



Introduction to UnitedHealthcare Community Plan of Virginia CCC Plus

Care Provider Education Session

Welcome/Agenda:

- Mission/Vision
- UnitedHealthcare Community Plan of Virginia CCC Plus
- 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 Virginia CCC Plus Overview



- **Summary of product/program:**

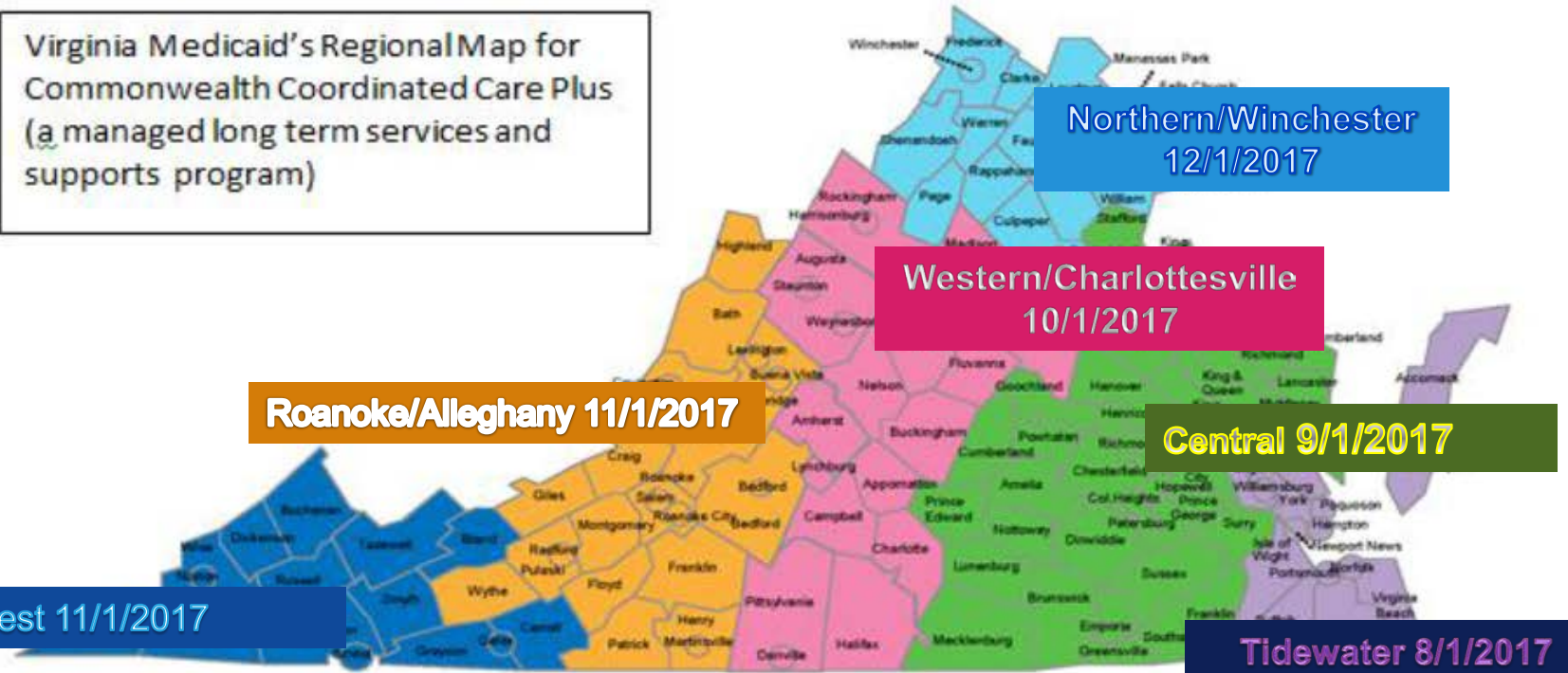
The goals of the CCC Plus plan are to provide coordinated long-term care services across different health care settings and to provide enrollee access to cost-effective community based long-term care services.

