Introduction to UnitedHealthcare Community Plan of Virginia CCC Plus

Ancillary Provider Education Session

UnitedHealthcare®
Community Plan

Welcome/Agenda:

- Mission/Vision
- UnitedHealthcare Community Plan of Virginia CCC Plus
- Member Eligibility and Benefits
- Notification and Prior Authorization
- Doing Business with Us
- Care Provider Resources
- Ancillary Advocate and Contracting Contacts
- 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.

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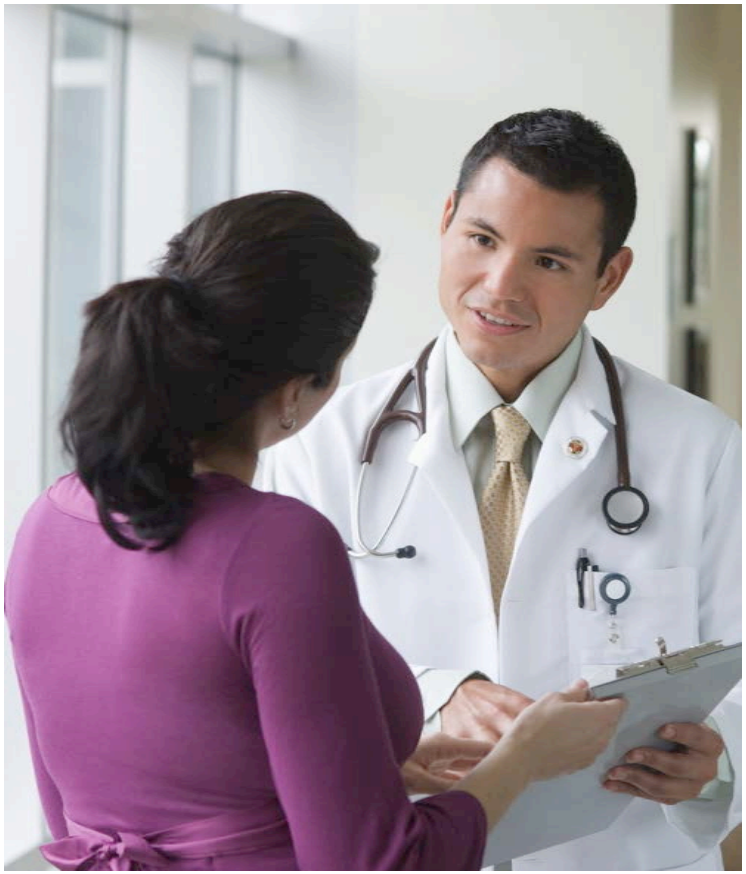
UnitedHealthcare Community Plan of Virginia CCC Plus Overview



The Commonwealth Coordinated Care (CCC) Plus plan aims to provide coordinated long-term care services across different health care settings and to provide enrollee access to cost-effective community based long-term care services.

- **Launch dates:**

Regions	Go Live Date
Tidewater	8/1/2017
Central	9/1/2017
Charlottesville/Western	10/1/2017
Roanoke/Alleghany/Southwest	11/1/2017
Northern/Winchester	12/1/2017

