of the customary fee or either (1) the contracted fee or (2) the fee required under PPACA requirements.
- The 52 and 90 modifiers for lab services must be used, where appropriate, in order for the claim to be paid in full.
• EPSDT referral codes (block 10d of CMS-1500), including, but not limited to: YD (dental referral), YM (medical referral), YV (vision referral), YH (hearing referral), YB (behavioral health referral), YO (other referral) must be included on the claim.
• Enter Visit Code 03 (Block 24h of CMS-1500) when providing EPSDT services.
• Newborn EPSDT screens performed in the inpatient hospital setting, ICD Z38.00 must be used as primary with Z76.1, Z76.2, or Z00.129 as a secondary field. Submit CPT code 99460 Newborn Care (during the admission) 99463 Newborn Care (same day as discharge).
• The Autism Screening is required for the 18-month and 24-month visit. This screening must be billed with CPT code 96110 with a U1 modifier.

For screening eligibility information and services required for a complete EPSDT screen, please consult the:
• EPSDT Program Periodicity Schedule and Coding Matrix
• Recommended Childhood Immunization Schedule
• You may direct EPSDT program specific questions to UnitedHealthcare Community Plan Provider Services Department at 800-600-9007.

Submit claims within 90 days of the date of service to:
UnitedHealthcare Community Plan
P.O. Box 8207
Kingston, NY 12402

Vaccines for Children (VFC) Program (Medicaid only)

Under Pennsylvania’s VFC program, vaccines are provided free of charge to providers for Medicaid members 0-18 years of age. Vaccines obtained through the VFC program are not billable.

To enroll in the PA VFC Program, please contact the PA VFC Line at 888-646-6864.

Philadelphia County only – Visit Philadelphia Vaccines for Children Program for more information.

CMS requires state Medicaid programs to reimburse for Vaccines for Children (VFC) services on administration codes 90460, 90471, 90472, 90473, and/or 90474 rather than the serum/toxoid code. Per the Patient Protection and Affordable Care Act (PPACA), CPT code 90461 is not reimbursable for VFC services. While some states will reimburse for all of these administration codes, some will only reimburse for 90460. For further details, please refer to updates posted by your State Fee-for-Service Medicaid Plan or see our reimbursement policy on UHCCommunityPlan.com. If you have any questions, please contact your Provider Relations or Network Management representative.

To enroll in the PA VFC Program, please contact the PA VFC Line at 888-646-6864.

Philadelphia County only – Visit Philadelphia Vaccines for Children Program for more information.

CMS requires state Medicaid programs to reimburse for Vaccines for Children (VFC) services on administration codes 90460, 90471, 90472, 90473, and/or 90474 rather than the serum/toxoid code. Per the Patient Protection and Affordable Care Act (PPACA), CPT code 90461 is not reimbursable for VFC services. While some states will reimburse for all of these administration codes, some will only reimburse for 90460. For further details, please refer to updates posted by your State Fee-for-Service Medicaid Plan or see our reimbursement policy on UHCCommunityPlan.com. If you have any questions, please contact your Provider Relations or Network Management representative.
Key Points to Remember:

- There must be both an administration code AND a serum code on the claim for all VFC claims (check your state requirements for which administration codes and serum codes are appropriate).
- Administration codes should be submitted on the same line with multiple units wherever possible to avoid potential duplicate denials.
- If your state requires this, an appropriate modifier MUST be appended to the serum and/or administration code(s) (e.g. SL).
- In order to appropriately track the information for the Healthcare Effectiveness Data and Information Set (HEDIS), Early Periodic Screening, Diagnosis and Treatment (EPSDT), and encounters, the claim form submitted should reflect the appropriate vaccination code with the modifier SL appended with a charge of $0.01 for the state-supplied vaccine, in addition to the appropriate code for administration of the vaccine. This will ensure administration reimbursement is processed accurately and that the state-supplied vaccine/serum is captured appropriately.
- All reimbursement for VFC immunizations will be made on the administration codes for ALL markets, effective for claims processed on or after May 18, 2013, beginning with Jan. 1, 2013 dates of service. Claims for dates of service prior will be processed as they had previously.

UnitedHealthcare Community Plan will reimburse Primary Care Providers who are billed for immunization biologicals not obtained through the VFC program. Primary Care Providers may request reimbursement by submitting an electronic claim or HCFA 1500 form or electronic claim. UnitedHealthcare Community Plan will make payment according to the UnitedHealthcare Community Plan fee schedule for immunizations.

UnitedHealthcare Community Plan will periodically monitor claims to assure that Primary Care Providers do not bill UnitedHealthcare Community Plan for immunizations that have been paid by or billed to another source.

Clinical Practice Guidelines

UnitedHealthcare Community Plan, using recognized sources, reviews, adopts and disseminates clinical practice guidelines to be followed by participating providers that are relevant to our enrolled membership.

All guidelines with links to the sites are posted on our website at UHCCommunityPlan.com; for hard copies call the Provider Helpline at 800-600-9007.
Chapter 18: Provider Appeals

UnitedHealthcare Community Plan operates three internal processes to review appeals by providers dissatisfied with UnitedHealthcare Community Plan’s decisions. Please see the different types as outlined below:

1. **Claims Administrative Appeals** – Appeals of claims regarding denials that do not involve UnitedHealthcare Community Plan’s determination of medical necessity. Typical denials include late filing or alleged inappropriate type or level of payment. Appeals of this type are addressed Claims Administrative Appeals.

2. **Appeals of Adverse Professional Review Action** – Appeals of decisions against a provider for quality concerns are addressed in the Quality Management Section.

3. **Provider Dispute to Participation Agreement Termination**

**Claims Administrative Appeals**

It is UnitedHealthcare Community Plan’s goal to identify, eliminate, and prevent dissatisfaction of providers making every effort to maintain open and intense lines of communication with providers.

If you submit a claim and receive either a payment or a denial for payment that you do not agree with, you should first utilize the claims reconsideration process, as well as utilize the following resources:

- Visit our secure web site for care providers and other health care professionals at [UHCCommunityPlan.com](http://UHCCommunityPlan.com).
  This is your best source for checking patient eligibility information, claim status, and filing claim adjustment requests. When you access the provider page at the site, you will find additional information about Claim Reconsiderations and links to instructions and forms to help you make a request.

*Many of the same transactions can also be completed by calling our toll free Provider Services Department at 800-600-9007.*

If you call about a claim issue, be sure to have the supporting documentation needed for prompt resolution of the matter. If you are not satisfied with the outcome of a Claim Reconsideration Request, you may submit a formal Claim Dispute/Appeal using the process outlined in this manual.

A formal Claim Dispute/Appeal is a comprehensive review of the disputed claim(s), and may involve a review of additional administrative or medical records by a clinician or other personnel.

You may send letters of appeal to this address:

UnitedHealthcare
Community Plan of Pennsylvania
P. O. Box 31364
Salt Lake City, UT 84131-0364

If you are not satisfied with the outcome of a Claim Reconsideration Request, you may submit a formal Claim Dispute/Appeal using the process outlined in your provider manual.

Your appeal must be submitted to us in writing within contractual guidelines from the date of payment shown on the EOB or PRA or within the time frame stated in your provider contract. Please include all information supporting your appeal.

For example, if you are appealing a claim that was denied because filing was not timely, for:

- **Electronic claims** – include confirmation that UnitedHealthcare Community Plan 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.

UnitedHealthcare Community Plan generally completes the review within 30 calendar days. However, depending on the nature of the review, a decision may take up to 60 days from the receipt of the claim dispute documentation. We will contact you if we believe it will take longer than 30 days to render a decision.

**Please allow 10 business days from the submission date to enable us to begin processing the review before requesting a status update.**

If you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed as described in your contract.
Chapter 18: Provider Appeals

Appeals of Adverse Professional Review Action

Providers may request review of a UnitedHealthcare Community Plan credentialing decision or other UnitedHealthcare Community Plan professional review action. Professional review actions are peer review actions subject to all protections provided by law and are reviewed pursuant to the UnitedHealthcare Community Plan Quality Improvement provider dispute process (as amended from time-to-time). Currently, such disputes are reviewed by a panel of UnitedHealthcare Community Plan-participating providers. Providers have the right to (1) appear and participate in person; (2) submit evidence, written and verbal; and (3) be represented by an attorney in such proceedings. Providers seeking review of professional review actions should submit their dispute in writing via certified mail within 30 days of the date of the professional review action notice to:

UnitedHealthcare
Community Plan of Pennsylvania
P. O. Box 31364
Salt Lake City, UT 84131-0364

The provider will receive a hearing notice setting the time, date and place of the hearing and relating the provider’s rights during the hearing process. A hearing will be held at least 30 days from the date of the hearing notice.

Provider Contract Termination

If we terminate your network participation agreement, you may have an opportunity to appeal this decision under state law. We will notify you of your rights and our appeals process, in accordance with applicable state laws.

Credentialing and Re-Credentialing

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

For appeals related to medical necessity decisions, a provider may choose one of two avenues:

1. Informal Dispute Resolution Process (IDR) is a contractually agreed upon method to resolve disputes.

2. Provider-Initiated Member Appeals is the Act 68 process as specified in Pennsylvania Department of Health regulations.

A care provider must choose either the Informal Dispute Resolution Process or Provider-Initiated Member Appeal process. Providers cannot use both methods for the same appeal.
Informal Dispute Resolution Process (IDR) or Provider Payment Dispute Process

Any care provider who disagrees with one of UnitedHealthcare Community Plan’s Medical Management decisions has a right to file an IDR appeal. These are appeals to contest UnitedHealthcare Community Plan’s determination of medical necessity. Examples include a decision by a UnitedHealthcare Community Plan Medical Director or his/her designee or care provider advisor that an admission, extension of stay, level of care (acute vs. sub-acute), or other health care service, based on review of the information available to UnitedHealthcare Community Plan, is not medically necessary or is considered experimental or investigational.

An IDR appeal must be initiated within forty-five (45) days from the date that UnitedHealthcare Community Plan notified the provider of the adverse determination. It may be initiated as follows:

1. If the attending or a treating care provider feels that waiting up to 30 calendar days to decide the appeal could seriously risk the member’s life or health, including his/her ability to reach, keep, or get back to maximum function, the care provider must tell us this when asking for an appeal. If we agree, we will expedite or make a decision sooner (within two days) on your appeal.

2. A written request for an IDR appeal mailed to the UnitedHealthcare Community Plan.

Mail the Appeal to:

UnitedHealthcare Community Plan of Pennsylvania
P. O. Box 31364
Salt Lake City, UT 84131-0364

All medical necessity decisions and administrative appeal must be in writing and contain the following information:

- Member name and UnitedHealthcare Community Plan member ID number.
- Provider name and Provider ID number.
- Provider’s address and phone number.
- Requested procedure or service.
- Date of denial (if known).
- Diagnosis and medical justification for the procedure or service.
- Additional information the provider wishes considered.
- A copy of the original denial letter.

The IDR Appeal Process (First Level)

UnitedHealthcare Community Plan will conclude first level appeals as soon as possible after receipt of all necessary information. The review time will not exceed thirty (30) days.

- Within five business days after the first level decision, UnitedHealthcare Community Plan will send a written decision on the first level appeal to the provider. The Medical Director or his/her designee rendering an appeal decision will respond in writing either to reinstate part or all of the denied services or to affirm the denial.
- A health care professional who was not involved in the initial UM determination will review the first level appeal.

The IDR Appeal Process (Second Level)

- If the provider disagrees with UnitedHealthcare Community Plan’s first level appeal decision, the provider can file a second level IDR Appeal.
- UnitedHealthcare Community Plan must receive the written request for a second level appeal within 45 days of receipt of written notice of denial of the first level appeal.
- A panel of health care professionals who were not involved in the initial UM determination will review the second level appeal.
- UnitedHealthcare Community Plan will notify the provider in writing of the time, date and place of the second level panel meeting.
- The provider will receive this notification within seven (7) days prior to the date of the meeting.
- All second level appeals will be concluded as soon as possible after receipt by UnitedHealthcare Community Plan and will not exceed 45 days after the receipt of all necessary information.
- Within five business days after the second level decision, UnitedHealthcare Community Plan will send a written decision on the second level appeal to the provider.
- The panel rendering an appeal decision will respond in writing either to reinstate some or all of the denied services or to affirm the denial. Decisions of the second level committee are final and binding.
Provider-Initiated Member Grievance (Act 68 Process)

Pennsylvania Act 68 gives providers the right, with the written permission of the member, to pursue a grievance in lieu of the member. A provider may ask for a member’s written consent in advance of treatment but may not require a member to sign a document allowing the filing of a grievance as a condition of treatment. The regulatory requirements for providers apply to items that must be in the document giving the provider permission to pursue a grievance, and the time frames for member notification of provider intent to pursue or not pursue a grievance.

These are important because under this scenario the provider assumes the grievance and appeal rights of the member. However, the member may rescind the consent at any time. The Act 68 Process applies to Medicaid and CHIP members. A form by which a member may consent to a provider-initiated Act 68 Complaint or Grievance, compliant with the regulatory requirements, is available in the appendices of this Administrative Guide.

A provider who uses this process to file an appeal may not also, for the same matter, use the provider IDR process described above.

Provider Responsibilities Under Provider-Initiated Member Appeals (Act 68 Process)

If a health care provider assumes responsibility for filing a grievance, the health care provider may not bill the member for services that are the subject of the grievance.

Medicaid and CHIP Members May Not be Billed or Balance Billed for Covered Services at Any Time

If the health care provider is prohibited from billing the member or chooses never to bill the member for the services that are the subject of the grievance, the health care provider may drop the grievance with notice to the member or the member's legal representative.

Any member can ask another person to act as his/her representative in the appeals process ("member’s representative"). If this representative is a health care provider, the provider must obtain the member’s written consent to pursue a grievance. The member’s, or the member’s legal representative, if the member is a minor or is legally incompetent, consent to a health care provider to pursue a grievance must be in writing, and is automatically rescinded upon the failure of the health care provider to file or pursue a grievance.