- **Program go-live date:**

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

Virginia CCC Plus Regional Go Live Timelines

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



Southwest

Roanoke/Alleghany

Western/Charlottesville

Northern/Winchester

Central

Tidewater

Member Eligibility

Who is Eligible?

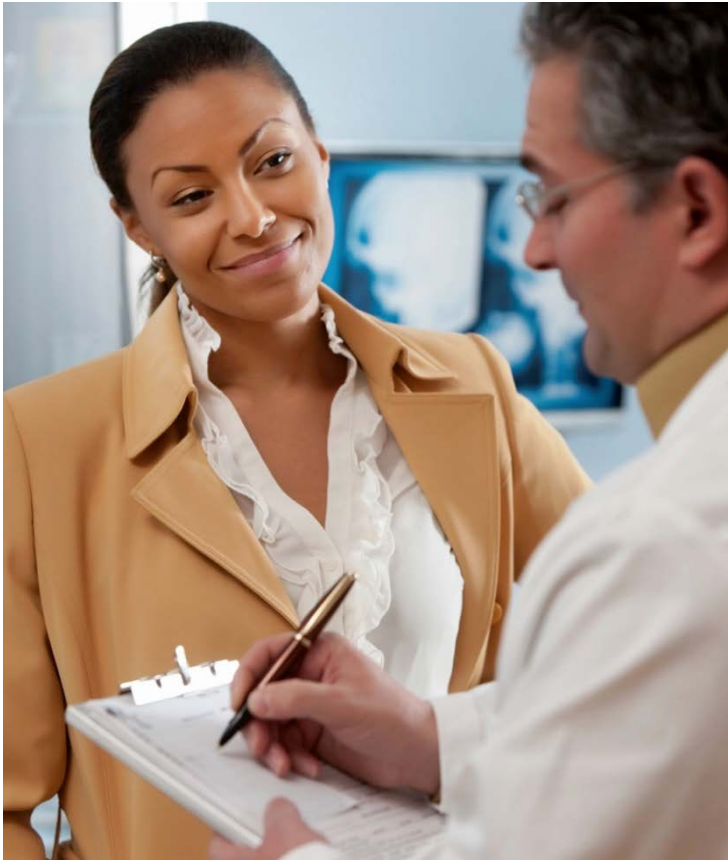
- Dual eligible individuals with full Medicaid and any Medicare A and/or B coverage.
- Non-dual eligible individuals who receive Long Term Support Services (LTSS) services through:
 - An institution; or
 - Home and Community-Based Services (HCBS) 1915(c) waivers:
 - Building Independence
 - Commonwealth Coordinated Care (CCC) Plus
 - Community Living (CL); and
 - Family and Individual Supports (FIS)

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

- Individuals enrolled in the Commonwealth Coordinated Care (CCC) program will transition to CCC Plus program on January 2018, which is after CCC program ends.
- Remaining Aged, Blind, and Disabled (ABD) population (non-duals and those who do not receive LTSS). The majority of this population will transition from the DMAS Medallion 3.0 Medicaid program to the CCC Plus program on January 1, 2018
- May include individuals enrolled in the Medicaid Works program, Native Americans, individuals with other comprehensive insurance, children in foster care and adoption assistance and individuals approved by DMAS as inpatients in long-stay hospitals.



