



Introduction to UnitedHealthcare Community Plan of California/Medi-Cal

Welcome/Agenda:

- Mission/Vision
- UnitedHealthcare Community Plan of California/Medi-Cal
- Member Eligibility and Benefits
- Notification and Prior Authorization
- Pharmacy Services
- Doing Business with Us
- Care Provider Resources
- Your Physician Advocate
- Questions

Mission and Vision



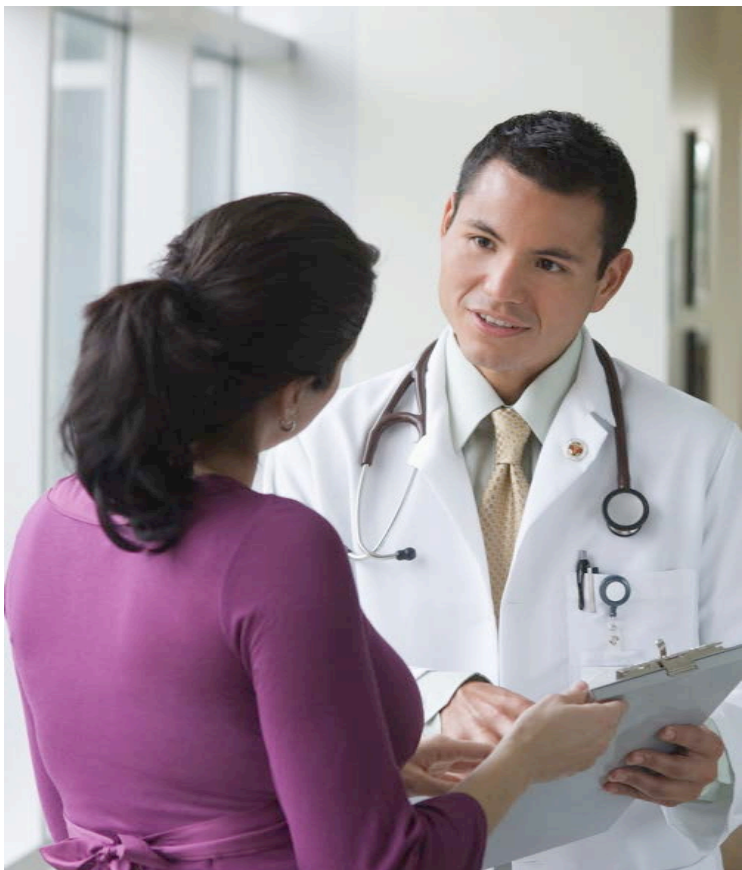
Our Mission

Our mission is to help people live healthier lives and to help make the health system work better for everyone.

Our Vision

To be the premier health care delivery organization in the eyes of our state partners, providing health plans that meet the unique needs of our Medicaid members as well as our members in other government-sponsored health care programs. And to be effective partners with physicians, hospitals and other health care professionals in serving their patients.

UnitedHealthcare Community Plan of California Medi-Cal Overview



- **Product/program:** Medi-Cal
- Sacramento and San Diego Counties
- **Program go-live date:** Oct. 1, 2017
- **Expected Membership:** TBD

Member Eligibility

Who is Eligible?