The consent document giving the health care provider authority to pursue a grievance on behalf of a member must include each of the following elements:

1. The name and address of the member, the member’s date of birth and the member’s identification number.
2. If the member is a minor, or is legally incompetent, the name, address and relationship to the member of the person who signs the consent for the member.
3. The name, address and identification number of the health care provider to whom the member is providing the consent.
4. The name and address of the plan to which the grievance will be submitted.
5. An explanation of the specific service for which coverage was provided or denied to the member to which the consent will apply.
The following statements must be in the consent document:

1. The member or the member’s representative may not submit a grievance concerning the services listed in this consent form unless the member or the member’s legal representative rescinds consent in writing. The member or the member’s legal representative has the right to rescind consent at any time during the grievance process.

2. The consent of the member or the member’s legal representative is automatically rescinded if the provider fails to file a grievance, or fails to continue to prosecute the grievance through the second level review process.

3. The member or the member’s legal representative, if the member is a minor or is legally incompetent, has read, or has been read this consent form, and has had it explained to his/her satisfaction. The member, or the member’s legal representative understands the information in the member’s consent form.

The consent document must also have the dated signature of the member, or the member’s legal representative if the member is a minor or is legally incompetent, and the dated signature of a witness. The member may rescind consent at any time during the grievance process. If the member rescinds consent, the member may continue with the grievance at the point at which consent was rescinded. The member may not file a separate grievance. A member who has filed a grievance may, at any time during the grievance process, choose to provide consent to a health care provider to continue with the grievance instead of the member. The member’s legal representative may exercise the rights conferred upon the member.

Provider-Initiated Member Appeals (Act 68 Process) – First Level
The member, member’s representative, or health care provider with written consent of the member, may file a written grievance with UnitedHealthcare Community Plan. A grievance is a request to have UnitedHealthcare Community Plan reconsider a decision solely concerning the medical necessity and appropriateness of a health care service.

A grievance may be filed by calling 800-414-9025, or by submitting in writing to:

UnitedHealthcare Community Plan of Pennsylvania
P.O. Box 31364
Salt Lake City, UT 84131-0364

A grievance may be filed regarding a decision to:

1. deny, in whole or in part, payment for a service (if based on lack of medical necessity)

2. deny or issue a limited authorization of a requested service, including the type or level of service

3. reduce, suspend, or terminate a previously authorized service

4. deny the requested service but approve an alternate service.

The member, member’s representative, or health care provider with written consent of the member, must file a grievance within 45 days of the medical management decision or from the date of receipt of notification about the medical management decision.

If the grievance (at first or second levels) is filed within 10 days of the decision or receiving notice of the decision, and the grievance is about a currently authorized service, Medicaid members will continue to receive service while the appeal is being considered. There is a similar right for Medicaid members if a member had filed a complaint to dispute a decision to discontinue, reduce, or change a service because it is not/or is no longer a covered benefit. If this type of complaint is filed within 10 days of receiving the decision (first or second levels) the Medicaid member must continue to receive the disputed service/item at the previously authorized level pending resolution of the complaints.

There is also an Expedited Grievance Process detailed at the end of this section.

The provider, having obtained consent from the member or the member’s legal representative to file a grievance, has 10 days from receipt of the standard written denial and any decision letter from a first level, second level, or external review to notify the member or the member’s legal representative of its intention not to pursue a grievance.

UnitedHealthcare Community Plan will send written confirmation of its receipt of the grievance to the member, the member’s representative (if the member has designated one), and the health care provider, if the health care provider filed the grievance with member consent, upon receipt of the grievance. The notification will include the following information:

- That UnitedHealthcare Community Plan considers the matter to be a grievance (rather than a complaint). The member, the member’s representative, or health care provider, may question the classification of complaints and grievances by contacting the Pennsylvania Department of Health.
- That the member may appoint a representative to act on the member’s behalf at any time during the internal grievance process.
• That the member, the member’s representative, or the health care provider that filed the grievance with member’s consent, may review information related to the grievance upon request and submit additional material to be considered by UnitedHealthcare Community Plan.

• That the member or the member’s representative may request the aid of an UnitedHealthcare Community Plan employee who has not participated in the medical management decision to assist in preparing the member’s first level grievance.

The first level grievance review shall be performed by a UnitedHealthcare Community Plan initial review committee. The members of the committee will not have been involved in any prior decision relating to the grievance. The committee will include a licensed care provider or an approved licensed psychologist, practicing in the same or similar specialty who would typically consult on the health care services in question. UnitedHealthcare Community Plan will provide the member, the member’s representative, or a health care provider that filed a grievance with member consent, access to all information relating to the matter being grieved and will allow the provision of written data or other material in support of the grievance. The member, the member’s representative, or the health care provider may specify the remedy or corrective action being sought.

UnitedHealthcare Community Plan will provide, at no charge, at the request of the member or the member’s representative, an employee who has not participated in previous denial decisions regarding the issue in dispute, to aid the member or the member’s representative in preparing the member’s grievance.

The Member must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The PH-MCO shall be flexible when scheduling the review to facilitate the Member’s attendance. The Member shall be given at least seven (7) days advance written notice of the review date. If the Member cannot appear in person at the review, an opportunity to communicate with the first level Grievance review committee by telephone or video conference must be provided. The Member may elect not to attend the first level Grievance meeting but the meeting must be conducted with the same protocols as if the Member was present.

UnitedHealthcare Community Plan will complete its review and investigation, and arrive at a decision within 30 days of the receipt of the grievance. The member, the member’s representative or the health care provider appealing with the written consent of the member, may request a 14 day extension. UnitedHealthcare Community Plan will notify the member, the member’s representative, and the health care provider of the decision of the internal review committee in writing within 5 business days of the committee’s decision not to exceed the 30 days of the receipt of the grievance.

The notice to the member, the member’s representative, and the health care provider, will include the basis for the decision and the procedures for the member or provider to file a request for a second level review of the decision of the initial review committee including:

• A statement of the issue reviewed by the first level review committee
• The specific reasons for the decision
• References to the specific UnitedHealthcare Community Plan provisions on which the decision is based and how to obtain these documents, if used.
• An explanation of the scientific or clinical judgment for the decision
• An explanation of how to file a request for a second level review of the decision which must be filed within 45 days of receipt of the first level decision.

The Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the PH-MCO’s first level Grievance decision.

Provider-Initiated Member Appeals (Act 68 Process) – Second Level Review

Upon receipt of a second level grievance, UnitedHealthcare Community Plan will send the member, the member’s representative, and the health care provider, an explanation of the procedures to be followed during the second level review. This explanation will include the following information:

• How to request the aid of a UnitedHealthcare Community Plan employee who has not participated in any discussion of the issue in dispute in preparing the member’s second level grievance.

• Notification that the member, the member’s representative, and the health care provider have the right to appear before the second level review committee and that UnitedHealthcare Community Plan will provide the member, the member’s representative, and the health care provider with 15 days advance written notice of the time scheduled for the review.

The second level review committee shall be made up of three or more individuals who did not previously participate in the decision to deny coverage or payment for the issue in dispute. The committee will include a licensed care provider or
a licensed psychologist, practicing in the same or similar specialty who would typically consult on the health care services in question. The second level review allows the following:

- The member, the member’s representative, and the health care provider have the right to be present at the second level review, and to present a case.
- UnitedHealthcare Community Plan shall notify the member, the member’s representative, and the health care provider at least 15 days in advance of the date scheduled for the second level review.
- That the member, the member’s representative, or the health care provider that filed the grievance with member’s consent, may review information related to the grievance upon request and submit additional material to be considered by UnitedHealthcare Community Plan.

UnitedHealthcare Community Plan will make reasonable accommodation to facilitate the participation of the member, the member’s representative, and the health care provider by conference call or in person. UnitedHealthcare Community Plan will take into account the member’s access to transportation and any disabilities or language barriers. If the member, the member’s representative or filing health care provider cannot appear in person at the second level review, UnitedHealthcare Community Plan will provide the member, the member’s representative or the provider, the opportunity to communicate with the review committee by telephone or other appropriate means.

Attendance at the second level review is limited to:

- members of the review committee who are not employed by the Plan.
- appropriate UnitedHealthcare Community Plan representatives.
- the member, or the member’s representatives, including any legal representative and/or attendant necessary for the member to participate in or understand the proceedings.
- the health care provider who filed the grievance with the member’s consent.
- applicable witnesses.

The committee may not discuss the case to be reviewed prior to the second level review meeting. A committee member who does not personally attend the review meeting may not vote on the case unless that person actively participates in the review meeting by telephone or video conference and has the opportunity to review any additional information introduced at the review meeting prior to the vote. UnitedHealthcare Community Plan may provide an attorney to represent the interests of the committee but the attorney may not argue UnitedHealthcare Community Plan’s position, or represent UnitedHealthcare Community Plan or UnitedHealthcare Community Plan staff. The committee may question the member, the member’s representative, the health care provider, and UnitedHealthcare Community Plan staff. The committee will base its decision solely upon the materials and testimony presented at the review. The proceedings will be recorded electronically and then summarized. The summary will be maintained as a part of the grievance record to be forwarded upon a request for an external grievance review.

UnitedHealthcare Community Plan will complete the second level grievance review and arrive at its decision within 45 days of receipt of the request for the review. UnitedHealthcare Community Plan will notify the member, the member’s representative, and the health care provider of the decision of the second level review committee in writing within 5 business days of the committee’s decision.

UnitedHealthcare Community Plan will include the basis for the decision and the procedures and time frames for the member, the member’s representative, or the health care provider, to file a request for an external grievance review including the following:

- A statement of the issue reviewed by the second level review committee.
- The specific reasons for the decision.
- References to the specific UnitedHealthcare Community Plan provisions on which the decision is based and how to obtain these documents, if used.
- An explanation of the scientific or clinical judgment for the decision, applying the terms of the plan to the member’s medical circumstances.
- The Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the PH-MCO’s second level Grievance decision.

**Expedited Grievances (Act 68 Process)**

The member, member’s representative, or health care provider can file at Expedited Grievance with UnitedHealthcare Community Plan by calling 800-414-9025 or by faxing to 800-757-2617.

The member, member’s representative, or health care provider may request an expedited review at any stage of the plan’s review process if the member’s life, health or ability to regain maximum function would be placed in
jeopardy by delay occasioned by the review process. In order to obtain an expedited review, the member, the member’s representative or the health care provider, must provide UnitedHealthcare Community Plan with a written certification from the member’s care provider that the member’s life, health or ability to regain maximum function would be placed in jeopardy by delay. The certification must include the clinical rationale and facts to support the care provider’s opinion.

A Member who files a request for expedited review of a Grievance to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the Grievance, if the request for expedited review of a Grievance is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

The expedited grievance will be put into written form and be reviewed by three or more individuals who did not previously participate in the decision to deny coverage or payment for the issue in dispute. The committee will include a licensed care provider or a licensed psychologist, practicing in the same or similar specialty who would typically consult on the health care services in question. The Expedited Grievance Process will follow the process described above in Provider-Initiated Member Appeals (Act 68 Process) – Second Level Review, with the following exceptions:

- **Time frame is 48 hours for a decision.**
- **The hearing may be held telephonically if the member cannot be present in the short time frame (All information presented at the hearing is read into the record).**
- **If UnitedHealthcare Community Plan cannot provide a copy of the report of the same or similar specialist to the member prior to the expedited hearing, the plan may read the report into the record at the hearing, and shall provide the member with a copy of the report at that time.**
- **It is the responsibility of the member, the member’s representative, or the health care provider to provide information to UnitedHealthcare Community Plan in an expedited manner to allow the plan to conform to the requirements of this section.**

An expedited internal review will be conducted within either 48 hours of receiving the Provider certification or three Business Days of receiving a request from the Member, the member’s representative, or health care provider, with written consent of the member, for an expedited review, whichever is shorter.

The PH-MCO must mail written notice of the decision to the Member, the Member’s representative, if the Member has designated one, and the member’s health care provider within two days of the decision. Pennsylvania Act 68 allows for an external grievance process by which a Medicaid/CHIP member, member’s representative, or a health care provider with the written consent of the member, may request an external review of a denial of an expedited grievance. If the external grievance is being requested by a health care provider, UnitedHealthcare Community Plan and the health care provider must each establish escrow accounts in the amount of half the anticipated cost of the review.

The notification to the member, member’s representative, or health care provider will state the basis for the decision, including any clinical rationale, and the procedure for obtaining an expedited external review and a DHS Fair Hearing (if applicable). The member, member’s representative, or health care provider with written consent of the member, has 2 business days from the receipt of the expedited grievance decision to request an expedited external review and a DHS Fair Hearing. **If the CRE’s decision in an external grievance review filed by a health care provider is against the health care provider in full, the health care provider shall pay the fees and costs associated with the external grievance.** Regardless of the identity of the grievant, if the CRE’s decision is against UnitedHealthcare Community Plan in full or in part, UnitedHealthcare Community Plan will pay the fees and costs associated with the external grievance review.

For Expedited External Review requests, UnitedHealthcare Community Plan will submit a request for an expedited external review to the Pennsylvania Department of Health by fax transmission and telephone within 24 hours of receipt of the member’s, member’s representative, or health care provider’s, with written consent of the member, request. The Department of Health will assign a certified review entity (CRE) within 1 business day of receiving the request for an expedited review. The CRE will have 2 business days following the receipt of the case file to make a decision.

**External Grievances (Act 68 Process)**

Pennsylvania Act 68 allows for an external grievance process by which a Medicaid/CHIP member, member’s representative, or a health care provider with the written consent of the member, may request an external review of a denial of a second level grievance. The external grievance process shall adhere to the following standards:

A member, the member’s representative or the health care provider who filed the grievance, have 15 days from receipt.
Chapter 18: Provider Appeals

of the second level grievance review decision to file with UnitedHealthcare Community Plan a request for an external review. If the request for an external grievance is being filed by a health care provider, the health care provider shall provide the name of the member involved and a copy of the member’s written consent for the health care provider to file the external grievance.