Program Benefits



Standard Benefits

- Available online – Link at [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com) > UHC Community Application > Health Care Professional > Virginia > Provider Resources

Value-Added Benefits

- Adult Preventative Dental
- Vision

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

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	

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

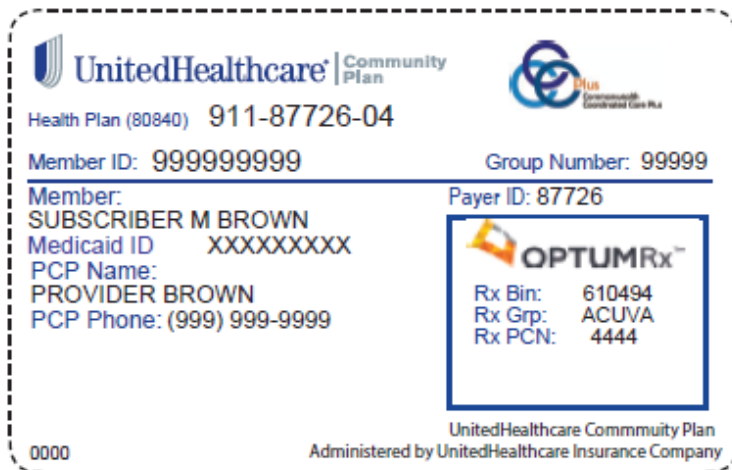
Verifying Member Eligibility and Benefits

Before providing services, please verify member eligibility.

- Link > Eligibility & Benefits application
- If you don't have an Optum ID, go to UnitedHealthcareOnline.com and select "New User" to begin registration.
- UnitedHealthcareOnline.com > Patient Eligibility & Benefits > Patient Eligibility
- 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

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 of your files.
- Member ID cards can also be viewed online using the Eligibility & Benefits application on Link.



CCC Plus Member Card Sample



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.
- Some services require advance notification and prior authorization. For more details, please refer to the Administration Guide.

Clinical Program Requirements

Advance Notification

- Advanced notification is required for certain planned services. You can find them in the Advance Notification List section of the Administrative Guide.
- 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 List including procedure codes and associated services, please go to [UnitedHealthcareOnline.com > Clinician Resources > Advance and Admission Notification Requirements.]

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.

Prior Authorization Resources

- To view the prior authorization list, visit [Link > 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 [Link > UnitedHealthcare Community Plan application > 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](#).

Prior Authorization Timeframes

- Please schedule procedures as far in advance as possible.
- We will provide a decision for standard/non-emergency requests within 3 days of receipt of 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

Radiology/Cardiology Prior Authorization Requirements

- The same advanced imaging/cardiac procedures requiring advance notification are the same procedures requiring 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.

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

Clinical Coverage Review Process

If insufficient clinical information is submitted, we will 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 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.

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.

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.

Hospital Admission Notification

To notify us of a hospital admission:

- Online: UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Notifications/Prior Authorization Submission
- Phone: 877-843-4366
- Fax: 844-882-7133

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

Continuity/Transition of Care Protocol

UnitedHealthcare adheres to two policies related to the Transition and Continuity of Care (TOC/CO C) 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/CO C requirements **before she or he** is required to transfer from an Out-of-Network (OON) provider to an In-Network (INN) 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.

TOC/CoC Criteria

- **Active Course of Treatment:** Involves regular visits with the practitioner to monitor the status of an illness or disorder, provider 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.
- **Post Partum:** Immediate post partum 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.

TOC/CoC Timeframe

If the criteria is met, the following timeline applies:

- **Transition of Care (TOC):** 90 days from member's date of enrollment
- **Continuity of Care (CoC):** 90 days from provider's termination date

- TOC/COG has an end date.
 - When approved, Case Managers and Provider Service Teams will educate the member(s) and Provider(s) about the timelines for TOC/COG.

Pharmacy

- OptumRx, our pharmacy benefits manager, oversees pharmacy network contracting and claims processing on our behalf.
- Our preferred drug list (PDL) is available at [Link > UnitedHealthcare Community Plan application > For Care Professionals > Virginia > Pharmacy Program](#).
- The drugs listed in the PDL have been reviewed and approved by the Commonwealth's Department of Medical Assistance Services.

E-Prescribing



We offer e-prescribing to help care providers save time and money, and help eliminate medication confusion.