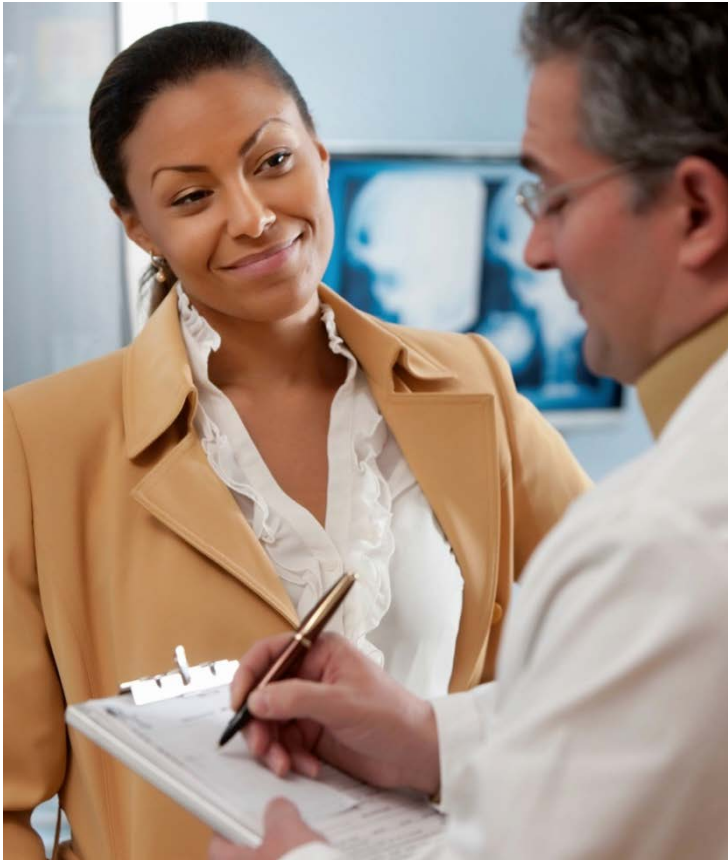
- Low-income adults
- Families with children
- Seniors
- People with disabilities
- Pregnant women

Members Who Can Voluntarily Enroll:

- Individuals with a complex or high-risk medical condition who are in an established treatment relationship with a care provider or who are not participating in one of the following other managed care Medi-Cal plans:
 - Geographic Managed Care
 - Two-Plan
- Children in foster care or the Adoptions Assistance Program
- Native Americans, their household members and those who qualify for services from an Indian Health Center



Program Benefits



Routine Medical Transportation

- Services available through LogisitCare
- Reservations: call 844-772-6623
- Ride Assist Help Line: call 844-772-6624

Palliative & Hospice Care Services

- Qualifying members may voluntarily enroll in Palliative Care or Hospice Care by contacting their PCP or specialist or health plan.

Standard Benefits

- Visit **UHCCommunityPlan.com > For Health Care Professionals > California > Provider Administrative Manual.**


Verifying Member Eligibility and Benefits

Please verify member eligibility and benefits one of the following ways before providing services:

- To sign in to Link, go to UHCprovider.com and click on the Link button in the top right corner. Then, select the eligibilityLink app tile on your Link dashboard.
- Call Provider Services at 866-270-5785 or the number on the back of the member's ID card.
- Always check benefits before providing services to a UnitedHealthcare Community Plan member.

Member ID Cards

- To submit claims accurately and completely, check the information on our members' ID cards.
- Be sure to check the member's ID card at each visit and copy both sides for your files.
- Member ID cards can also be viewed online using the Eligibility & Benefits application on Link.


 **UnitedHealthcare** Community Plan
Health Plan (80840) 911-87726-04

Member ID: 999999999 Group Number: CAMCMP

Member:
SUBSCRIBER A MEMBER

PCP Name:
PROVIDER PHYSICIAN
PCP Phone: (999)999-9999

Payer ID: 87726



Rx Bin: 610494
Rx Grp: ACUCA
Rx PCN: 4444

0501 Administered by UnitedHealthcare Community Plan of California, Inc.

In case of emergency call 911 or go to nearest emergency room. Printed: 07/18/17

This card does not guarantee coverage. To verify benefits or to find a provider, visit the website myuhc.com/communityplan or call. Emergency Services rendered to the Member by non-Contracting providers are reimbursable by the Contractor without Prior Authorization.

For Member Customer Service: 866-270-5785 TTY 711

For Providers : uhccommunityplan.com 866-270-5785
Claims: PO Box 30884, Salt Lake City, UT 84130-0884

Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 877-305-8952

Member Responsibilities

- Each member selects a primary care provider (PCP) at enrollment. If a member does not select a PCP, UnitedHealthcare Community Plan will assign one.
- When there are multiple members in the same household, each may choose a unique PCP.
- Members may change their PCP at any time.
 - Members can see their old or new PCP without having to wait for the change to take effect. We won't interrupt claims payment or access to care, no matter which PCP is on file. Our only requirement is that the PCP is a network care provider and that services performed are covered under Medi-Cal.
- Members do not need a referral before seeing another in-network physician or specialist.
- Some services require advance notification and prior authorization.