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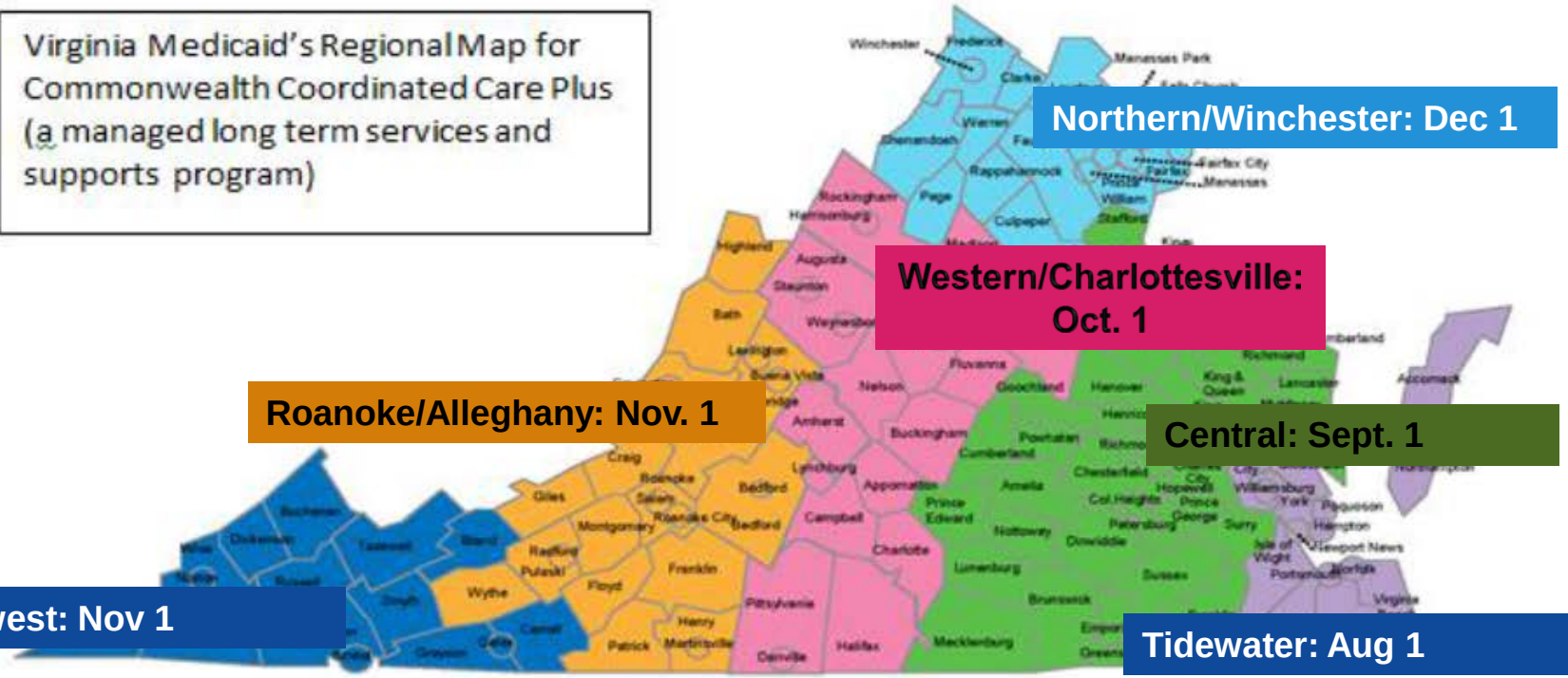
Virginia CCC Plus Regional Timelines

Virginia Medicaid's Regional Map for Commonwealth Coordinated Care Plus (a managed long term services and supports program)



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Member Eligibility

Who is Eligible?

- Dual-eligible individuals with full Medicaid and any Medicare A and/or B coverage.
- Non-dual eligible individuals who receive Long Term Support Services (LTSS) services through:
  - An institution or Home and Community-Based Services (HCBS) 1915(c) waivers:
    - Building Independence
    - CCC Plus
    - Community Living (CL); and
    - Family and Individual Supports (FIS)
- Individuals enrolled in the Commonwealth Coordinated Care (CCC) program, who will transition to CCC Plus program on Jan. 1, 2018, after the CCC program ends.
- Remaining Aged, Blind, and Disabled (ABD) population (non-duals eligible and those who do not receive LTSS); most will transition from the DMAS Medallion 3.0 Medicaid program to the CCC Plus program on Jan. 1, 2018.
- Some individuals enrolled in the Medicaid Works program, Native Americans, individuals with other comprehensive insurance, children in foster care and adoption assistance