Within 5 business days of receiving the external grievance from the member or a health care provider filing a grievance with member consent, UnitedHealthcare Community Plan will notify the Pennsylvania Department of Health, the member and the health care provider that a request for an external grievance review has been filed. UnitedHealthcare Community Plan’s notification to the Pennsylvania Department of Health by phone and fax shall include a request for assignment of a certified review entity (CRE). If the external grievance is being requested by a health care provider, UnitedHealthcare Community Plan and the health care provider must each establish escrow accounts in the amount of half the anticipated cost of the review. UnitedHealthcare Community Plan will notify the provider or the member of the name, address and phone number of the assigned CRE within 2 business days.

UnitedHealthcare Community Plan will, within 15 days of request for an external review, forward the case file to the assigned CRE. UnitedHealthcare Community Plan will also send the provider or member a listing of all documents forwarded to the CRE. Once the CRE reaches its decision, UnitedHealthcare Community Plan will authorize a health care service and pay claim(s) determined to be medically necessary and appropriate by the CRE whether or not UnitedHealthcare Community Plan appeals the CRE’s decision to a court of competent jurisdiction. If the CRE’s decision in an external grievance review filed by a health care provider is against the health care provider in full, the health care provider shall pay the fees and costs associated with the external grievance. Regardless of the identity of the grievant, if the CRE’s decision is against UnitedHealthcare Community Plan in full or in part, UnitedHealthcare Community Plan will pay the fees and costs associated with the external grievance review. The assigned CRE will review and issue a written decision within 60 days of the filing of the request for an external grievance review. The decision will be sent to the member and the member’s representative, the health care provider, the plan, and the Pennsylvania Department of Health.
Chapter 19: Quality Management Program

The UHC Community Plan’s Quality Improvement Program (QIP) establishes the standards that encompass all quality improvement activities within the health plan including:

Promoting and incorporating quality into the health plan’s organizational structure and processes.
- Facilitate a partnership between members, providers, state agencies and health plan staff for the continuous improvement of quality health care delivery.
- Clearly define roles, responsibilities and accountability for the quality program.
- Continuously improve communication and education in support of these efforts.
- Consider and facilitate achievement of public health goals in the areas of health promotion and early detection and treatment.

Providing effective monitoring and evaluation of patient care and services to ensure that care provided by the health plan delivery system meets the requirements of standard medical practice, meets the cultural and linguistic needs of the membership, and is perceived positively by health plan members and health care professionals.
- Evaluate and disseminate clinical and preventive practice guidelines.
- Monitor provider performance against established evidence-based medicine.
- Develop guidelines for quality improvement activities (e.g. access and availability, credentialing/ recredentialing, peer review, etc.).
- Survey health plan members’ and providers’ satisfaction with the quality of care and services provided.
- Conduct and analyze data such as CAHPS® and HEDIS®, develop programs to improve satisfaction and preventive services as identified. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
- Collect and analyze data for population specific Quality Improvement (QI) projects.
- Develop, define and maintain data systems to support quality improvement activities and encourage datadriven decision-making.
- Provide culturally proficient care and services
- Provide disease management programs that improve the quality of life for chronically ill members.

Ensuring prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up.
- Identify and monitor important aspects, quality indicators, problems and concerns about health care services provided to members.
- Implement and conduct a comprehensive Quality Improvement Program.
- Recognize that opportunities for improvement are unlimited.
- Provide ongoing feedback to health plan members and providers regarding the measurement and outcome of quality improvement (clinical and non-clinical) activities including access and availability studies.
- Support re-measurement of effectiveness and continued development and implementation of improvement interventions.

Coordinating quality improvement, risk management and patient safety activities.
- Aggregate and use data to develop quality improvement activities.
- Provide a regular means by which risk management and patient safety are included in the development of quality improvement initiatives.
- Identify, develop and monitor key aspects of patient safety including injury protection.

Maintaining compliance with local, state and federal regulatory requirements and accreditation standards.
- Monitor compliance with regulatory requirements for quality improvement and risk management opportunities and respond as needed.
- Ensure that reporting systems provide appropriate information for meeting the requirements of external regulatory review and accrediting bodies.
- Monitor performance and compliance
Quality Management Committee Structure and Processes

The Quality Management Program is supported at both the local and national levels. Local processes include:

The Board of Directors is the governing body of the organization. The Board of Directors reviews the annual Quality program description, work plan and the annual evaluation and reviews and approves the updates to the Credentialing Plan. It has delegated the responsibilities for the oversight of the quality improvement activities to the Quality Management Committee.

The Quality Management Committee (QMC) is the decision-making body that is ultimately responsible for the implementation, coordination and integration of all quality improvement activities for the health plan.

The Service Quality Improvement Subcommittee (SQIS) monitors the quality of service delivered to the Plan’s membership. The SQIS oversees non-clinical services and delegated functions to monitor and to support improved service to members.

Care Provider Advisory Committee/Healthcare Quality and Utilization Management Committee

The Care Provider Advisory Committee/Healthcare Quality and Utilization Management Committee (PAC/HQUM) monitors all clinical quality improvement and utilization management activities within the Health Plan. In Pennsylvania the Health Plan has combined the PAC committee with the HQUM Committee.

The Care Provider Advisory Committee (PAC) performs peer review activities, including credentialing and review and disposition of concerns about quality of clinical care provided to members as requested by the Health Plan CMO. In addition, the committee is responsible for evaluating and monitoring the quality, continuity, accessibility, availability, utilization, and cost of the medical care rendered within the network.

Our program has national support with the following processes:

The National Quality Oversight Committee (NQOC) serves as the responsible governing body monitoring and regulating the affairs of the UnitedHealthcare Community Plan Quality Improvement and Outreach Programs in all health plans.

The National Credentialing Committee’s purpose is to conduct initial credentialing and recredentialing, of practitioners that may provide care and services to a UnitedHealthcare Community Plan member as indicated in the UnitedHealthcare Community Plan Credentialing Plan.

The National Medical Technology Assessment Committee (MTAC) is responsible for ensuring that clinical decisions about the safety and efficacy of medical care are consistent across all products and businesses, the maintenance or externally licensed guidelines, and for evaluating and incorporating nationally accepted consensus statements, clinical guidelines, and expert opinions into the establishment of national standards for UnitedHealth Group. The Executive Medical Policy Committee (EMPC) is responsible for overseeing the development, implementation and evaluation of the medical policies across UnitedHealth Group.

The National Medical Technology Assessment Committee (MTAC) is responsible for:

- The development and review of evidence-based position statements on selected medical technologies.
- Assessments of the evidence supporting new and emerging technologies as well as new indications for existing technologies.
- Review and approval of externally licensed criteria and references.
- Review, evaluation and recommendation for approval of Clinical Practice Guidelines (CPGs) for company wide implementation.
- The consideration and incorporation of nationally accepted consensus statements and expert opinions into the establishment of national standards for UnitedHealth Group.
- Ensuring that clinical decisions about the safety and efficacy of medical care are consistent across all products and businesses.

The National Pharmacy and Therapeutics (P&T) Committee is responsible for providing the clinical oversight for the development and maintenance of the Preferred Drug List (PDL) and Clinical Pharmacotherapy policies. The mission of the National P&T Committee is to promote the use of appropriate drug therapy based upon clinical evidence.

The Behavioral Health Joint Operating Committee is responsible for the coordination of care and service between United Behavioral Health (UBH), UnitedHealthcare...
Community Plan and UHC Community and State and the collaboration and oversight of accreditation processes as related to behavioral health.

The National Service Improvement Committee (NSIC) provides coordination of all customer and care provider/provider service and satisfaction monitoring activities on a national scope.

The Delegation Oversight Committee whose primary focus is to perform oversight of all nationally delegated entities of UHC Community and State.

**Quality Management Roles**

Although the Board of Directors/Executive Committee has ultimate responsibility for the QI Program and related processes and activities, key staff of the health plan provides the day to day operational support for the program. These key staff includes:

The **Chief Executive Officer (CEO)** is responsible for oversight of the implementation of the Quality Improvement Program and chairs the QMC. The president is responsible for monitoring the quality of care and service and ensuring the appropriate level of resources is available for the QI Program. The president also ensures that fiscal and administrative management decisions do not compromise the quality of care and service UHC Community Plan provides to members.

The **Quality Management Manager (QMM)** is responsible for developing and implementing community and provider based programming and initiatives. They are responsible for the CAPHS survey and community collaboration initiatives in relation to grant and funding projects. This position is responsible for working directly with Six Sigma, Performance Improvement Projects and with the National HEDIS team to support the use of HEDIS data to identify quality improvement opportunities and monitor quality improvement interventions for the health plans.

The **Chief Medical Officer (CMO)** is a Pennsylvania licensed physician who is responsible for implementation of the QI Program. The CMO reports to the President and provides the medical direction for health plan staff. The CMO or designee chairs the PAC. The CMO participates in the credentialing process for the health plan and coordinates review and approval with the PAC. The CMO oversees and implements activities to measure health services efficacy.

The **Director of Quality Management (QM)** is responsible for oversight of the implementation of the QI Program, including monitoring the quality of care and service complaints and, provides the evaluation of quality improvement initiatives involving member and provider outreach, activities designed to increase performance on HEDIS, and for implementation of quality improvement studies and patient safety initiatives, oversight.

The **Clinical Practice Consultant (CPC) RN** is responsible for developing and implementing CQI initiatives designed to assist providers in delivering timely and effective health services. The CPCs report to the Director Quality Management and also works with other Quality Management, provider relations staff and operations staff to resolve provider issues which impact quality. The CPCs are responsible for analysis and review of quality outcomes at the provider level, provider education on quality programs, monitoring and reporting on key measures to ensure providers meet quality standards and implementation of pay for performance initiatives.

The **Manager of Clinical Quality/HEDIS/EPSDT Coordinator** is responsible for developing and implementing CQI initiatives designed to assist and educate members and providers in delivering timely and complete Early Periodic Screening, Diagnosis and Treatment services and HEDIS project planning, data collection and analysis at the health plan level. This position is responsible for working directly with Six Sigma, Performance Improvement Projects and with the National HEDIS team to support the use of HEDIS data to identify quality improvement opportunities and monitor quality improvement interventions for the health plans.

The **Sr. Quality Analyst/NCQA Coordinator** is responsible to support the plan in maintaining continual readiness with all aspects of NCQA accreditation by assisting with the management and monitoring of quality processes across all departments as they relate to maintaining NCQA Accreditation status for the health plan. This individual also identifies and initiates outreach projects and collaborations with key stakeholders in the community. This position is responsible for working directly with Six Sigma, Performance Improvement Projects and with the National HEDIS team to support the use of HEDIS data to identify quality improvement opportunities and monitor quality improvement interventions for the health plans.

**Peer Review Procedures**

The UnitedHealthcare Community Plan medical director will always contact a provider if there is a question about services delivered, in response to a complaint, credentialing, quality of care or sentinel events. If the medical director and individual provider or practice can not resolve the issues adequately and pursuant to state and Federal regulations, the issues will then be sent to the appropriate UnitedHealthcare Community Plan Committee.
Types of Providers Subject to Credentialing and Recredentialing

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

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

- MDs (Doctors of Medicine)
- DOs (Doctors of Osteopathy)
- DDSs (Doctors of Dental Surgery)
- DMDs (Doctors of Dental Medicine)
- DPMs (Doctors of Podiatric Surgery)
- DCs (Doctors of Chiropractic)
- CNMs (Certified Nurse Midwives)
- CRNPs (Certified Nurse Practitioners)
- Behavioral Health Clinicians (Psychologists, Clinical Social Workers, Masters Prepared Therapists) for Pennsylvania’s Children’s Health Insurance Program (CHIP).

Excluded from the credentialing and recredentialing process are practitioners who:

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

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

Credentialing/Recredentialing Process

The UnitedHealthcare Community Plan credentialing/recredentialing process is completed by our National Credentialing Center (NCC).

Applications are retrieved from the Council for Affordable Quality Healthcare (CAQH) web site. First time applicants will need to contact the National Credentialing Center (VETTS line) at 877-842-3210 to obtain a CAQH number in order to complete the application on line.

The following supporting documents must be submitted to CAQH upon completion of the application:

- Medical License
- Federal DEA Certificate
- CDS Certificate
- ECFMG Certificate (if applicable)
- Insurance Coverage

CAQH sends reminders to Providers electronically by e-mail every three months requesting any updates required regarding expired documents. Please follow their instructions to insure that your information is current.

Peer Review

Credentialing Process

All applicants are reviewed by the Credentialing Committee. Decisions are final and binding and not subject to appeal if they relate to mandatory participation criteria at the time of initial credentialing.

The practitioner is notified in writing of the credentialing determination within 60 calendar days of the credentialing decision.

Recredentialing Process

UnitedHealthcare Community Plan recredentials practitioners every three years to assure that time-limited documentation is updated, that changes in health and legal status are identified, and that practitioners comply with UnitedHealthcare Community Plan’s guidelines, processes, and provider performance standards.

Practitioners are notified 180 days prior to their next credentialing cycle to complete their application on the CAQH web site.

Failure to respond to UnitedHealthcare Community Plan’s request for recredentialing information will result in administrative termination of his/her privileges as an UnitedHealthcare Community Plan participating provider. The practitioner will be afforded multiple opportunities to respond to UnitedHealthcare Community Plan’s request for recredentialing information before action is taken to terminate participation privileges.

Provider Performance Review

As part of the recredentialing process, UnitedHealthcare Community Plan queries its Quality Management database for information regarding provider performance. This includes but is not limited to:
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- Member Complaints
- Quality of Care Issues

**Applicant Rights and Notification**
Practitioners have the right to review the information in support of their credentialing/recredentialing applications and to request the status of their application. This review is at the practitioner’s request and is facilitated by the credentialing staff.