Advance Notification

- Advanced notification is required for certain planned services listed in the Advance Notification List section of the Administrative Guide.
- **Advance notification is required at least 14 calendar days for standard services and 72 hours for expedited service.**
- Submitting the request with complete clinical information will help expedite the decision process.
- You can submit advance notification at UHCCommunityPlan.com > For Health Care Professionals California > Provider Forms & Resources > Prior Authorization Fax Request Form

To view the most current and complete Advance Notification List including procedure codes and associated services, please go to UHCProvider.com > For Health Care Professionals > California > Provider Information > UnitedHealthcare Community Plan Prior Authorization CA

Prior Authorization Requirements

- Prior authorization is usually required when a UnitedHealthcare Community Plan member's benefit document requires that services be medically necessary to be covered.
- Notification of a request for service is not a guarantee of payment. The care provider or facility requesting prior authorization will receive a written decision of clinical coverage determination based on medical necessity.
- If prior authorization is required, a clinical coverage review is conducted to determine if the service is medically necessary based on evidence-based clinical guidelines.
- After the clinical review is completed, if the information submitted does not meet medical necessity guidelines, the care provider will be offered a peer-to-peer with the reviewing UnitedHealthcare physician.

Prior Authorization Resources

- You can view the prior authorization list at UHCCommunityPlan.com > For Health Care Professionals > California > Billing & Reference Guides > Advanced Notification/Prior Authorization List.
- To download the prior authorization fax request form, visit UHCCommunityPlan.com > For Health Care Professionals > California > Provider Forms > Prior Authorization Faxed Request Form.

Prior Authorization Standards

- Please schedule procedures as far in advance as possible.
- We will provide a decision for standard/non-emergency requests within 14 days of receiving clinical information.
- Urgent requests will have a decision rendered within 72 hours of receipt of clinical information.
- Additional information may be required to make a determination on some requests. Turnaround times may be affected by delays in receiving that information. If the requested information is submitted after the time limit in your contract, the authorization request will be denied.

Prior Authorization Contact Information



Phone: 866-270-5785, weekdays, 7 a.m. - 7 p.m. Pacific Time;
available 24 hours for emergencies.

Fax: 855-432-2828

Pharmacy

- OptumRx, our pharmacy benefits manager, oversees pharmacy network contracting and claims processing.
- Our preferred drug list (PDL) is available at UHCCommunityPlan.com > For Health Care Professionals > California > Pharmacy Program.
- The drugs listed in the PDL have been reviewed and approved by the UnitedHealthcare Community Plan Pharmacy and Therapeutics Committee.

E-Prescribing



E-prescribing can help care providers save time and money, and help eliminate medication confusion. We offer e-prescribing for pharmacy claims through Surescripts.

E-prescribing allows care providers to:

- Access a member's medication history
- Check a member's eligibility
- Access the formulary
- Send real-time electronic prescriptions

Pharmacy Prior Authorization



Medications can be dispensed as an emergency five-day supply when drug therapy must start without delay and prior authorization is not available. This rule applies to non-preferred drugs on PDL and to any drug that is affected by a clinical or prior authorization edit.



To request pharmacy prior authorization, please call our Pharmacy Help Desk at 800-310-6826 or fax your authorization request to 866-940-7328.

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

Radiology/Cardiology Prior Authorization Requirements

- All advanced imaging/cardiac procedures requiring advance notification also requires prior authorization.
- All providers, facilities and other health care professionals are required to obtain authorization **prior** to performing select inpatient, outpatient and office-based procedures.
- Prior authorizations are **not required** for cardiac or radiology procedures **ordered** through an:
 - Emergency room treatment visit
 - Observation unit
 - Urgent care facility
 - Inpatient stay

Exception: Electrophysiology implants like pacemakers, which require authorization in an inpatient setting

Requesting Radiology/Cardiology Prior Authorization

- You can initiate authorization online at UHCProvider.com > Prior Authorization and Notification > Cardiology **OR** Radiology > Prior Authorization and Notification App.
- Additional information and a Quick Reference Guide are available at this location as well.