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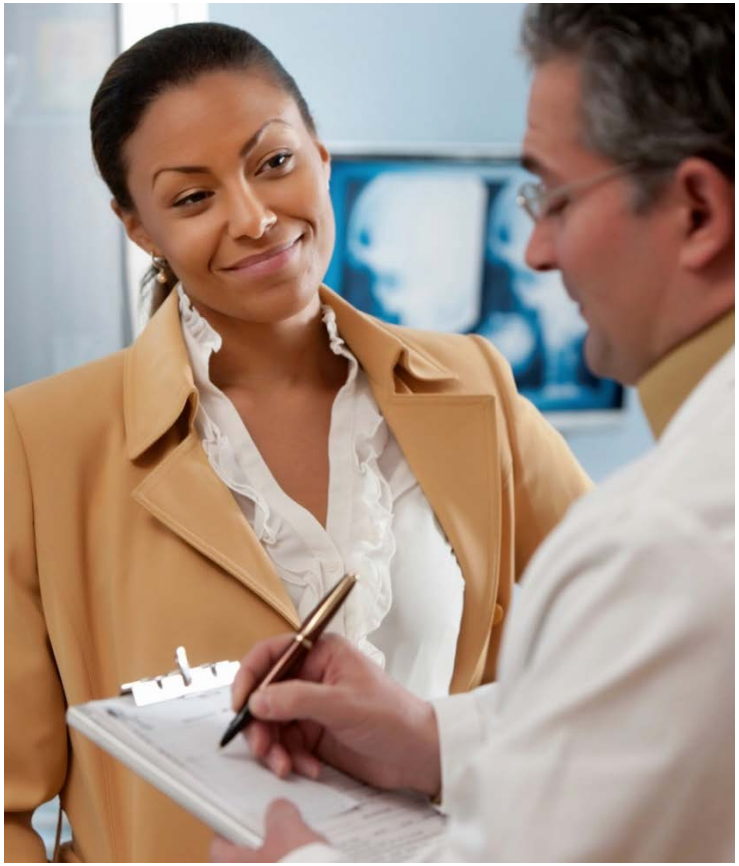
Program Benefits



Standard Benefits

- Please visit UHCCommunityPlan.com > For Health Care Professionals > Virginia > Provider Resources

Value-Added Benefits

- Adult Preventive Dental
- Vision

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CCC Plus Program Benefits

SUMMARY OF COVERED SERVICES - MEDICAL BENEFITS		
Service	**Coverage Type**	**Limits/Considerations**
Abortions, induced	Covered	Must meet current federal and state guidelines and be medically necessary
Acupuncture	Not Covered	
Allergy Testing	Covered	
Audiology	Covered	
Autism	Limited Coverage	
Ambulance Services	Covered	
Chemotherapy	Covered	
Chiropractic Services	Not Covered	See Chapter 4 for EPSDT services.
Clinic Services - preventative, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinic visits.	Covered	
Colorectal Cancer Screening	Covered	
Community Intellectual Disability Case Management	Not Covered	
Cosmetic Surgery	Not Covered	
Court Ordered Services	Covered	Medical necessity rules apply
Dental	Covered	Under 21 and adult pregnant: not covered; Covered Limits apply when older than 21
Developmental Disability Support Coordination	Not covered	
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services	Covered	See Chapter 4 for EPSDT services
Early Intervention Services	Covered	See Chapter 4 for EPSDT services
Emergency Services	Covered	
Emergency Services - Post Stabilization Care	covered	See chapter 4 for criteria
End Stage Renal Disease (ESRD)	covered	Limitations may apply

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CCC Plus Program Benefits

SUMMARY OF COVERED SERVICES - MEDICAL BENEFITS		
Service	**Coverage Type**	**Limits/Considerations**
Experimental and Investigational Procedures	Not Covered	
Family Planning Services	covered	
FQHC/RHC	Covered	
HIV Testing and Treatment	Covered	
Home Health Services	covered	Limited to 32 home health aide visits per year. Authorization requirements may apply
Hospice	Covered	
Immunizations	Covered	Coverage only for under 21.
Inpatient Hospital Services	covered	Authorization requirements may apply
Infertility	Not Covered	
Laboratory, Radiology and Anesthesia Services	Covered	
Mammograms	Covered	
Maternity Services	Covered	
Medical Supplies and Equipment	covered	Authorization requirements may apply
Certified Nurse-Midwife Services	Covered	
Organ Transplantation	covered	Authorization requirements may apply
Outpatient Hospital Services, including preventative, diagnostic, surgical services rendered by hospitals	covered	Authorization requirements may apply
Pain Management/Clinic	Covered	
Pap Smears	Covered	
Personal Care	Limited Coverage	Coverage only applies for CCC Plus home/community-based service waivers or under EPSDT
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	covered	Authorization requirements may apply
Physician Services	Covered	