The credentialing staff notifies practitioners of any information obtained during the credentialing or recredentialing process that varies significantly from the information given to UnitedHealthcare Community Plan by the practitioner.

Practitioners have the right to correct erroneous information within 30 days of the request for clarification by the credentialing staff. Corrections are to be submitted in writing to the requesting credentialing staff.

**Medicare/Medicaid Program Participation**
UnitedHealthcare Community Plan complies with federal requirements to ensure that health care providers do not appear on the Office of Inspector General (OIG) List of Excluded Individuals/Entities, General Services Administration (GSA) System Awards Management, and Medicheck (Precluded Providers) List.

**Medicaid Numbers/PA PROMISe™**
All contracted providers are required to have an active Medicaid number. UnitedHealthcare Community Plan queries the PA PROMIsë™ website to determine if the provider has been assigned a Medicaid number.

**Confidentiality**
All information and files used during the credentialing and recredentialing process are considered confidential and available only to employees, individuals or organizations involved in the credentialing and recredentialing process.
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UnitedHealth Group’s Integrity of Claims, Reports and Representations to Government Entities Policy

UnitedHealth Group requires compliance with the requirements of the federal and state laws that prohibit the submission of false claims in conjunction with federal health care programs, including Medicare and Medicaid. Every UnitedHealth Group employee, and in particular, every employee of each UnitedHealth Group business organization that receives or makes payments of $5 million or more under a state Medicaid contract, as well as employees of UnitedHealth Group’s contractors and agents, must receive the information set forth in this policy.

Guidelines

Federal and state governments have adopted a number of statutes to deter and punish misrepresentations with regard to health care programs. Failure to comply with these laws could result in civil and criminal sanctions imposed on individuals and UnitedHealth Group’s subsidiaries by government entities. In addition to sanctions imposed by the government, employees’ noncompliance with this policy (and any state or federal law designated to detect and prevent fraud, waste, and abuse) may result in discipline up to and including termination of employment.

- **Federal False Claims Act**: The federal False Claims Act prohibits knowingly submitting (or causing to be submitted) to the federal government, as false or fraudulent claim for payment or approval. It also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by a state Medicaid program, the federal government or its agents, such as a carrier or other claims processor.

- Civil penalties can be imposed on any person or entity that violates the federal False Claims Act, including monetary penalties of $5,500 to $11,000 as well as damages of up to three times the federal government’s damages for each false claim.

- **Federal Fraud Civil Remedies**: The Program Fraud Civil Remedies Act of 1986 also allows the government to impose civil penalties against any person who make, submits or presents false, fictitious or fraudulent claims or written statements to designated federal agencies, including the U.S. Department of Health and Human Services, which is the federal agency that oversees the Medicare and Medicaid Programs.

- **State False Claims Acts**: Several states also have enacted broad false claims laws modeled after the federal False Claim Act or have legislation pending that is similar to the federal False Claims Act. Other states have enacted false claims laws that have provisions limited to health care fraud.

- **Whistleblower and Whistleblower Protections**: The federal False Claims Act and some state false claims acts permit private citizens with knowledge of fraud against the U.S. Government or state government to file suit on behalf of the government against the person or business that committed the fraud.

Individuals who file such suits are known as a “qui tam” plaintiff or “whistleblower.” the federal False Claims Act and some state false claims acts also prohibit retaliation against an employee for investigating, filing or participating in a whistleblower action.

- **Manager Responsibilities**: Managers must inform their employees that the UnitedHealth Group does not tolerate or condone activities that result in or contribute to the submissions of false claims to any federal health care programs, including the Medicare and Medicaid programs, and a manager must take appropriate action if he or she learns about possible fraudulent or abusive activities.

- **Business Organization Responsibilities**: UnitedHealth Group’s policy on Detecting Fraud and Abuse requires each Business Organization to establish procedures to detect, investigate, eliminate and report fraud and abuse.

- **UnitedHealth Group’s Responsibilities**: UnitedHealth Group’s Ethics and Integrity policy on Detecting Fraud and Abuse Business Organizations’ policies on Detecting Fraud and Abuse provide details regarding internal policies, procedures and individuals’ responsibilities to prevent and detect fraud waste and abuse. Additionally, UnitedHealth Group’s Ethics and Integrity Program provides for rigorous internal investigations and prompt resolution of alleged violations. Depending on the nature of the violation, investigations of integrity or compliance issues may be
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performed by the Compliance Officer, Legal Services, Corporate Security, Human Capital and/or other appropriate staff of consultants.

- **Contractor and Agent Responsibilities**: UnitedHealth Group requires that its contractors and agents, and their employees, who perform services for UnitedHealth Group’s government program health plans (i.e., Medicaid and Medicare) comply with all federal and state laws that prohibit the submission of false claims in connection with federal healthcare programs. UnitedHealth Group also requires that its contractors and agents, and their employees, comply with all UnitedHealth Group policies and procedures relating to detection and prevention of fraud and abuse in government health care programs. Lastly, UnitedHealth Group requires that its contractors and agents distribute this information to their employees to educate them on the federal and state statutes, as well as, UnitedHealth Group and its subsidiary’s policies and procedures relating to fraud detection and prevention in connection with federal healthcare programs.

**UnitedHealthcare Community Plan Code of Conduct and Compliance Program**

As a business segment of UnitedHealth Group, UnitedHealthcare Community Plan is committed to continuing to conduct its business with members, providers, suppliers and governmental officials and agencies in adherence to our core values of honesty and integrity. The following provisions guide UnitedHealthcare Community Plan’s dealing with providers and government agencies:

1. UnitedHealthcare Community Plan reports to government payers on the number of members enrolled in our plans and the services those members receive. UnitedHealthcare Community Plan will not tolerate any falsification or intentional misstatements in such reports. UnitedHealthcare Community Plan depends on providers for a substantial portion of the data included in these reports and expects providers to be conscientious and entirely forthright in providing this information. The submission of claims is the provider’s certification that the data are accurate, detailed, and complete.

2. UnitedHealthcare Community Plan does not make, offer or accept payments or anything of value in order to induce referrals of Medicaid, CHIP, or beneficiaries to its health plans. UnitedHealthcare Community Plan does not make or receive payments from its providers in exchange for entering into contracts or extending favorable rates.

3. UnitedHealthcare Community Plan is honest in its dealings with government officials and will cooperate with any lawful government investigation. In doing so, however, it is essential that the legal rights of UnitedHealthcare Community Plan and our personnel be protected. Therefore, if any provider receives an inquiry, subpoena or other legal document regarding UnitedHealthcare Community Plan business, UnitedHealthcare Community Plan requests the provider notify the UnitedHealthcare Community Plan plan immediately.

4. UnitedHealthcare Community Plan has an active Corporate Compliance Program, Compliance Officer, and a Compliance Committee representing a cross-section of organizational functions. The Corporate Compliance Program is designed to educate all employees regarding the ethical standards that guide our operations, provide methods for reporting inappropriate practices or behavior, and procedures for investigation of and corrective action for any unlawful or inappropriate activity. The Compliance Officer, who serves as chairperson of the Compliance Committee, coordinates the functions of the corporate compliance program for a particular UnitedHealthcare Community Plan business unit and serves as the principal officer to whom compliance-related inquiries for that business unit should be directed.

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

6. If a provider becomes the subject of a governmental inquiry or investigation, or a government agency requests or subpoenas documents relating to the provider’s operations (other than a routine request for documentation from a regulatory agency), the provider must advise the UnitedHealthcare Community Plan plan of the details of this and of the factual situation which gave rise to the inquiry.
7. Any unethical, unlawful or otherwise inappropriate activity by UnitedHealthcare Community Plan employees which comes to the attention of the provider should be reported to the Vice President of Market and Network Development, the Compliance Officer, or the President of UnitedHealthcare Community Plan in Pennsylvania at 100 Penn Square East, Suite 400, Philadelphia, PA 19107.

8. UnitedHealthcare Community Plan’s Special Investigations Unit (SIU) is an important component of the Corporate Compliance Program. The SIU focuses on proactive prevention, detection, and investigation of potentially fraudulent and abusive acts committed by providers and plan members. This department is responsible for anti-fraud activities in all UnitedHealthcare Community Plan business units.

9. UnitedHealthcare Community Plan’s Values, listed in the front of this manual, also underscore our commitment to ethical behavior and form a core component of the Compliance Program.

**Commitment to Health Care Providers**

UnitedHealthcare Community Plan is committed to collaborating and supporting participating healthcare providers with delivery of quality healthcare.

UnitedHealthcare Community Plan will:

1. Give written notice of rules of participation, terms of payment, credentialing, and other rules directly related to participation decisions. Further, UnitedHealthcare Community Plan will consult with contracting care providers regarding medical policy, quality assurance program, and medical management procedures.

2. Not discriminate in terms of participation, reimbursement, or indemnification against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification.

3. Not prohibit or otherwise restrict participating providers, acting within the lawful scope of practice, from advising or advocating on behalf of their patients.

4. Structure business arrangements with providers to ensure compliance with legal requirements and prohibitions. Such arrangements will be in writing and approved by the corporate Legal Department.

5. In order to meet all standards regarding referrals and enrollment in an ethical and legal manner, adhere strictly to two primary rules:

   - **Primary Rule 1:** UnitedHealthcare Community Plan does not pay or offer to pay anyone – employees, associates, care providers or any other person – for referring persons to an UnitedHealthcare Community Plan plan. Violation of this policy may have grave consequences for the organization and the individuals involved, including civil and criminal penalties, and possible exclusion from participation in federally funded healthcare programs.

   - **Primary Rule 2:** UnitedHealthcare Community Plan does not accept payments for referring members to providers. No UnitedHealthcare Community Plan employee, associate, or any other person acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of members. Similarly, when making member referrals to another healthcare provider, UnitedHealthcare Community Plan does not take into account the volume or value of referrals that the provider has made (or may make) to UnitedHealthcare Community Plan.

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**The Provider’s Role in Managed Care Ethics: Assuring Appropriate Utilization**

- UnitedHealthcare Community Plan is committed to collaborating with participating providers to ensure that members receive the appropriate level and type of medical service.

- UnitedHealthcare Community Plan uses a combination of accepted methodologies to compare the delivery of services among providers who have similar panels and to compare members’ utilization of services to established utilization norms.

- UnitedHealthcare Community Plan supplements statistical analysis with medical record review and other techniques.

- UnitedHealthcare Community Plan monitors member complaints and grievances in order to identify inappropriate barriers to service that may be created by UnitedHealthcare Community Plan or by participating providers.

- Inappropriate barriers to service, such as the following, can result in the underutilization of services by our members.

- UnitedHealthcare Community Plan and its participating providers must be alert to these barriers:

  1. Unreasonable prior authorization or referral requirements, and/or delays in approvals. These could be caused by unreasonable policy or procedures by plan or provider, an intentional
attempt to inappropriately limit or delay services, or simply due to inefficiency.

2. Problems with access to providers because of limited office hours or inconvenient location. These may be viewed as a way of discouraging patients and thereby limiting services.

3. Unreasonable delays in scheduling appointments, waiting time to see providers or obtaining referrals from Primary Care Providers. These could indicate intentional denial of services or just inefficiency.

4. Non-care providers providing services requiring a doctor or misrepresenting their credentials. This may be a failure of proper policy, procedure or practice, or an intentional method of reducing the costs of treatment. Under the latter circumstances or where there is misrepresentation of the credentials or qualifications of a provider, this can also constitute fraud and/or abuse.

Compliance in the Provider’s Office or Facility

The Federal Office of Inspector General encourages health care providers to develop compliance programs for their entities as a measure to prevent, detect, and resolve potential regulatory violations.

A well-developed compliance program is a continuous process that requires the participating providers to:

• Develop policies and procedures
• Assess risk areas where violations could potentially occur
• Develop employee training modules and open lines of communication
• Routinely monitor procedures
• Develop mechanisms for resolving operational irregularities and prevent recurrence

The OIG has issued a series of guides to assist various segments within the health care industry in the development of effective compliance programs.

The OIG has established the following areas as being crucial focus areas for developing a care provider practice compliance program:

• **Coding and Billing:** Code correctly and avoid exclusive use of one or two middle levels of service codes
• **Medical Necessity:** Provide only reasonable and necessary services to the patient
• **Medical Records:** Maintain sufficient documentation to support services rendered and ensure legibility of information provided
• **Improper Payments:** Avoid improper inducements, kickbacks, and self-referrals
• **Provider Billing:** Submit claims under the provider identification number of the provider actually rendering services (ID numbers should not be shared)
• **Record Retention:** Maintain records for the period of time established by law

In addition to the aforementioned risk areas cited by the OIG, UnitedHealthcare Community Plan asks form providers’ attention to the following areas:

• **Member Billing:** UnitedHealthcare Community Plan members should NEVER receive a bill or a balance bill for covered services. Sending bills or balance bills to UnitedHealthcare Community Plan members for covered services is a violation of your Participating Provider Agreement with UnitedHealthcare Community Plan and violates Pennsylvania law and regulation. Instruct office staff to ask for appropriate documentation of a patient’s insurance coverage and accurately maintain this information in all billing systems. If your office has not received payment for covered services provided to an UnitedHealthcare Community Plan member, call 800-600-9007.

• **Encounter Reporting:** Instruct office staff that the submission of claims is the provider’s certification that the data are accurate, detailed, and complete.

UnitedHealthcare Community Plan encourages all participating providers to periodically review their office procedures.

Health Insurance Portability and Accountability Act (HIPAA) Compliance

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 improved the portability and continuity of insurance coverage for workers and strengthened the government’s ability to fight health care fraud and abuse. The portions of the Act with the most
significant impact on providers and health plans are the administrative simplification regulations which include rules related to electronic transactions and code sets, privacy and security of individually identifiable health information and unique identifiers.