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



Some medications may require a prior authorization. The dispensing pharmacist may provide a 3 day emergency supply of medication if it has been determined that drug therapy must begin prior to receiving approval.



To request pharmacy prior authorization, please contact the UnitedHealthcare Community Plan Pharmacy Department by phone 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.

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.

Paper Claims



Mail claims to:



UnitedHealthcare Community Plan
– Virginia
PO Box 5270
Kingston, NY 12402-5240

Standard Timely Filing: 365 days from date of service

Submitting a Claims Reconsideration

- **Preferred Method:** Please submit claims reconsideration requests electronically 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 UnitedHealthcareOnline.com > Claims & Payments > Claim Reconsideration > Claim Reconsideration Request.

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.

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

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 Virginia.



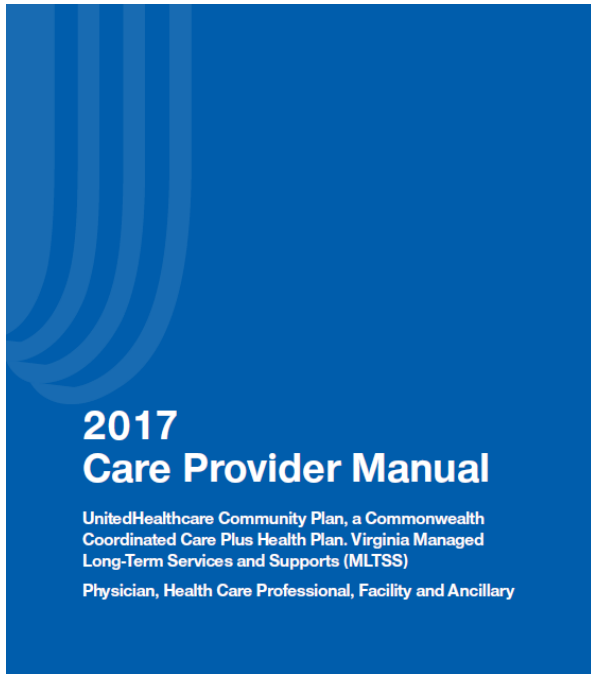
For more information, please call 877-620-6194.



Visit [UnitedHealthcare.com](https://www.unitedhealthcare.com) > Quick Links > Electronic Payments and Statements.

Provider Administrative Guide

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



Visit Link > Community Plan Application Tile > **Virginia** > Provider Administrative Guide.

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Link Resources

Link is your new gateway to UnitedHealthcare's online tools.

Use Link applications to help simplify daily administrative tasks:

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



To register for Link, sign in to [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com) using your Optum ID or click “New User” if you do not have an Optum ID.

For more information, click “Link” in “Learn more about Link”.

Online Provider Resources

UnitedHealthcare Community Plan Application

- Documents specific to UnitedHealthcare Community Plan of Virginia, including:
- Administrative Guide
- Reimbursement & Clinical policies

UnitedHealthcareOnline Application

- Resources including claim submission, advance notification and prior authorization guidelines and member eligibility

How We Communicate with You

Administrative Guide:

- Updated annually
- Available using the UnitedHealthcare Community Plan application Link

Reimbursement Policy Update

- Alerts for any changes in the reimbursement policies or procedures

Practice Matters Newsletter: Published quarterly

Network Bulletin Newsletter:


- Announces any change in policies or procedures and updates to the Administrative Guide
- View *Network Bulletin* at UnitedHealthcareOnline.com > Tools & Resources > News & Network Bulletin