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CCC Plus Program Benefits

SUMMARY OF COVERED SERVICES - MEDICAL BENEFITS		
Service	**Coverage Type**	**Limits/Considerations**
Podiatry- diagnostic, medical or surgical treatment of disease, injury, or defect to human foot.	Limited Coverage	Limitations may apply. Not Covered: preventative care, routine foot care cutting/removal of corns, warts, calluses.
Pregnancy-Related Services	covered	
Prescription Drugs	covered	Copay and limits may apply
Private Duty Nursing (PDN)	Covered	Coverage only applies for CCC Plus home/ community-based service waivers or under EPSDT
Prostate Specific Antigen (PSA) and digital rectal exams	Covered	
Prosthetics/Orthotics	covered	Authorization requirements may apply
Prostheses, Breast	Covered	
Radiology Scans (MRI, PET, MRA, CT)	Covered	
Reconstructive Breast Surgery	Covered	
Second Opinions	Covered	When medically necessary
School Health Services	Not covered	
Skilled Nursing Facility Care -	Covered	
Tobacco Cessation	covered	
Telemedicine Services	Covered	
Transportation	covered	
Urgent Care	Covered	
Vision Services	Limited Coverage	ages 20 and younger: 1 exam per year, 1 frames unit every 2 years, 2 lens every 2 years, contact lenses only when medically necessary ages 21 and older: 1 exam per year, 1 frames unit every 2 years, 2 lens every 2 years, no contact lenses

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Verifying Member Eligibility and Benefits

Before providing services, please verify member eligibility.

- To verify eligibility, please sign in to UnitedHealthcareOnline.com to access Link, then select the eligibilityLink app.
  - If you don’t have an Optum ID, go to UnitedHealthcareOnline.com and select “New User” to begin registration.
- Call Provider Services at 877-843-4366 or call the number on the back of the member’s ID card.
- Always check benefits before providing services to a UnitedHealthcare Community Plan member.

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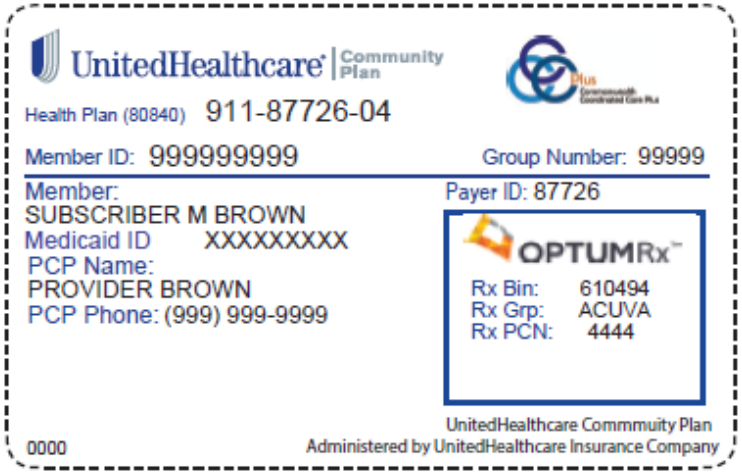
Member ID Cards

- UnitedHealthcare Community Plan members receive member ID cards with information to help you submit claims accurately and completely.
- Be sure to check the ID card at each visit and copy both sides for your files.
- Member ID cards can also be viewed online using the eligibilityLink app on Link.



CCC Plus Member ID Card Sample

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PCP 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 monthly if not enrolled in the Patient Utilization Management and Safety (PUMS) program.
- PUMS members may be limited to a single primary care provider.
- **Referrals are required for specialty care not offered by the member's primary care provider.**
- Some services require advance notification and prior authorization. For more details, please refer to the Care Provider Manual.

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Clinical Program Requirements

Advance Notification

- Advance notification is required for certain planned services. You can find them in the Advance Notification List section of the Care Provider Manual.
- Advance notification is required at least 14 calendar days before the planned service date.
- Submitting the request with complete clinical information will help expedite the decision process.
- You can submit advance notifications at UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Notification/Prior Authorization Submission.

To view the most current and complete advance notification requirements, please go to UHCCommunityPlan.com > For Health Care Professionals > Virginia > Billing & Reference Guides > Advanced Notification/Prior Authorization List.