The Transactions and Code Set Final Rule required the adoption of standardized electronic transactions and codes to identify health care procedures and affected nine common administrative and financial health care transactions. The Standards for Privacy of Individually Identifiable Health Information Final Rule and the Security Standards Final Rule required the healthcare industry to take steps to provide greater levels of protection for protected health information (PHI) and required major changes in the way health care information had traditionally been managed.

The Standard Unique Identifier for Health Care Providers Final Rule establishes a single national standard for enumeration and identification of each covered health care provider. A standard for identification of health plans is awaiting publication by The Department of Health and Human Services.

UnitedHealthcare Community Plan is a HIPAA “covered entity” and therefore must fully comply with all regulations and rules by the established deadlines. A provider who transmits any health information in an electronic form in connection with a transaction governed by the regulation is also considered a covered entity and is required to comply with the regulation. Both electronic and written health care records developed or maintained by a covered entity are covered by the HIPAA regulations.

Use of national standard code sets for medical and non-medical code sets and identifiers is required unless directed otherwise by the regulating body in a given state. UnitedHealthcare Community Plan expects all participating providers to be in compliance with the HIPAA regulations that apply to their practice or facility within the established deadlines.

To learn more about the HIPAA regulations you can visit the CMS website at http://www.cms.hhs.gov/hipaageninfo/01_overview.asp? and the Office for Civil Rights (OCR) website at http://www.hhs.gov/ocr/hipaa/.

UnitedHealthcare Community Plan Corporate Compliance Phone Numbers

We welcome your comments or questions about the UnitedHealthcare Community Plan Corporate Compliance Program. You may find the following numbers helpful:

Fraud and Abuse Hotline/Special Investigations Unit:
877-401-9430

Definitions/Examples of Fraud, Waste and Abuse

There is no single definition of “fraud” in the health care industry. Generally speaking, fraud as a legal concept involves an intentional misrepresentation of a material fact made to induce detrimental reliance by another. A misrepresentation can entail an affirmative false statement or the omission of a material fact. Moreover, fraud can be both intentional (knowing), reckless, or negligent. Intentional or knowing fraud can include both misrepresentations made to deceive and induce reliance, and those made with the knowledge that they are substantially likely to induce reliance. Federal and state statutes and regulations variously define fraud (e.g., 42 C.F.R. § 455.2 defines fraud as “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.”). For the purposes of this Program, PSMG construes health care fraud liberally in its broadest sense.

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

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

• Billing for services/goods never provided
• Billing for services/goods not medically necessary
• Billing for services/goods not covered (e.g., experimental services) and/or for services to ineligible members
• Duplicative billing for the same services/goods
• Billing without adequate supporting documentation
• Billing for more costly/complex services/goods than those actually provided (“upcoding”)
• Billing separately services/goods required to be billed collectively (“unbundling”)
• Improper modifications of billing codes
• Billings by fictitious, sanctioned, and/or unqualified providers
• Excessive fees charged for services/goods
• Poor quality services that are tantamount to no services provided
• Provider/member identity theft
• Provider waiver of patient copayments
• Misrepresentations in cost reports
• Unlawful referrals of patients to related providers

Some examples of member/beneficiary health care fraud, waste and abuse include:
• Selling/loaning member identification information
• Intentional receipt of unnecessary/excessive services/goods
• Unlawful sales of prescriptions and/or prescription medications
• Misrepresentations to establish program/plan eligibility (e.g., non-disclosure of income/assets)

Pennsylvania Medical Assistance Provider Self-Audit Protocol

The Pennsylvania Medical Assistance Provider Self Audit Protocol allows providers to voluntarily disclose overpayments or improper payments of MA funds.

The Fraud and Abuse protocol is available on the Department’s website at [http://www.dhs.state.pa.us/learnaboutdhs/fraudandabuse/index.htm](http://www.dhs.state.pa.us/learnaboutdhs/fraudandabuse/index.htm).

Pennsylvania Medical Assistance Hotline to Report Fraud and Abuse

The Department of Human Services has established a hotline to report suspected fraud and abuse committed by any entity providing services to Medical Assistance recipients.

The hotline number is **844-347-8477** and (844-DHS-TIPS) and operates between the hours of 8:30 AM and 3:30 PM, Monday through Friday.

Voice mail is available at all other times. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

Suspected fraud and abuse may also be reported via the website at: [http://www.dhs.state.pa.us/learnaboutdhs/fraudandabuse/index.htm](http://www.dhs.state.pa.us/learnaboutdhs/fraudandabuse/index.htm).

Information reported via the website or email can also be done anonymously. The website contains additional information on reporting fraud and abuse.
Appendix A

Forms
1. Care provider Certification Form
2. Patient Consent to file grievance on their behalf
3. Authorization to appoint a personal representative
4. Statewide Obstetrical Needs Assessment Form

Appendix B

UnitedHealthcare Community Plan Medical Record Documentation Standards

Appendix C

PA Medical Assistance Manual

Appendix D

Medicaid and CHIP Complaints and Grievances and DHS Medicaid Fair Hearings

Appendix E

LEGAL/ADVOCACY HELP
Appendix A

PHYSICIAN CERTIFICATION FORM

DATE CERTIFICATION SUBMITTED: __________________________ DATE SERVICE REQUESTED: __________________________

PRESCRIBING PHYSICIAN INFORMATION:

Prescribing Physician: __________________________ Telephone Number: __________________________

Physician’s MA ID #: __________________________ Fax Number: __________________________

MEMBER INFORMATION:

Member’s Name: __________________________ Member’s MCO Name: __________________________

Member’s Date of Birth: __________________________ Member’s Social Security #: __________________________

CERTIFICATION IN SUPPORT OF NEED FOR EXPEDITED CONSIDERATION:

Please explain why utilizing the regular MCO complaint or grievance review process or the regular DPW fair hearing process would place the member’s life, health or ability to regain maximum function in jeopardy.

You must include the clinical rationale and the facts necessary to support your opinion that the regular timeframe for resolution of a complaint, grievance or fair hearing will jeopardize the member’s life, health or ability to regain maximum function.

Enter information below. (Attach additional pages if necessary)

________________________________________________________
________________________________________________________
________________________________________________________

Physician’s Signature

CERTIFICATION SUBMITTED TO SUPPORT:

Expected Complaint Review ☐  Expected Grievance Review ☐  Expedited DPW Fair Hearing ☐
(Fax to MCO) (Fax to MCO) (Fax to MCO)

NOTE: IF SUBMITTING FOR BOTH EXPEDITED COMPLAINT OR GRIEVANCE AND EXPEDITED DPW FAIR HEARING, SUBMIT CERTIFICATION VIA FAX TO BOTH MCO AND DPW.
Appendix A

**Patient Consent for My Provider to File a Grievance on my Behalf with my Health Insurance Plan**

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Provider Plan ID Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Description of services that may be reviewed:</th>
<th>Date(s) services were provided:</th>
</tr>
</thead>
</table>

I agree to allow this health care provider file a grievance on my behalf with the following health plan if there is a question about coverage for the services listed below.

I understand that:

1. If I consent, I will not be able to file my own grievance concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing.
2. I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
3. This consent shall be automatically rescinded if my health care provider does not file a grievance, or stops the grievance process regarding my case.

I have read this consent or have had it read to me, and it has been explained to my satisfaction.

I understand the information in the consent form, and grant my consent to this provider to file a grievance on my behalf.

<table>
<thead>
<tr>
<th>Print Patient Name:</th>
<th>Patient Date of Birth:</th>
<th>Health Insurance Company:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Address:</th>
<th>Patient Insurance ID Number:</th>
</tr>
</thead>
</table>

| Patient Signature:            | Signature Date:             |
| X                             | X                            |

The above name enrollee is unable to sign this consent form because of the following reasons and I consent for the above named enrollee:

<table>
<thead>
<tr>
<th>Print Representative Name:</th>
<th>Relationship to the Patient:</th>
</tr>
</thead>
</table>

| Representative Signature:    | Signature Date:              |

<table>
<thead>
<tr>
<th>Print Witness Name:</th>
<th>Witness Signature:</th>
<th>Signature Date:</th>
</tr>
</thead>
</table>
Appendix A

Authorization to Appoint a Personal Representative

A personal representative is a person authorized to represent you through the complaint and grievance process.

Instructions: Please complete and sign this form to appoint a personal representative. A separate form is required for each member. Return in the self-addressed, stamped envelope. UnitedHealthcare of Pennsylvania, Inc., will provide your appointed personal representative the same rights to your protected health information (PHI) that is provided to you.

Member Information: (individual whose information will be released)

Name (Last, First, MI) _____________________________________________
Identification Number ___________________________________________
Social Security Number ___________________ Date of Birth ____________
Telephone Number _____________________________________________
Street Address _________________________________________________

Authorization:
I hereby authorize the request and release of my PHI, held by UnitedHealthcare, to my personal representative. By appointing the person named on this form as my personal representative, I understand that I am authorizing UnitedHealthcare to give this person access to my PHI and medical records and the right to talk to UnitedHealthcare about my account.

I understand that my authorization will remain in effect of the length of time specified below.

I have had full opportunity to read and consider the contents of this authorization. I understand that by signing this form, I am confirming my authorization for the request and release of my PHI, as described in this form.

I ____________________________ appoint ___________________________ to be my personal (Member) (Personal Representative) representative.

Time Period for Representation: From: __/__/____ To: __/__/____

Note: If no time period is provided, this request will remain in effect until the member or his/her legal representative notifies UnitedHealthcare, in writing, requesting a change.

Your Right to Revoke: You may revoke this authorization, at any time, by giving written notice to UnitedHealthcare. Cancellation of this authorization will not affect any action we took prior to receiving your written notification. Please contact UnitedHealthcare for more information if you desire to cancel this authorization.

Personal Representative Information: (required for privacy verification purposes)

Name (Last, First, MI) ___________________________________________
Social Security Number (last 4 digits) _____________________________ Date of Birth ____________
Telephone Number _____________________________________________
Address _______________________________________________________

Relationship to Member _________________________________________

Important: Guardians, court-appointed representatives or other responsible parties must send a copy of legal documents. If you have questions or need help, call Member Services at the number listed on the back of the member card.

Signature of Member/Requestor: ______________________ Date: __________

Printed Name: ____________________________
OBSTETRICAL NEEDS ASSESSMENT FORM (ONAF) – INSTRUCTIONS FOR COMPLETION

This form is intended for Medicaid Recipients participating in a HealthChoices Voluntary or Mandatory Managed Care Organization (MCO) or the Fee for Service delivery system.

This form serves as an MCO's or Fee for Service's initial notification of a member's pregnancy. Its prompt submission from your office allows us to enroll our members in the maternity program as early as possible.

General Instructions (the form does not need to be completed by a physician)

1. Please do not leave any question or section blank; fill out all information completely.
2. For maximum accuracy, please use a black pen and print CAPITAL LETTERS, avoiding contact with the edges of the boxes.
3. Please place an "X" or check mark through the box. (Do NOT shade in the squares completely).
4. Please write only in designated areas. Do not cross out entry and write above the box.
5. Please attach additional information if necessary.
6. Use the same form for all visits (so you will not need to complete the top part each time).
7. Please fill in the demographics section in its entirety.

Dates to complete the sections of the form are:

<table>
<thead>
<tr>
<th>Visit (Fax at these times)</th>
<th>Section to Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>First prenatal visit</td>
<td>Top portion; Past OB Complications; Current Risks; Active Medical/Mental Health Conditions and Social, Economic, Lifestyle</td>
</tr>
<tr>
<td>28-32 week visit</td>
<td>Update all areas as needed, adding dates of prenatal visits thus far</td>
</tr>
<tr>
<td>Postpartum visit</td>
<td>Add postpartum information with date of visit and any additional visit dates as needed</td>
</tr>
</tbody>
</table>

New risk factors identified: Indicate on form where appropriate and fax form at any time during pregnancy.