Virginia CCC Plus Physician Advocates


Physician Advocates


Linda Sweet - Tidewater

 763-732-6755


 va_pr_team@uhc.com


Oasis Sykes – Central, Roanoke,

 804-267-5296


 va_pr_team@uhc.com


Jessika DeFelice – Central, Charlottesville/Western

 804-267-5215


 va_pr_team@uhc.com


Kathy Blevins – Northern/Winchester

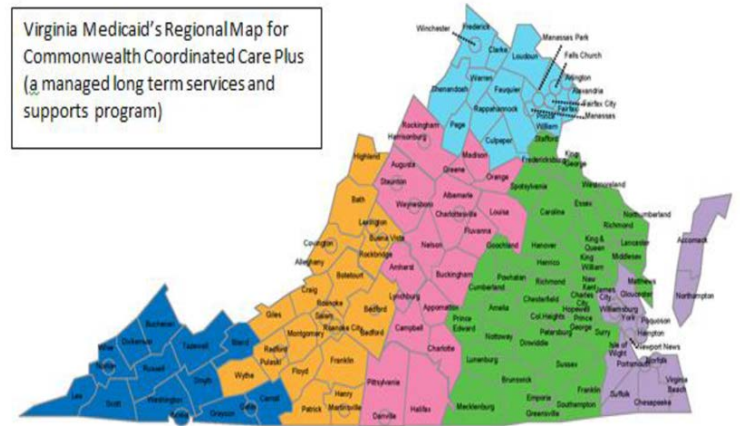
 952-406-3370

 va_pr_team@uhc.com

Alexandra Mateo – Northern/Winchester

 571-262-8958

 va_pr_team@uhc.com



Southwest Roanoke/Alleghany Western/Charlottesville Northern/Winchester Central Tidewater



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.

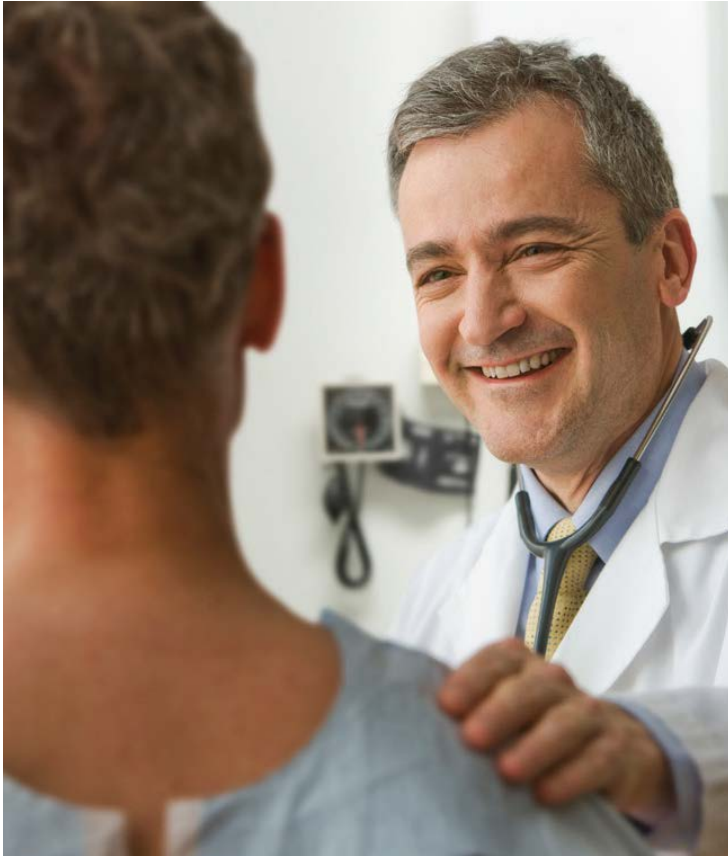
Please follow the Provider Relations Service Model before contacting a Physician Advocate about claim payment decisions.

1. If you disagree with a claim payment decision, you can:
 - Use the Claims Reconsideration application on Link. To access Link, please sign in to UnitedHealthcareOnline.com
 - Submit a paper reconsideration.
 - Call 877-843-4366

Be sure to obtain a 5-digit number tracking number for future reference.



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 resources to determine the cause and resolve your issue.

Additional 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](https://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: 855-586-1419

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

Questions & Thank you