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Prior Authorization Requirements

- Prior authorization is required if a UnitedHealthcare Community Plan member's benefit document requires that only medically necessary services are 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 will use evidence-based clinical guidelines to determine if the service is medically necessary.
- If the information submitted does not meet medical necessity guidelines, the care provider will be offered a peer-to-peer review with the reviewing UnitedHealthcare physician.

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Prior Authorization Resources

- To view the prior authorization list, visit UHCCommunityPlan.com > For Health Care Professionals > Virginia > Billing & Reference Guides > Advanced Notification/Prior Authorization List.
- You can find and download the prior authorization fax request form at UHCCommunityPlan.com > For Health Care Professionals > Virginia > Provider Forms > Prior Authorization Faxed Request Form.
- To submit prior authorization requests, visit UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Notification/Prior Authorization Submission.

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Prior Authorization Timeframes

- Please schedule procedures as far in advance as possible.
- We'll provide a decision for standard/non-emergency requests within three days of receiving clinical information.
- Urgent requests will have a decision rendered within 72 hours of receipt of clinical information.
- If we need additional information, response times may vary.

Prior Authorization Contact Information

Phone: 877-843-4366, weekdays, 8 a.m. – 6 p.m. ET; available 24 hours for emergencies

Fax: 844-882-7133

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Radiology/Cardiology Prior Authorization Requirements

- The same advanced imaging/cardiac procedures requiring advance notification are the same procedures requiring prior authorization.
- All care providers, facilities and other health care professionals are required to obtain authorization **prior** to performing select inpatient, outpatient and office-based procedures.
- The ordering care provider is responsible for obtaining the authorization.
- Prior authorizations is **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.

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Initiating Radiology/Cardiology Prior Authorization

- Initiate authorization online at UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Cardiology Notification & Authorization – Submission & Status **OR** Radiology Notification & Authorization – Submission & Status

Check Prior Authorization Status:

- Online: UnitedHealthcareOnline.com
- Phone: 866-889-8054

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Clinical Coverage Review Process

If insufficient clinical information is submitted, we will fax or call the requesting 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 may be denied.

If medical necessity criteria is not met for a prior authorization or precertification request, a clinical denial will be issued.

- The member and care provider will receive a denial notice with the option to appeal.

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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 and are different for each different clinical area. This number is also provided by Utilization Management nurse reviewer at the time of notification of denial.

Timeframe for Peer-to-Peer Reviews

- Pre-service/outpatient: 30 calendar days from notice of denial
- Inpatient: 30 calendar days from notice of denial or three business days after discharge, whichever comes first.

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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.

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Continuity/Transition of Care Protocol

UnitedHealthcare adheres to two policies related to the transition and continuity of care for its members.

- **Transition of Care (TOC)** allows newly enrolled members or members switching to another UnitedHealthcare plan a transition period based on standard TOC/COC requirements **before she or he** is required to transfer from an Out-of-Network provider to an In-Network provider in order to receive INN benefits.

- **Continuity of Care (CoC)** allows current members a transition period based on standard TOC/CoC requirements when a participating provider leaves the network.

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TOC/CoC Criteria

- **Active Course of Treatment:** Involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify a treatment
- **Significant Acute Condition:** A medical condition, more serious in nature, with a sudden onset of symptoms due to injury, illness or other medical problems that requires prompt medical attention for a limited duration; examples include pneumonia or cellulitis, acute cholangitis or pancreatitis, heart attack or stroke
- **Postpartum:** Immediate postpartum period is six weeks for vaginal birth and eight weeks for cesarean birth
- **Serious Chronic Condition:** A medical condition due to disease, illness or other medical problem or disorder that is serious in nature and that continues without cure, or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration

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TOC/CoC Timeframe

If the criteria is met, the following timeline applies:

- **Transition of Care:** 90 days from member's date of enrollment
- **Continuity of Care:** 90 days from care provider's termination date

- TOC/COC has an end date. When approved, we'll educate the member and care provider-about timelines for TOC/COC.

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Electronic Claims

Electronic submission options**: Payer ID 87726** is the most common primary Payer ID – confirm with eSolutions and health plan if any different Payer ID must be used.