Complete the first section as follows (OB/GYN Office Information):

<table>
<thead>
<tr>
<th>Entry</th>
<th>Instructions/Reason to Provide Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice name</td>
<td>Document the name of your practice or clinic</td>
</tr>
<tr>
<td>Phone # and Fax #</td>
<td>Document the phone number and fax number of practice or clinic</td>
</tr>
<tr>
<td>Provider MAID# (13-digits)</td>
<td>Document provider’s individual/group identification # including address locator</td>
</tr>
<tr>
<td>Date initially faxed</td>
<td>Document date accordingly</td>
</tr>
<tr>
<td>28-32 week fax date</td>
<td>Document date accordingly</td>
</tr>
<tr>
<td>Postpartum (PP) fax date</td>
<td>Document date accordingly</td>
</tr>
<tr>
<td>Form Completed By</td>
<td>Document accordingly (This should be completed by healthcare professional)</td>
</tr>
</tbody>
</table>

Complete the first section as follows (Member's Information):

<p>| First Name/Last Name                  | Document Member’s full name                                                       |
|DOB                                    | Document Member’s date of birth                                                   |
|Age                                    | Document Member’s age at Expected Date of Confinement (EDC)                      |
|Mem ID/MAID#                           | Document MCO Member ID# or Medical Assistance ID#                                 |
|Member Health Plan                    | Document whether Member belongs to Aetna Better Health, AmeriHealth Caritas Pennsylvania, AmeriHealth Northeast, LLC, CoventryCares, Fee for Service, Gateway HealthSM, Geisinger Health Plan, Health Partners, Keystone First Health Plan, United Healthcare, or UPMC for You |
|Healthy Beginnings Plus Member        | Indicate whether Member is enrolled as Healthy Beginnings Plus Member             |
|Home Phone/Alternate Phone            | Document Member’s home phone and alternate phone (if applicable)                  |
|Language(s)                           | List primary language and any secondary language(s) (if applicable)                |
|Hospital for Delivery                 | Document Member’s choice of hospital for delivery                                  |
|1st Prenatal Visit                    | Date of first prenatal visit                                                     |
|EDC:                                  | Expected date of confinement                                                      |
|By LMP of                              | Document if determined by last menstrual period and date of last menstrual period  |
|By US, Date                           | Document if determined by ultrasound and date of ultrasound                        |
|GA at 1st Visit                       | Document gestational age at first prenatal visit                                   |
|Gravida                               | Document Member’s number of pregnancies                                           |
|Full-term                             | Document number of pregnancies to full-term                                        |
|Pre-term                              | Document number of pregnancies to pre-term                                         |
|AB                                     | Document number of abortions, if none indicate 0, DO NOT LEAVE BLANK               |
|SAB                                    | Document number of spontaneous abortions, if none indicate 0, DO NOT LEAVE BLANK    |
|TAB                                   | Document number of terminated abortions, if none indicate 0, DO NOT LEAVE BLANK    |</p>
<table>
<thead>
<tr>
<th>Living</th>
<th>Document number of living children, if none indicate 0, DO NOT LEAVE BLANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height/Weight/BMI</td>
<td>Document Member’s height, weight and BMI</td>
</tr>
<tr>
<td>Date Last PAP</td>
<td>Document date of last Pap Smear</td>
</tr>
<tr>
<td>Date Last Chlamydia Screen</td>
<td>Document date of last Chlamydia screen</td>
</tr>
<tr>
<td>17P Candidate</td>
<td>Indicate whether Member is a candidate for 17P</td>
</tr>
<tr>
<td>Depression Screen</td>
<td>Document whether Member was screened for Depression</td>
</tr>
<tr>
<td>Validated Depression Tool</td>
<td>Document whether a validated depression tool was used. List the name of tool and date administered.</td>
</tr>
<tr>
<td>Result</td>
<td>Document whether Member screened positive or negative for Depression</td>
</tr>
<tr>
<td>Referral</td>
<td>Document whether Member was referred for treatment for Depression</td>
</tr>
<tr>
<td>Dental Visit, last 6 months</td>
<td>Document whether Member had a dental visit in the last 6 months</td>
</tr>
</tbody>
</table>

**Complete the middle section as follows:**

The information requested in the middle of the form allows the MCOs and ACCESS Plus to risk-stratify our members and to make appropriate referrals into our Case Management or Disease Management programs. The Current Risks and Active Medical/Mental Health Conditions sections have been expanded to better identify specific risks that could impact a pregnancy.

<table>
<thead>
<tr>
<th>Entry</th>
<th>Instructions/Reason to Provide Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past OB Complications</td>
<td>Identifies members whose past complications increase their risk for current problems; If member has had no Past OB Complications, check No Past OB Complications box in section header.</td>
</tr>
<tr>
<td>Current Risks</td>
<td>Identifies potential risks for adverse outcomes; If member has had no Current Risks, check No Current Risks box in section header.</td>
</tr>
<tr>
<td>Active Medical/Mental Health Conditions</td>
<td>Identifies medical/mental health condition related to the mother; If member has had no Active Medical/Mental Health Conditions, check No Active Medical/Mental Health Conditions box in section header. For the following conditions, list specific disease type(s): Autoimmune, Cardiac, Hepatitis, Renal, Sickle Cell, STD, Thyroid. For all others, check Y/N.</td>
</tr>
<tr>
<td>Social, Economic, Lifestyle</td>
<td>Identifies lifestyle issues that can lead to adverse outcomes; If member has had no Social, Economic, Lifestyle indicators, check No Social, Economic, Lifestyle box in section header.</td>
</tr>
<tr>
<td>Delivery</td>
<td>Document date delivered, gestational age at the time of delivery, elective delivery, delivered vaginal or c-section, delivered vertex, birth weight (in grams), if baby was admitted to NICU, is the baby viable and if antenatal steroids were administered.</td>
</tr>
<tr>
<td>Postpartum Visit</td>
<td>Document the date of the visit, screen for post partum depression, if yes whether a validated depression tool was used, list the name of tool and date administered, and was referral made, feeding method, whether contraception discussed and plan, whether quit tobacco during pregnancy and whether remains tobacco free.</td>
</tr>
<tr>
<td>Prenatal Visit Dates</td>
<td>Complete for all visits after the first visit (first visit is already documented in the demographics section).</td>
</tr>
</tbody>
</table>

**Attach additional information if necessary**

**Questions regarding the form contact:**

**Department of Human Services**

**Bureau of Fee for Service Programs**

Attn: Intense Medical Case Management Unit

1006 Hemlock Drive

Willow Oak Building – DGS Annex Complex

Harrisburg, PA 17110-3595

Phone: 1-800-537-8862 or 717-772-6777

Fax: 717-265-8030

**Aetna Better Health**

Special Needs Case Management

2000 Market Street, Suite 850

Philadelphia, PA 19103

Phone: 215-282-3521

Fax: 877-683-7354

**AmeriHealth Caritas Pennsylvania - Lehigh/Capital and New West Zone**

Bright Start Program

8040 Carlson Drive, Suite 500

Harrisburg, PA 17112

Phone: 1-877-364-6797

Fax: 1-866-755-9935

**AmeriHealth Northeast, LLC – New East Zone**

Bright Start Program

8040 Carlson Drive, Suite 500

Harrisburg, PA 17112

Phone: 1-888-208-9528

Fax: 1-855-809-9205

**CoventryCareS**

3721 TecPort Drive

Harrisburg, PA 17111

Phone: 717-541-5927

Fax: 866-769-2401

**Geisinger Health Plan Family**

Right From the Start Program

100 North Academy Avenue

Danville, PA 17822-3220

Phone: 570-271-5108

Fax: 570-214-1583

**Health Partners of Philadelphia**

Baby Partners Program

901 Market Street, Suite 500

Philadelphia, PA 19107

Phone: 215-967-4690

Fax: 215-967-4492

**Keystone First Health Plan**

Bright Start Program

200 Stevens Drive

Philadelphia, PA 19113

Phone: 1-800-521-6867

Fax: 1-866-405-7946

**United Healthcare for Families**

Healthy First Steps

1001 Brinton Road

Pittsburgh, PA 15221

Phone: 1-800-599-5985

Fax: 1-877-353-6913

**UPMC for You**

UPMC for a New Beginning

U.S. Steel Tower 41st Floor

600 Grant Street

Pittsburgh, PA 15219

Phone: 1-888-778-6073

Fax: 412-454-8558

**Gateway HealthSM**

MOM Matters Program®

Four Gateway Center

444 Liberty Avenue, Suite 2100

Pittsburgh, PA 15222-1222

Phone: 1-800-624-3550 - Option 2

Fax: 1-888-225-2360

**Questions regarding the form contact:**

**UnitedHealthcare for Families**

Healthy First Steps

1001 Brinton Road

Pittsburgh, PA 15221

Phone: 1-800-599-5985

Fax: 1-877-353-6913
OBSTETRICAL NEEDS ASSESSMENT FORM (ONAF)

<table>
<thead>
<tr>
<th>OB/Gyn Office Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Name</td>
</tr>
<tr>
<td>Phone</td>
</tr>
<tr>
<td>Fax</td>
</tr>
<tr>
<td>MAID</td>
</tr>
<tr>
<td>Date Initially Faxed</td>
</tr>
<tr>
<td>28-32 Wks Fax Date</td>
</tr>
<tr>
<td>Postpartum Fax Date</td>
</tr>
<tr>
<td>Form Completed By</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member’s Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
</tr>
<tr>
<td>Last Name</td>
</tr>
<tr>
<td>DOB</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Mem.ID/MAID#</td>
</tr>
<tr>
<td>Member’s Health Plan</td>
</tr>
<tr>
<td>Healthy Beginnings</td>
</tr>
<tr>
<td>Plus Member?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Home Phone</td>
</tr>
<tr>
<td>Alternate Phone</td>
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<tr>
<td>Language(s)</td>
</tr>
<tr>
<td>Hospital for Delivery</td>
</tr>
<tr>
<td>1st Prenatal Visit</td>
</tr>
<tr>
<td>ED</td>
</tr>
<tr>
<td>by LMP of</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>by US Date</td>
</tr>
<tr>
<td>GA at 1st Visit</td>
</tr>
<tr>
<td>Gravida</td>
</tr>
<tr>
<td>Full Term</td>
</tr>
<tr>
<td>Pre-Term</td>
</tr>
<tr>
<td>Pre-Term</td>
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<td>Full Term</td>
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<td>Pre-Term</td>
</tr>
<tr>
<td>Living</td>
</tr>
<tr>
<td>Height</td>
</tr>
<tr>
<td>Weight</td>
</tr>
<tr>
<td>BMI</td>
</tr>
<tr>
<td>Date/Last PAP</td>
</tr>
<tr>
<td>Date/Last Chlamydia Screen</td>
</tr>
<tr>
<td>17P Candidate?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Depression Screen?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Result:</td>
</tr>
<tr>
<td>Positive</td>
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<tr>
<td>Negative</td>
</tr>
<tr>
<td>Validated Depression Tool Used?</td>
</tr>
<tr>
<td>List:</td>
</tr>
<tr>
<td>Date Admin:</td>
</tr>
<tr>
<td>Referral?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Tobacco (Tob.) Use</td>
</tr>
<tr>
<td>Average # of Cigarettes Smoked/Day</td>
</tr>
<tr>
<td>Pre-Pregnancy</td>
</tr>
<tr>
<td>1st Trimester</td>
</tr>
<tr>
<td>2nd Trimester</td>
</tr>
<tr>
<td>3rd Trimester</td>
</tr>
<tr>
<td>Tob. Counseling Offered?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Tob. Counseling Received?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Exposure to Environmental Smoke?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Counseling for Environmental Smoke?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Past OB Complications</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Current Risks</td>
</tr>
<tr>
<td>1st</td>
</tr>
<tr>
<td>2nd</td>
</tr>
<tr>
<td>3rd</td>
</tr>
<tr>
<td>No Active Medical/Mental Health Conditions</td>
</tr>
<tr>
<td>Postpartum Depression</td>
</tr>
<tr>
<td>Hx Leep/Cone Biopsy</td>
</tr>
<tr>
<td>Late and/or inconsistent prenatal care</td>
</tr>
<tr>
<td>Anemia Hb &lt; 10</td>
</tr>
<tr>
<td>RH Incompatibility</td>
</tr>
<tr>
<td>Abnormal Ultrasound</td>
</tr>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>Hx of DVT/PE</td>
</tr>
<tr>
<td>Abnormal Placenta:</td>
</tr>
<tr>
<td>Cardiac Disease:</td>
</tr>
<tr>
<td>Gestational Diabetes</td>
</tr>
<tr>
<td>Gestational Diabetes</td>
</tr>
<tr>
<td>Chronic Hypertension, Pregestational</td>
</tr>
<tr>
<td>IUGR</td>
</tr>
<tr>
<td>2nd/3rd Trimester Bleeding</td>
</tr>
<tr>
<td>Diabetes, Pregestational</td>
</tr>
<tr>
<td>Premature ROM</td>
</tr>
<tr>
<td>Periodontal Disease</td>
</tr>
<tr>
<td>HIV</td>
</tr>
<tr>
<td>Prematurity Labor/Delivery &lt; 32 wks</td>
</tr>
<tr>
<td>Poor Weight Gain</td>
</tr>
<tr>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Preterm Labor/Delivery 32 - 36 wks</td>
</tr>
<tr>
<td>IUGR</td>
</tr>
<tr>
<td>Renal Disease:</td>
</tr>
<tr>
<td>Fetal Demise/Hx 2nd/3rd Tri Loss</td>
</tr>
<tr>
<td>PIH</td>
</tr>
<tr>
<td>Seizure Disorder</td>
</tr>
<tr>
<td>Previous C-Section</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Classical incision:</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Previous delivery w/in 1 yr of EDC</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Prenatal Visits</td>
</tr>
<tr>
<td>No Social, Economic, Lifestyle</td>
</tr>
<tr>
<td>1st</td>
</tr>
<tr>
<td>2nd</td>
</tr>
<tr>
<td>3rd</td>
</tr>
<tr>
<td>Social, Economic, Lifestyle</td>
</tr>
<tr>
<td>Mental/Physical/Sexual Abuse</td>
</tr>
<tr>
<td>Hx</td>
</tr>
<tr>
<td>Intellectual Impairment</td>
</tr>
<tr>
<td>Homelessness</td>
</tr>
<tr>
<td>Eating Disorder:</td>
</tr>
<tr>
<td>Substance Abuse</td>
</tr>
<tr>
<td>ETOH</td>
</tr>
<tr>
<td>Hx</td>
</tr>
<tr>
<td>Rx</td>
</tr>
<tr>
<td>Hx</td>
</tr>
<tr>
<td>Street</td>
</tr>
<tr>
<td>Hx</td>
</tr>
<tr>
<td>Opioid Therapy</td>
</tr>
<tr>
<td>Preterm Dilation of cervix/preterm labor</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Postpartum Visit (Between 21-56 days after delivery)</td>
</tr>
<tr>
<td>Delivery: Date</td>
</tr>
<tr>
<td>at</td>
</tr>
<tr>
<td>Weeks Gestation</td>
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<td>Birth Wgt:</td>
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<td>NCIU Admission</td>
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<td>Viable:</td>
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<td>Antenatal Steroids</td>
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<td>No</td>
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<tr>
<td>Postpartum Visit (Between 21-56 days after delivery)</td>
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<td>Visit</td>
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<td>Feeding Method:</td>
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<td>Breast</td>
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<td>Bottle</td>
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<td>Both</td>
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<td>PP Contraception</td>
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<td>Discussed:</td>
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<td>Yes</td>
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<td>No</td>
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<td>PP Contraception Plan</td>
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<td>Yes</td>
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<td>No</td>
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<td>PP Depression Present</td>
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<td>Yes</td>
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<td>No</td>
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<td>Validated Depression Tool Used?</td>
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<td>List:</td>
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<td>Date Admin:</td>
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<td>Referral:</td>
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<td>Yes</td>
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<td>Quit Tob. During Preg.</td>
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<td>Y</td>
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<td>N</td>
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<td>Remains Tob. Free</td>
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<td>N</td>
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<tr>
<td>Physician Signature</td>
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<td>Date Signed</td>
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</table>
Appendix B