Check Prior Authorization Status:

- Online: UHCProvider.com > Link > Prior Authorization and Notification
- Phone: 866-270-5785

Clinical Coverage Review Process

If insufficient clinical information is submitted, we will send a fax or call the care provider to request additional information.

- If information is provided within the requested timeframe, a clinical coverage review will be conducted to determine medical necessity.
- If additional information is not provided within the requested timeframe, the request for authorization will be denied.

If medical necessity criteria is not met for a prior authorization or precertification requests:

- A clinical denial will be issued if it is determined that the requested service does not meet medical necessity criteria.
- The member and care provider will receive a denial notice with the option to appeal.

Reconsideration Processes

1. **Additional clinical information** received can be reviewed as long as it meets state turnaround timeframe guidelines.
2. **Peer-to-Peer Review:** The phone numbers to request peer-to-peer review will be on the notice of adverse determination (denial) letter. They differ for each clinical area. The Utilization Management nurse reviewer will also provide this number at the time of notification of denial.

Timeframe for Peer-to-Peer Reviews

- Pre-service/outpatient: 14 calendar days from notice of denial
- Inpatient: 14 calendar days from notice of denial or three business days after discharge, whichever comes first.

Notification Timeframes

Notification must include all items and services needed to give appropriate care during a stay at a participating hospital, including room and board, nursing care, medical supplies and all diagnostic and therapeutic services.

Notification Timeframes:

- **Emergency/Urgent Admission:** Within two business days of the admission.
- Observation does not require notification, but if the member's level of care is adjusted to inpatient, notification is required.
- **After Ambulatory Surgery:** Within two business days of the admission.

Notification Options

You can notify us of a hospital admission in three ways:

- Online: UHCProvider.com > Prior Authorizations and Notification > Go to Prior Authorization and Notification App
- Phone: 866-270-5785
- Fax: 855-432-2828

If notification timeframes are not followed, claims may be denied.

Claims Submission

Electronic submission options: Payer ID 87726 is the primary Payer ID.

- UHCProvider.com > Menu > Claims, Billing and Payments > Submit a Claim
- Clearinghouse of your choice: If you receive 835 Electronic Remittance Advice (ERAs) through a vendor, please ask them to enroll you for the 835 through OptumInsight.
- For more information, please contact your vendor or call Electronic Data Interchange (EDI) at 800-842-1109.

Claims Submission cont'd



Mail claims to:



UnitedHealthcare Community Plan
– California
P.O. Box 30884
Salt Lake City, UT 84130-0884

Standard Timely Filing:

- 180 days from date of service

Submitting a Claims Reconsideration

- **Preferred Method:** Please submit claims reconsideration requests electronically through your EDI Clearinghouse or using the Claim Reconsideration application on Link.
- To submit paper claim reconsideration, please use the Claim Reconsideration Request Form for corrections that require specific instructions. The form is not required for basic corrections or adjustments.
- The Claim Reconsideration Request Form is available at UHCPProvider.com > Claims, Billing and Payments > Submit a Claim Reconsideration / Begin Appeal Process > Resources for Community Plan.

Submitting a Corrected Paper Claim

- On the Claim Reconsideration Form, check the box #4, *Resubmission of a corrected claim*.
- Complete the Comments section, clearly stating what data elements have been corrected and why.

the accounting software information must also include proof that the claim is for the correct patient and the correct visit.

• Proof of timely filing could also include other insurance carrier's denial/rejection, EOB, letter indicating terminated coverage, not a plan participant, etc.