- UnitedHealthcareOnline.com > Claims & Payments > Claim Submission (CMS-1500 claims only)
- 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.
- Connectivity Director
- For more information, please contact your vendor or call Electronic Data Interchange (EDI) at 800-842-1109.

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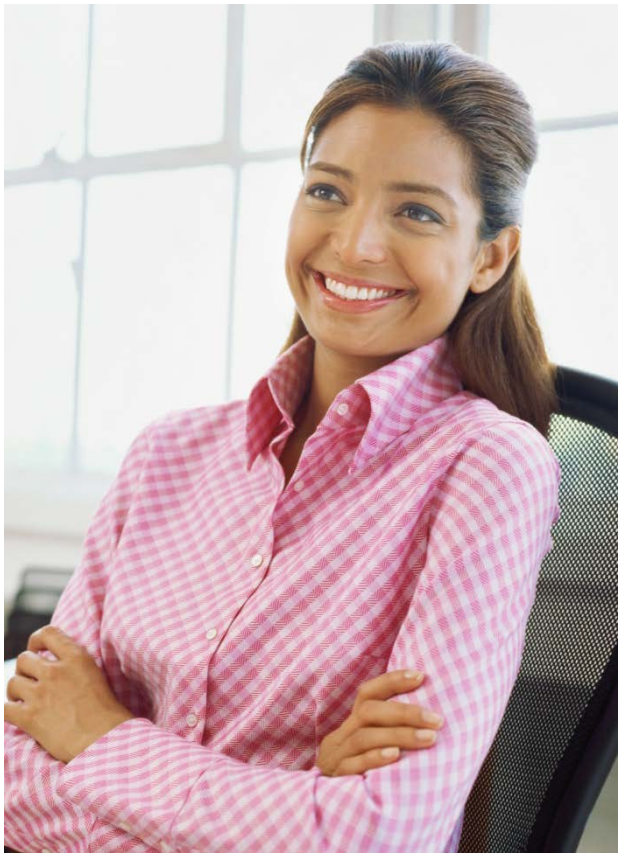
Paper Claims



Mail claims to:

UnitedHealthcare Community Plan
– Virginia
P.O. Box 5240
Kingston, NY 12402-5240

Standard Timely Filing: 365 days from date of service

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Submitting a Claims Reconsideration

- **Preferred Method:** Please submit claims reconsideration requests electronically through your EDI Clearinghouse or using the claimsLink app 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 UnitedHealthcareOnline.com > Claims & Payments > Claim Reconsideration > Claim Reconsideration Request.

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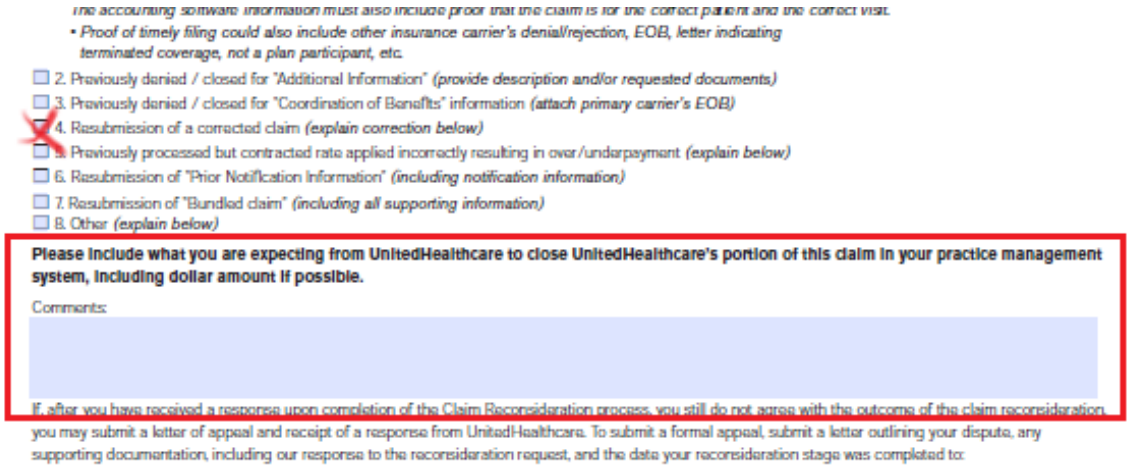
Submitting a Corrected Paper Claims

- 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.