Medical Record Charting Standards

• All pages of the record must contain patient identification (name and identifying number).
• The record must contain biographical/personal data, such as age, date of birth, sex, race/ethnicity, and marital status/social supports as well as a notation of cultural/linguistic needs.
• Each entry must have provider name, initials, or other identification (even for solo practitioner sites).
• Each entry must be dated and signed.
• The record must be legible, as judged by the auditor (illegibility of records may result in the need for provider assistance in completing the audit).
• The record must contain a completed, up-to-date, problem list and a list of all prescribed medications.
• Allergies and adverse reactions to medications must be prominently displayed for patients of all ages. Document even if no allergies exist.
• The record must contain an appropriate and organized medical history and physical exam.
• Preventive services/risk screenings must be appropriately used and documented.
• Pediatric charting must contain a completed immunization record and BMI charting.
• Adolescents should be screened for and counseled on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition.
• The record must document smoking habits and history of alcohol and substance use: negative histories also must be noted. If the history is positive for any of these habits, document advice to quit.
• Lab and other studies must be signed and documented.
• Notes must be appropriate in presenting a problem or complaint.
• Working diagnosis(es) must be documented and must be consistent with findings.
• Plans of action/treatment must be consistent with diagnosis(es).
• Episodes of emergency care, hospitalizations and discharge summaries must be documented, including follow-up care, such as home health visits, physical therapy reports, etc.
• Each encounter must include documentation of clinical findings and evaluation, as well as a follow-up plan, such as date for return visit.
• Each encounter must present evidence that unresolved problems from previous visits have been addressed.
• Consultations documented in the record must be appropriate given patient characteristics, history, and presenting problems.
• The record must document appropriate coordination of care between the Primary Care Provider and authorized specialty care providers.
• Consultant summaries, lab reports, imaging study reports, operative procedures, and tissue excisions must be noted in the chart or otherwise reflect care provider’s review.
• Care must be medically appropriate.
• The record must document efforts to educate patients, including lifestyle counseling, and disease specific education.
• Records should reflect the patient’s advance directives.
• Providers are to maintain an organized medical record keeping system and standards for the availability of medical records and medical record retention.
• Providers are to maintain the confidentiality of all medical records in accordance with any applicable statutes and regulations.
• All medical records are to be stored securely. Only authorized personnel are to have access to the records and all staff should receive periodic training on maintaining confidentiality of member information.
# Medical Record Charting Audit Tool and Standards

**Medical Record Review**  
Quality Management Department  
Clinical Medical Record Review Tool

<table>
<thead>
<tr>
<th>Medical Record Policies</th>
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<tbody>
<tr>
<td>☐ Office staff have signed a written policy regarding medical record confidentiality</td>
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<tr>
<td>☐ Policy and procedure for safeguarding of medical records</td>
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<tr>
<td>☐ Policy and procedure for release of information</td>
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<tr>
<td>☐ Policy for record retention</td>
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<tr>
<td>☐ Policy for availability of the medical record when housed in a different office location</td>
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## Auditor / Reviewer ____________________________ Date of Review ____________________________

### Site / Provider Name

<table>
<thead>
<tr>
<th>Provider #</th>
<th>Address</th>
<th>Phone #</th>
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</thead>
</table>

### Primary Care Physician or Specialty

### Member Names

### Member's ID #

### Is this a Special Needs Member? (Yes or No)

<table>
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<tr>
<th>Criteria</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tr>
<td>1. Is the record legible? (1 Point) **</td>
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<td>2. Is there evidence of continuity and coordination of care between primary and specialty physicians? (1 Point) **</td>
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<td>3. Is there evidence of continuity and coordination of care between primary physician and acute facility, skilled nursing facility, rehabilitation centers or homecare services? (1 point)</td>
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<td>4. Is there documentation of the patient having a communicable disease? (1 point)</td>
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<td>5. Is there documentation of provider reporting communicable diseases to the Department of Health? Are copies in the record? (1 Point)</td>
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<td>6. Do all pages contain patient ID # / name? (1 Point)</td>
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<td>7. Is biographical data available in the record? (1 Point)</td>
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<td>8. Is the provider identified on each page? (1 Point)</td>
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<td>9. Is entry signed and dated? (1 Point)</td>
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<td>10. Are allergies and adverse reactions to medications prominently displayed in the record? (1 Point)</td>
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**Critical Elements**

<table>
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<tr>
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<th>No</th>
<th>N/A</th>
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<th>N/A</th>
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<tr>
<td>11 Is there an appropriate past medical history in the record? (1 Point)</td>
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<td>12. Is there documentation of smoking habits, history of alcohol use, or substance abuse? (1 Point)</td>
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<td>13. Is there pertinent history and physical exam of the problem? (1 Point)</td>
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<td>14. Are laboratory and other studies ordered as appropriate? (1 Point)</td>
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<td>15. Are working diagnoses consistent with findings? (1 Point)</td>
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<td>16. Are plans of action / treatment consistent with diagnoses and risk factors? (1 Point)</td>
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<td>17. Is there a date for return visit or other follow-up plan for each encounter? (1 Point)</td>
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<td>18. Are unresolved problems from previous visits addressed? (1 Point)</td>
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<td>19. Is there a completed problem list? (Medical and Psychological conditions) (1 Point)</td>
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<td>20. Is there evidence of appropriate use of consultants / referrals? (1 Point)</td>
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<td>21. Do consultant summaries, labs and imaging study results reflect primary care physician review? (1 Point)</td>
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<td>22. Does the care appear to be medically appropriate? (1 Point)</td>
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<td>23. Is there an updated immunization record in the record, if appropriate? (1 Point)</td>
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<td>24. Did the Primary Care Physician see the patient prior to referral? (1 Point)</td>
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<td>25. Is there a list of prescribed medications, including dosages and dates of initial or refill prescriptions? (1 Point)</td>
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<td>26. Is there information on advance directives documented in the record? (1 Point)</td>
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<td>27. Is there a Mental Health/Substance Abuse Screening Tool completed? (UnitedHealthcare Community Plan, Provider’s Own Tool or other plans tool) (1 Point)</td>
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<td>28. Are preventive services/risk screenings appropriately used? (1 Point)</td>
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<td>29. Is there a completed Pediatric Symptoms/Systems checklist? (1 Point)</td>
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<td>30. Has reviewer checked for notation of cultural/linguistic needs of member? (1 point)</td>
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** Critical Elements **
Appendix C

PA Medical Assistance Manual

The DHS web site also has a wealth of information for providers. The main page for provider information is: http://www.dhs.state.pa.us/provider/index.htm.
Appendix D

Medicaid and CHIP Complaints and Grievances and DHS Medicaid Fair Hearings

Complaints and Grievances
If a provider or UnitedHealthcare Community Plan does something that you are unhappy about or do not agree with, you can tell UnitedHealthcare Community Plan or the Department of Human Services what you are unhappy about or that you disagree with what the provider or UnitedHealthcare Community Plan has done. This section describes what you can do and what will happen.

Complaints
What is a complaint? A complaint is when you tell us you are unhappy with UnitedHealthcare Community Plan or your provider or do not agree with a decision by UnitedHealthcare Community Plan. Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that UnitedHealthcare Community Plan has approved.

What Should I do if I Have a Complaint?
First-Level Complaint
To file a complaint, you can:

- Call us at 800-414-9025 (TTY 711) and tell us your complaint, or
- Write down your complaint and send it to us at: UnitedHealthcare Community Plan of Pennsylvania P. O. Box 31364 Salt Lake City, UT 84131-0364
- Your provider can file a complaint for you if you give him or her your consent in writing to do so.

This is called a first-level complaint. For more information on how to authorize a member representative, please refer to the Personal Representative Authorization form in Appendix A, Form 3.

When Should I File a First-Level Complaint?
You must file a complaint within 45 days of getting a letter telling you that:

- UnitedHealthcare Community Plan has decided you cannot get a service or item you want because it is not a covered service or item,
- UnitedHealthcare Community Plan will not pay a provider for a service or item you got, or
- UnitedHealthcare Community Plan did not decide a complaint or grievance you told us about before within 30 days.

You must file a complaint within 45 days of the date you should have gotten a service or item if you did not get a service or item. The time by which you should have received a service or item is listed below.

You may file all other complaints at any time.

What Happens After I File a First-Level Complaint?
After you file your complaint, you will get a letter from UnitedHealthcare Community Plan telling you that we have received your complaint, and about the first-level complaint review process. You may ask UnitedHealthcare Community Plan for copies of information we have about your complaint. You may also send information that may help with your complaint to UnitedHealthcare Community Plan.

You may attend the complaint review if you want to. You may come to our offices or be included by phone or by video conference, if available. We will send you a letter notifying you of the date of your complaint review with at least seven (7) days advance written notice of the review date. If you decide that you do not want to attend the complaint review, it will not affect our decision.

A committee of one or more UnitedHealthcare Community Plan staff who has not been involved in the issue you filed your complaint about will review your complaint and make a decision. Your complaint will be decided no later than 30 days after we receive your complaint, which may be extended by fourteen (14) days at the request of the member. A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don’t like the decision.

If you need more information or help during the complaint process, follow the instructions in the letters you receive from UnitedHealthcare Community Plan, or call the UnitedHealthcare Community Plan Member Helpline at 800-414-9025.

What to do to Continue Getting Services
If you have been receiving services or items that are being reduced, changed or stopped and you file a complaint that is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services or items
you have been receiving are not covered services or items for you, the service or items will continue until a decision is made.

What if I Don’t Like UnitedHealthcare Community Plan’s Decision?

Second-Level Complaint
If you do not agree without first-level complaint decision, you may file a second-level complaint with UnitedHealthcare Community Plan.

When Should I File a Second-Level Complaint?
You must file your second-level complaint within 45 days of the date you receive the first-level complaint decision letter. To file a second-level complaint, you can:

• Call UnitedHealthcare Community Plan at 800-414-9025 (TTY 711) and tell us your second-level complaint, or
• Write down your second-level complaint and send it to us at:
  UnitedHealthcare Community Plan of Pennsylvania
  P. O. Box 31364
  Salt Lake City, UT 84131-0364

What Happens After I File a Second-Level Complaint?
You will receive a letter from UnitedHealthcare Community Plan telling you that we have received your complaint, and telling you about the second-level complaint review process. You may ask UnitedHealthcare Community Plan for copies of any information we have about your complaint. You may also send information that may help with your complaint to UnitedHealthcare Community Plan.

You may attend the complaint review if you want to. You may come to our offices or be included by phone or by videoconference, if available. If you decide that you do not want to attend the complaint review, it will not affect our decision. A committee made up of three or more people, including at least one person who does not work for UnitedHealthcare Community Plan, who have not been involved in the issue you filed your complaint about, will review your complaint and make a decision.

Your complaint will be decided no later than 45 days after we receive your complaint. A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision.

What can I do if I Still Don’t Like UnitedHealthcare Community Plan’s Decision.

You must ask for an external review within 15 days of the date you received the second-level complaint decision letter. If you ask, the Department of Health will help you put your complaint in writing. You must send your request for external review in writing to either:

Pennsylvania Department of Health Bureau of Managed Care Attention: Complaint Appeals
Room 912 Health and Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701
Phone: 888-466-2787

Pennsylvania Insurance Department Bureau of Consumer Services 1209 Strawberry Square
Harrisburg, PA 17120
Phone: 877-881-6388

If you send your request for external review to the wrong department, it will be sent to the correct department. The Department of Health or the Insurance Department will get your file from UnitedHealthcare Community Plan. You may also send them any other information that may help with the external review of your complaint. You may be represented by an attorney or another person during the external review. A decision letter will be sent to you after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don’t like the decision.

What to do to Continue Getting Services
If you have been receiving services or items that are being reduced, changed or stopped because they are not covered services or items for you and you file a request for an external complaint review that is hand-delivered or postmarked within 10 days of the date on the second-level complaint decision letter, the services or items will continue until a decision is made.

Grievances
What is a grievance? When UnitedHealthcare Community Plan denies, decreases or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a letter (notice)
telling you UnitedHealthcare Community Plan’s decision. A grievance is when you tell us you disagree with UnitedHealthcare Community Plan’s decision.

What Should I do if I Have a Grievance?

First-Level Grievance
To file a grievance, you can:
• Call UnitedHealthcare Community Plan at 800-414-9025 (TTY: 711) and tell us your grievance,
• Your provider can file a grievance for you if you give your Primary Care Provider your consent in writing to do so, or
• Write down your grievance and send it to us at:
  UnitedHealthcare
  Community Plan of Pennsylvania
  P. O. Box 31364
  Salt Lake City, UT 84131-0364

Note: If your provider files a grievance for you, you cannot file a separate grievance on your own.

When Should I File a First-Level Grievance?
You have 45 days from the date you receive the letter (notice) that tells you about the denial, decrease or approval of a different service or item to file your grievance.

What Happens After I File a First-Level Grievance?
After you file your grievance, you will get a letter from UnitedHealthcare Community Plan telling you that we have received your grievance, and about the first-level grievance review process. You may ask UnitedHealthcare Community Plan for copies of any information we have about your grievance. The Member shall be given at least seven (7) days advance written notice of the review date.

You may also send information that may help with your grievance to UnitedHealthcare Community Plan.

You may attend the grievance review if you want to. You may come to our offices or be included by phone or by video conference, if available. If you decide that you do not want to attend the grievance review, it will not affect our decision. A committee of one or more UnitedHealthcare Community Plan staff, including a licensed doctor or dentist, who have not been involved in the issue you filed your grievance about, will review your grievance and make a decision. Your grievance will be decided no later than 30 days after we received your grievance, which may be extended by fourteen (14) days at the request of the member.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don’t like the decision.