2. Previously denied / closed for "Additional Information" (provide description and/or requested documents)

3. Previously denied / closed for "Coordination of Benefits" information (attach primary carrier's EOB)

4. Resubmission of a corrected claim (explain correction below)

5. Previously processed but contracted rate applied incorrectly resulting in over/underpayment (explain below)

6. Resubmission of "Prior Notification Information" (including notification information)

7. Resubmission of "Bundled claim" (including all supporting information)

8. Other (explain below)

Please include what you are expecting from UnitedHealthcare to close UnitedHealthcare's portion of this claim in your practice management system, including dollar amount if possible.

Comments:

If, after you have received a response upon completion of the Claim Reconsideration process, you still do not agree with the outcome of the claim reconsideration you may submit a letter of appeal and receipt of a response from UnitedHealthcare. To submit a formal appeal, submit a letter outlining your dispute, any supporting documentation, including our response to the reconsideration request, and the date your reconsideration stage was completed to:

- Send the claim and Claim Reconsideration Request Form to the address on the explanation of benefits (EOB) or back of the member ID card.

Electronic Payments & Statements (EPS)

With EPS, you receive electronic funds transfer (EFT) for claim payments, plus Explanation of Benefits (EOBs) are delivered online.

- Lessens administrative costs and simplifies bookkeeping
- Reduces reimbursement turnaround time
- Funds are available as soon as they are posted to your bank account.



To receive direct deposit and electronic statements through EPS, please enroll at myservices.optumhealthpaymentservices.com.

Here's what you'll need:

- Bank account information for direct deposit
- Either a voided check or a bank letter to verify bank account information
- A copy of your practice's W-9 form

Electronic Payments & Statements (EPS) cont'd

If you're already signed up for EPS, you will automatically receive direct deposit and electronic statements through EPS for UnitedHealthcare Community Plan of California.



For more information, please call 866-842-3278, option 5.



Go to UHCPProvider.com > Menu > Claims, Billing and Payments > Electronic Payments and Statements.

Appeals and Grievances

Submitting a Provider Formal Claims Appeals

- All formal claims appeals must be filed within 365 days of the date of the provider remittance. Care providers should mail a written appeal to:

Attention: Formal Claims Appeal
P.O. Box 31364
Salt Lake City, UT 84131-0364

Submitting an Appeal on Behalf of a Member

- A care provider may submit an appeal on behalf of a member.
- Appeals must be filed within 90 days of the Notice of Action letter for denial and must be submitted in writing.
- Care providers must complete the Authorization of Representative (AOR) on the appeal form.
- The appeal form is located online at UHCPProvider.com > Claims, Billing and Payments > Submit a Claim Reconsideration / Begin Appeal Process > Resources for Community Plan.



Complaints and Grievances

Submitting an Appeal on Behalf of a Member (cont'd)

When submitting an appeal on behalf of a member, please mail the form to:

UnitedHealthcare Community Plan – California
Attention: Provider Dispute
P.O. Box 31364
Salt Lake City, UT 84131

- You may also submit an appeal by phone; however, you will need to submit a written request as well.

Submitting an Expedited Appeal on Behalf of the Member

- You may submit an Expedited Appeal on behalf of a member by calling Provider Services at 866-270-5785.
- The expedited appeal will be urgently routed and reviewed by clinical staff.
- If the case doesn't qualify for urgent status, it will be reclassified as standard appeal and processed accordingly. The analyst assigned to the case will attempt to call the care provider to tell them about the change and will follow up in writing.



Communicating Provider Data Changes

To help us provide our members with the most accurate and up-to-date information about our network, please notify us of changes to your information at least 30 days before the change is effective. Examples of changes include:

- Whether you're accepting new patients
- Address, phone numbers, email addresses and office hours of all locations where you currently practice
- Medical group and hospital affiliations
- Hospital, facility or clinic name
- Your specialties and board certifications
- Licenses, NPIs and tax identification number
- Languages spoken/written by you and your staff
- The ages and genders you serve
- Any care providers who have left your practice

Communicating Provider Data Changes

As a registered health care provider, you can update your practice information in multiple ways:



Use the My Practice Profile and Attestation application on Link. To access Link, please sign in to UHCProvider.com using your Optum ID.