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Electronic Payments & Statements (EPS)

With EPS, you receive electronic funds transfer (EFT) for claim payments; 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

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cont.)

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

For more information, please call 877-620-6194.

Visit UnitedHealthcareOnline.com > Quick Links > Electronic Payments and Statements.

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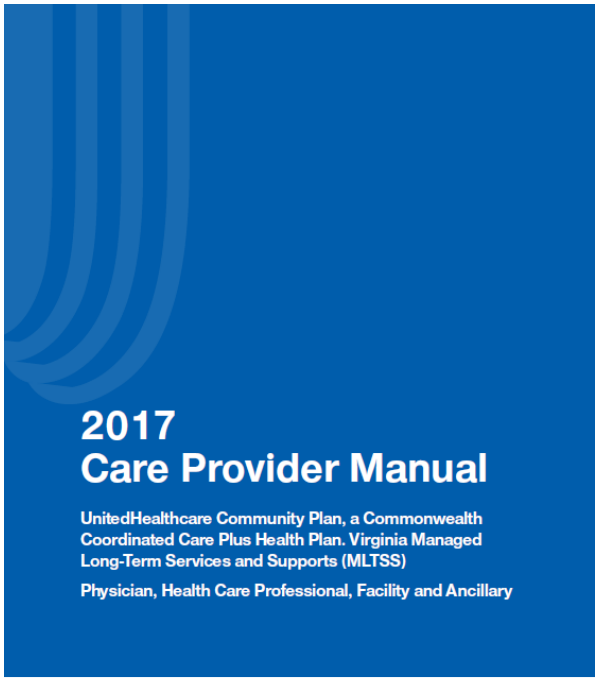
Provider Administrative Guide

The new VA CCC Plus program administrative guide becomes effective the first day Community Plan begins managing CCC Plus members.



To find your administrative guide, visit Link > Community Plan Application Tile > **Virginia** > Provider Administrative Guide.

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Li esources

Use Link applications to help simplify daily administrative tasks:

- Check member eligibility
- Submit a claim reconsideration request
- Review coordination of benefits information
- View care opportunities for members

To access Link, sign in to **UnitedHealthcareOnline.com** using your Optum ID or click “New User” to register if you don’t have an Optum ID yet.

For more information, go to UnitedHealthcareOnline.com > Quick Links > Link: Learn More.

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Online Care Provider Resources

UnitedHealthcareCommunityPlan.com

- Documents specific to UnitedHealthcare Community Plan of Virginia, including:
- Care Provider Manual
- Reimbursement and clinical policies

UnitedHealthcareOnline.com

- Resources including advance notification and prior authorization guidelines, available training and quick reference guides

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How We Communicate with You

Care Provider Manual:

- Updated annually
- Available on UHCCommunityPlan.com

Reimbursement Policy Update

- Alerts for any changes in the reimbursement policies or procedures

***Practice Matters* Newsletter:** Published quarterly

Network Bulletin Newsletter:

- Published the first of each month to announce any change in policies or procedures and updates to the Care Provider Manual
- View *Network Bulletin* at UnitedHealthcareOnline.com > Tools & Resources > News & Network Bulletin

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Virginia CCC Plus Ancillary Provider Contacts

If you have a question or concern regarding your contract, please contact a Network Account Manager.

Home Health Hospice, Home Infusion: Donna Smith
Phone: 763-361-0611 Email: donna_smith1@uhc.com

DME, Transportation, Dialysis, Sleep Centers : Jackie Williams
Phone: 443-896-9053 Email: jacquelyn_v_williams@uhc.com

ASC: Valerie Severtson
Phone: 763-361-0083 Email: valerie_severtson@uhc.com

Radiology: Ira Goldman
Phone: 804-267-5251 Email: ira_goldman@uhc.com

Lab: Lynne Hollingsworth
Phone: 952-406-5086
Email: lynne_s_hollingsworth@uhc.com

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Virginia CCC Plus Ancillary Provider Advocate

You can reach an Ancillary Provider Advocate at the email addresses below. A member of our Service Team will respond to you within two business days of your request.