If you need more information about help during the grievance process, follow the instructions in the letters you receive from UnitedHealthcare Community Plan, or call the UnitedHealthcare Community Plan Member Helpline at 800-414-9025.

What to do to Continue Getting Services
If you have been receiving services or items that are being reduced, changed or stopped, and you file a grievance that is hand delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services or items you have been receiving are being reduced, changed or stopped, the services or items will continue until a decision is made.

What if I Don’t Like UnitedHealthcare Community Plan’s Decision?
Second-Level Grievance
If you do not agree with our first-level grievance decision, you may file a second-level grievance with UnitedHealthcare Community Plan.

When Should I File a Second-Level Grievance?
You must file your second-level grievance within 45 days of the date you receive the first-level grievance decision letter. To file a second-level grievance, you can:
• Call UnitedHealthcare Community Plan at 800-414-9025 (TTY: 711) and tell us your grievance,
• Write down your grievance and send it to us at:
  UnitedHealthcare
  Community Plan of Pennsylvania
  P. O. Box 31364
  Salt Lake City, UT 84131-0364

What Happens After I File a Second-Level Grievance?
You will receive a letter from UnitedHealthcare Community Plan telling you that we have received your grievance and telling you about the second-level grievance review process. You may ask UnitedHealthcare Community Plan for copies of any information we have about your grievance. You may also send information that may help with your grievance to UnitedHealthcare Community Plan.
You may attend the grievance review if you want to. You may come to our offices or be included by phone or by video conference, if available. If you decide that you do not want to attend the grievance review, it will not affect our decision. A committee of three or more people including a doctor or dentist who have not been involved in the issue you filed your grievance about, will review your grievance and make a decision. Your grievance will be decided no later than 45 days after we receive your grievance.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don’t like the decision.

**What to do to Continue Getting Services**
If you have been receiving services or items that are being reduced, changed or stopped and you file a second-level grievance that is hand-delivered or postmarked within 10 days of the date on the first-level grievance decision letter, the services or items will continue until a decision is made.

**What can I do if I Still Don’t Like UnitedHealthcare Community Plan’s Decision?**

**External Grievance Review**
If you do not agree with UnitedHealthcare Community Plan’s second-level grievance decision, you may ask for an external grievance review. You must call or send a letter to UnitedHealthcare Community Plan asking for an external grievance review within 15 days of the date you received our grievance decision letter. The address is:

UnitedHealthcare
Community Plan of Pennsylvania
P. O. Box 31364
Salt Lake City, UT 84131-0364

We will then send your request to the Department of Health. The Department of Health will notify you of the external grievance reviewer’s name, address and phone number. You will also be given information about the external review process.

UnitedHealthcare Community Plan will send your grievance file to the reviewer. You may provide additional information that may help with the external review of your grievance to the reviewer, within 15 days of filing the request for an external grievance review.

You will receive a decision letter within 60 days of the date you asked for an external grievance review. This letter will tell you all the reasons for the decision and what you can do if you don’t like the decision.

You may call UnitedHealthcare Community Plan’s toll-free telephone number at **800-414-9025** if you need help or have questions about complaints and grievances, you can contact your local legal aid office at **800-322-7572**, or call the Pennsylvania Health Law Project at **800-274-3258** if you need help or have questions about complaints and grievances.

**What to do to Continue Services**
If you have been receiving services or items that are being reduced, changed or stopped and you request an external grievance review that is hand-delivered or postmarked within 10 days of the date on the second-level grievance decision letter, the services or items will continue until a decision is made.

**What Can I Do If My Health Is At Immediate Risk?**

** Expedited Complaints and Grievances**
If your doctor or dentist believes that the usual time frames for deciding your complaint or grievance will harm your health, you or your doctor or dentist can call UnitedHealthcare Community Plan at 800-414-9025 and ask that your complaint or grievance be decided faster. You will need to have a letter from your doctor or dentist faxed to 801-994-1261 explaining how the usual time frame for deciding your complaint or grievance will harm your health.

If your doctor or dentist does not fax UnitedHealthcare Community Plan this letter, your complaint or grievance will be decided within the usual time frames.

**Expedited Complaints**
The expedited complaint will be decided by a licensed doctor who has not been involved in the issue you filed your complaint about.

UnitedHealthcare Community Plan will call you with our decision within 48 hours of when we receive the letter from your doctor explaining how the usual time frame for deciding your complaint will harm your health or within 3 business days of your request for an expedited (faster) complaint review, whichever is sooner. You will also receive a letter telling you the reasons for the decision and how to file a second-level complaint, if you don’t like the decision. An expedited complaint decision may not be requested after a second-level complaint decision has been made on the same issue.

For information on how to file a second-level complaint:
• Call UnitedHealthcare Community Plan at 800-414-9025 (TTY 711) and tell us your second-level complaint, or
Chapter 21: Appendix

- Write down your second-level complaint and send it to us at:

UnitedHealthcare
Community Plan of Pennsylvania
P. O. Box 31364
Salt Lake City, UT 84131-0364

**Expedited Grievances and Expedited External Grievances**

A committee of three or more people, including a licensed doctor and at least one UnitedHealthcare Community Plan member, will review your grievance. The licensed doctor or dentist will decide your expedited grievance with help from the other people on the committee. No one on the committee will have been involved in the issue you filed your grievance about.

UnitedHealthcare Community Plan will call you with our decision within 48 hours of when we receive the letter from your doctor explaining how the usual time frame for deciding your complaint will harm your health or within 3 business days of your request for an expedited (faster) complaint review, whichever is sooner. You will also receive a letter telling you the reasons for the decision and that you can ask for an expedited external grievance review, if you don’t like the decision.

If you want to ask for an expedited external grievance review by the Department of Health, you must call UnitedHealthcare Community Plan at 800-414-9025 within 2 business days from the date you get the expedited grievance decision letter. UnitedHealthcare Community Plan will send your request to the Department of Health within 24 hours after receiving it. An expedited grievance decision may not be requested after a second-level grievance decision has been made on the same issue.

**Help With the Complaint and Grievance Processes**

If you need help filing your complaint or grievance, a staff member of UnitedHealthcare Community Plan will help you. This person can also represent you during the complaint or grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your complaint or grievance.

You may also have a family member, friend, lawyer or other person help you file your complaint or grievance. This person can also help you if you decide you want to appear at the complaint or grievance review.

- For legal assistance you can contact Legal Aid at 800-322-7572.

At any time during the complaint or grievance process, you can have someone you know represent you or act on your behalf. If you decide to have someone represent or act for you, tell UnitedHealthcare Community Plan, in writing, the name of that person and how we can reach him or her.

You or the person you choose to represent you may ask UnitedHealthcare Community Plan to see any information we have about your complaint or grievance. Persons whose primary language is not English: If you ask for language interpreter services, UnitedHealthcare Community Plan will provide the services at no cost to you.

Persons with disabilities: UnitedHealthcare Community Plan will provide persons with disabilities with the following help in presenting complaints or grievances at no cost, if needed. This help includes:

- providing sign language interpreters;
- providing information submitted by UnitedHealthcare Community Plan at the complaint or grievance review in an alternative format. The alternative format version will be given to you before the review; and
- providing someone to help copy and present information.

**NOTE:** For some issues you can request a fair hearing from the Department of Human Services in addition to or instead of filing a complaint or grievance with UnitedHealthcare Community Plan. See below for the reasons you can request a fair hearing.

**Your Providers Responsibility to Provide Interpreter Services**

UnitedHealthcare Community Plan in accordance with Title VI of The Civil Rights Act of 1964 requires participating providers (doctors) to provide interpreter services.

Title VI of the Civil Rights Act of 1964 states, “No person in the United States shall, on grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” Title VI applies to all recipients of federal funds, without regard to the amount of federal funds that they have received. It covers care providers who treat Medicaid or Medicare patients.
Under federal law, providers are:

1. Prohibited from singling out patients based on race or national origin, and

2. Cannot employ practices that have a discriminatory impact on individuals based upon their race or national origin.

3. To notify patients with language barriers (hearing impaired or those with limited English proficiency) regarding their right to language assistance services as needed.

4. To ensure equal access to and quality of health care for diverse populations he/she services.

Upon request, UnitedHealthcare will provide information and instructions to provider’s offices on how to access Hearing Impaired and Language Interpreter services in order to meet the cultural and linguistic needs of its members.

### Department of Human Services Fair Hearings

In some cases you can ask the Department of Human Services to hold a hearing because you are unhappy about or do not agree with something UnitedHealthcare Community Plan did or did not do. These hearings are called fair hearings. You can ask for a fair hearing at the same time you file a complaint or grievance or you can ask for a fair hearing after UnitedHealthcare Community Plan decides your first- or second-level complaint or grievance.

### What kinds of things can I request a fair hearing about and by when do I have to ask for your fair hearing?

<table>
<thead>
<tr>
<th>If You Are Unhappy Because:</th>
<th>You Must Ask for a Fair Hearing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Community Plan decided to deny a service or item because it is not a covered service or item</td>
<td>within 30 days of getting a letter from UnitedHealthcare Community Plan telling you of this decision</td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan decided to not pay a provider for a service or item you got and the provider can bill you for the service or item</td>
<td>within 30 days of getting a letter from UnitedHealthcare Community Plan telling you of this decision</td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan did not decide within 30 days a complaint or grievance you told UnitedHealthcare Community Plan about before</td>
<td>within 30 days of getting a letter from UnitedHealthcare Community Plan telling you that we did not decide your complaint or grievance within the time we were supposed to</td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan decided to deny, decrease or approve a service or item different than the service or item you requested because it was not medically necessary</td>
<td>within 30 days of getting a letter from UnitedHealthcare Community Plan telling you of this decision or within 30 days of getting a letter from UnitedHealthcare Community Plan telling you of its decision after you filed a complaint or grievance about this issue</td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan did not provide a service or item by the time you should have received it (the time by which you should have received it is listed on page 16)</td>
<td>within 30 days from the date you should have received the service or item</td>
</tr>
</tbody>
</table>
How do I ask for a Fair Hearing?
You must ask for a fair hearing in writing and send it to:

Department of Human Services
Office of Medical Assistance Programs – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

Your request for a fair hearing should include:
• Member name, social security number and date of birth.
• Telephone number where you can be reached during the day.
• If you want to have the fair hearing in person or by telephone.
• Any letter you may have received about the issue you are requesting your fair hearing for.

What Happens After I ask for a Fair Hearing?
You will get a letter from the Department of Human Services Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing. You may come to where the fair hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the fair hearing. UnitedHealthcare Community Plan will also go to your fair hearing to explain why we made the decision or explain what happened.

If you ask, UnitedHealthcare Community Plan must give you (at no cost to you) any records, reports and other information we have that is relevant to what you requested your fair hearing about.

When will the Fair Hearing be Decided?
If you ask for a fair hearing after a first-level complaint or grievance decision, the fair hearing will be decided no more than 90 days after the Department of Human Services gets your request. If your appeal is not decided within 90 days from the date that the Department of Human Services receives your request, you may be able to get interim assistance from the Department of Human Services until the decision is made. If you ask for a fair hearing and did not file a first level complaint or grievance, or if you ask for a fair hearing after a second-level complaint or grievance decision, the fair hearing will be decided within 90 days from when the Department of Human Services gets your request.

What to do to Continue Getting Services
If you have been receiving services or items that are being reduced, changed or stopped and your request for a fair hearing is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that UnitedHealthcare Community Plan has reduced, changed or denied your services or items or telling you UnitedHealthcare Community Plan’s decision about your first or second-level complaint or grievance, your services or items will continue until a decision is made.

What can I do if my Health is at Immediate Risk?

Expedited Fair Hearing
If your doctor or dentist believes that using the usual time frames to decide your fair hearing will harm your health, you or your doctor or dentist can call the Department of Human Services at 800-798-2339 and ask that your fair hearing be decided faster. This is called an expedited fair hearing. You will need to have a letter from your doctor or dentist faxed to 717-772-6328 explaining why using the usual time frames to decide your fair hearing will harm your health. If your doctor or dentist does not send a written statement, your doctor or dentist may testify at the fair hearing to explain why using the usual time frames to decide your fair hearing will harm your health.

The Bureau of Hearings and Appeals will contact you to schedule the expedited fair hearing. The expedited fair hearing will be held by telephone within 3 business days after you ask for the fair hearing.

If your doctor does not send a written statement and does not testify at the fair hearing, the fair hearing decision will not be expedited. Another hearing will be scheduled, and the time frame for the fair hearing decision will be based on the date you asked for the fair hearing. If your doctor sent a written statement or testifies at the hearing, the decision will be made within 3 business days after you asked for the fair hearing.

You may call UnitedHealthcare Community Plan’s toll-free telephone number at 800-414-9025 if you need help or have questions about fair hearings, you can contact Legal Aid at 800-322-7572 or call the Pennsylvania Health Law Project at 800-274-3258 if you need help or have questions about complaints and grievances.
## Appendix E

### Legal/Advocacy Help

<table>
<thead>
<tr>
<th>Legal Aid Offices</th>
<th>Phone Number</th>
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</thead>
<tbody>
<tr>
<td>Organization</td>
<td>Phone Number</td>
</tr>
<tr>
<td>Pennsylvania Health Law Project</td>
<td>800-274-3258</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Resources</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization</td>
<td>Phone Number</td>
</tr>
<tr>
<td>AIDS Health Information Hotline/Client Services</td>
<td>800-929-5602</td>
</tr>
<tr>
<td>Domestic Violence Hotline</td>
<td>800-799-7233</td>
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</table>
| Child Abuse Hotline        | 800-932-0313 (In State)  
                          | 717-783-1964 (In and Out of State) |
| Pennsylvania Elder Abuse Hotline | 800-490-8505   |
| Smoking Quitline           | 800-784-8669       |
| (Run by PA Health Department and American Cancer Society) |