Access form the Provider Demographic Change Form at UHCProvider.com > Resource Library > Link Self-Service Tools > My Practice Profile and Attestation.



Call Provider Services at 877-842-3210.

Link Overview

Overview

- Link is your gateway to UnitedHealthcare's online tools and resources.
- Use Link to check member eligibility and benefits, manage claims, submit claim reconsideration requests and more.
- Link's enhanced features can help make it easier to do business with us. Complete transactions faster* so you can focus on what's important – providing care to your patients.
- You can even customize your dashboard to put your most common tasks at your fingertips.
- To **sign in** to Link, go to UHCprovider.com and click on the Link button in the top right corner.

* Based on ongoing usability studies using keystroke-level modeling when comparing Link to UnitedHealthcareOnline.com and Optum Cloud Dashboard

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Sign In to UHCProvider.com to Access Link



Search Term



LINK



NEW USER



SIGN IN

*Use the MENU
to explore by topic*

*Search can take you
quickly to what you want*

*Head straight to LINK
for self-service tools*

Hello!

Welcome to your new home for the latest news, policy information and access to Link self-service tools for care providers.

[Learn More](#)

*The most common actions are
grouped into these tiles below*

*See the blue tab? We'd
love to hear your feedback!*



Use Your Optum ID to Sign In

If you can't remember your Optum ID or password, click *Forgot Optum ID* or *Forgot Password*.

Don't have an Optum ID yet? Please register for one by clicking *Create an Optum ID*.

Sign In With Your Optum ID

Optum ID or email address

Password

[Forgot Optum ID](#) [Forgot Password](#)

Additional options:
[Create an Optum ID](#)
[Manage your Optum ID](#)
[What is an Optum ID?](#)

What's on Link?

Apps on Link include:

- eligibilityLink
- claimsLink
- My Practice Profile
- And more

Access other UnitedHealthcare websites, including:

- UHCCommunityPlan.com
- UHCProvider.com
- And more

The screenshot displays the 'eligibilityLink' web application interface. At the top left, there is a search form with the following fields and labels:

- *Required**
- *Confirm Payer Name (Insurance Company)/Payer ID**: A text input field containing 'UnitedHealthcare - 87726' and a close button (X).
- * Member ID**: A text input field.
- * Date of Birth**: A date selection field with the format 'MM/DD/YYYY' and a calendar icon.
- First Date of Service**: A date selection field with the format 'MM/DD/YYYY' and a calendar icon.
- Last Date of Service**: A date selection field with the format 'MM/DD/YYYY' and a calendar icon.

Below the date fields, a note states: *If a date range is not entered, current date will be used.* A blue 'Search' button is positioned below the note, and a link for [More Search Options](#) is located at the bottom of the search section.

To the right of the search form is a grid of navigation tiles:

- Electronic Payments & Statements**: Features a circular icon with three colored segments.
- UHC On Air**: Features a television icon.
- UnitedHealthcare Online**: Features the UnitedHealthcare logo.
- claimsLink**: Features the UnitedHealthcare logo.
- Care Conductor**: Features a red cross icon on a white background.
- My Practice Profile**: Features a blue document icon.
- ICD 10 Lookup Tool**: Features a blue book icon.
- Quick Reference Guides**: Features a red document icon.

Link Resources

To learn more about Link, please visit the Link resources page at UHCProvider.com > Resource Library > Link Self-Service Tools

Link Self-Service Tools

Care Conductor App

claimsLink App

Document Vault and Paperless Delivery Options

EPS App

eligibilityLink App

My Practice Profile and Attestation

PreCheck MyScript App

Prior Authorization and Notification App

referralLink App

Training

Link Self-Service Tools

Link is your gateway to UnitedHealthcare's online tools.

With Link, you can get member eligibility, benefits and claims information for multiple UnitedHealthcare plans – without having to pick up the phone or jump between multiple websites.