- Home Health, Hospice: NE_Reg_Anc_HH@uhc.com

- DME, Dialysis, Home Infusion, Sleep Center Transportation, Surgical Centers, Radiology and Lab: Mid_Anc@uhc.com

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Ancillary Provider Relations Service Model

The Ancillary Provider Advocate is an important resource when you have questions.

Please follow the Provider Relations Service Model before contacting an Ancillary Provider Advocate about claim payment decisions.

1. If you disagree with a claim payment decision, you can:

- Use the claimsLink app on Link. To access Link, please sign in to UnitedHealthcareOnline.com.
- Submit a paper reconsideration.
- Call 877-843-4366.

Be sure to obtain a five-digit number tracking number for future reference.

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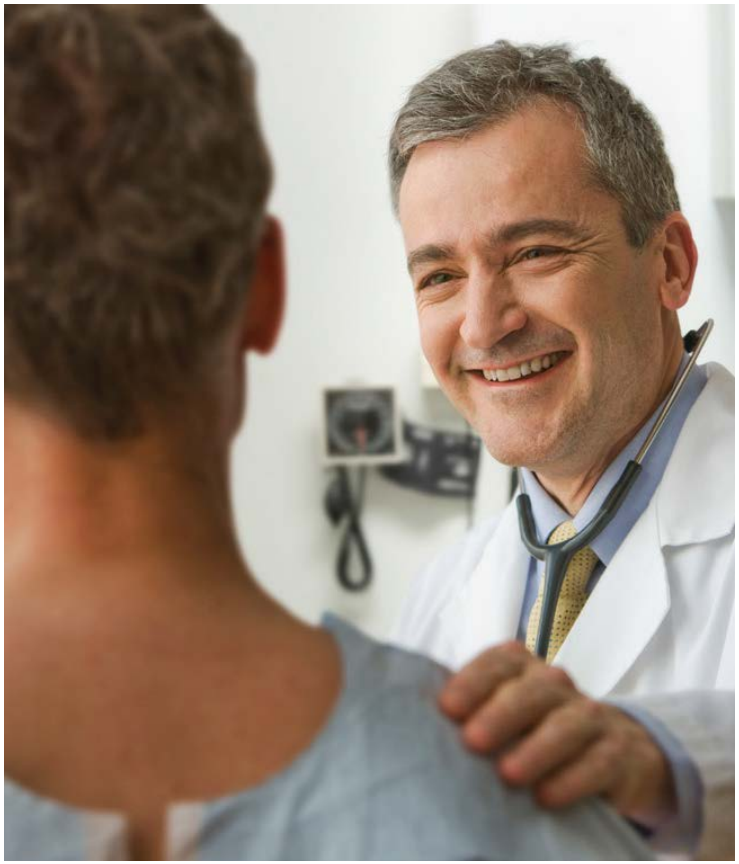
Ancillary Provider Relations Service Model (cont.)



2. If the issue remains unresolved after 30 days, please submit to the Ancillary Provider Service Mailbox. The issue will be assigned to an Advocate.
3. The Ancillary Provider Service Advocate will work with Market Service Agents and other resources to determine the cause and resolve your issue.

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Additional Care Provider Resources and Key Phone Numbers

- Department of Medical Assistance Services: dmas.virginia.gov
- CCC Plus Provider Registration & Enrollment: Virginiamedicaid.dmas.virginia.gov/wps/portal/Home

Behavioral Health
Phone: 877-843-4366
Hours: Monday – Friday, 8 a.m. to 6 p.m. Eastern time

Dental: UHC Dental
Phone: 877-843-4366
Hours: Monday – Friday, 8 a.m. to 6 p.m. Eastern time

Vision: March Vision
Phone: 855-476-2724
Hours: Monday – Friday, 8 a.m. to 5 p.m. Eastern time

Non-Emergent Transportation: MTM (Tidewater, Western/Charlottesville, and Northern/Winchester)
Phone: 888-258-0521
Hours: Monday – Friday, 8 a.m. to 5 p.m. Eastern time

Non-Emergent Transportation: Liberty (Central, Roanoke/Alleghany, and Southwest)
Phone: 855-855-9080
TTY: 855-762-6236
Hours: Monday – Friday, 8 a.m. to 5 p.m. Eastern time

OptumHealth NurseLine
Phone: 877-543-4293
Hours: Available 24 hours a day/seven days a week

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Questions & Thank you