[Link Overview \(PDF\)](#)

[Go to Link Self-Service Tool Dashboard](#)

For general Link information and help, click on any plus sign (+) below to access quick reference guides, tutorials, FAQs and more.

Getting Started With Link +

User ID & Password Management +

Care Provider Resources

Visit UHCCommunityPlan.com > For Health Care Professionals > California for resources that include:

Administrative Guide:

- Available using the UnitedHealthcare Community Plan application Link

Practice Matters Newsletter: Published quarterly

Network Bulletin Newsletter:

- Alerts you to any change in policies or procedures and updates to the Administrative Guide
- View *Network Bulletin* at UHProvider.com > Resource Library > News and Network Bulletin > Network Bulletin

Reimbursement Policy Updates: Alerts you to any change in the reimbursement policies or procedures



Provider Relations Service Model

Your Physician Advocate is an important resource when you have questions. They are your single point of contact across all lines of business and benefit plans to help make your interactions with us easier and more efficient.

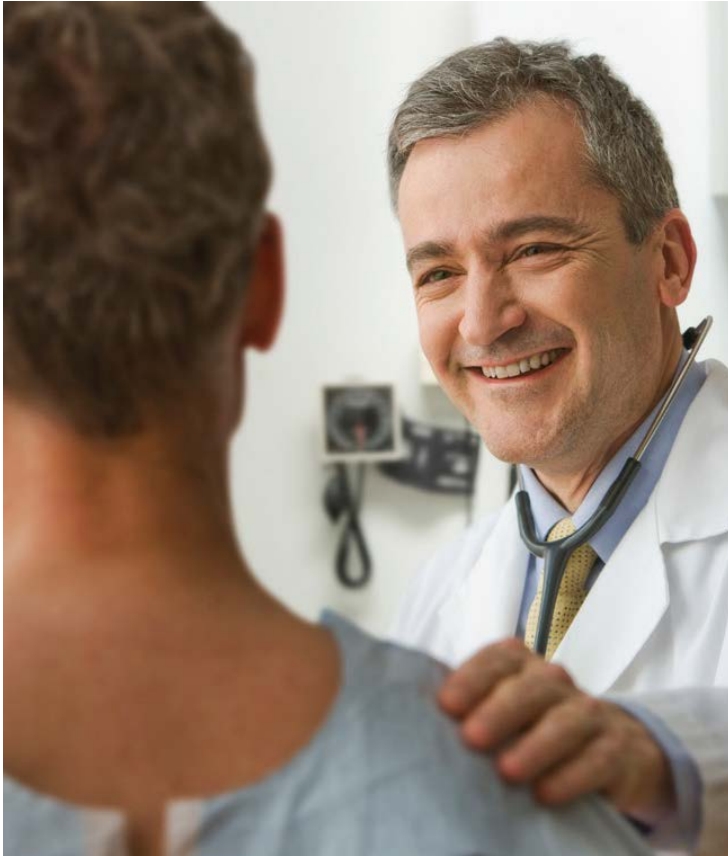
Please follow the Provider Relations Service Model before contacting a Physician Advocate about claim payment decisions:

1. If you disagree with a claim payment decision, please do one of the following:
 - Use the Claims Reconsideration application on Link.
 - Submit a paper reconsideration.
 - Call 866-270-5785.

Be sure to obtain a tracking number for future reference. This is a 15-digit number beginning with a “C.”



Provider Relations Service Model cont'd




2. If the issue remains unresolved after 30 days, please send your Physician Advocate the member name, member ID number, date of service and tracking number or a copy of the claim.
3. Your Physician Advocate will work with Market Service Agents and other to determine the cause and resolve your issue.

California Physician Advocates


Physician Advocates

Christin Dillon

 858-658-8728

 christin.dillon@uhc.com

Lisa Fang

 916-403-0635

 lisa.fang@uhc.com

Keshona M. Rolle

 858-658-8530


 keshona.rolle@uhc.com

Elva A. Felix

 858-658-8532

 elva.felix@uhc.com

Sonia Labrado

 916-403-0481

 sonia.labrado@uhc.com



Thank You
