Welcome to UnitedHealthcare Community Plan

This administrative guide is designed as a comprehensive reference source for the information you and your staff need to conduct your interactions and transactions with our Long Term Care program in the quickest and most efficient manner possible. Much of this material, as well as operational policy changes and additional electronic tools, are available on our website at UHCCommunityPlan.com.

Our goal is to ensure our members have convenient access to high-quality care provided according to the most current and efficacious treatment protocols available. We are committed to working with and supporting you and your staff to achieve the best possible health outcomes for our members.

If you have any questions about the information or material in this administrative guide or about any of our policies or procedures, please do not hesitate to contact Provider Services at 800-377-2055.

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

Important Information Regarding the Use of This Guide

In the event of a conflict or inconsistency between your applicable Provider Agreement and this guide, the terms of the Provider Agreement shall control.

In the event of a conflict or inconsistency between your Provider Agreement, this guide and applicable federal and state statutes and regulations will control. UnitedHealthcare reserves the right to supplement this guide to ensure that its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This guide will be amended as operational policies change.
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UnitedHealthcare, a business unit of UnitedHealth Group, the nation’s largest health and well-being company, is the country’s premier provider of high quality, personalized public sector health care programs. Our mission is to help the people we serve live healthier lives. UnitedHealthcare understands that health care cannot be delivered in a vacuum. That is why our services seek to address the social and economic factors that affect a person’s health. Since 1989, UnitedHealthcare, through its predecessor affiliates, has served the public sector market. Today, we facilitate care for 2.8 million beneficiaries of government health care programs in more than 26 states, plus the District of Columbia.

A number of factors distinguish UnitedHealthcare from other companies serving Healthy Options and other government health care programs:

- UnitedHealthcare has a private sector focus on cost accounting, data analysis and fiscal discipline, coupled with sensitivity to the imperatives of public sector accountability.
- UnitedHealthcare invests in the systems and personnel required to successfully manage our business.
- UnitedHealthcare emphasizes service to all our customers — regulators, members and providers.
- UnitedHealthcare understands the unique needs of the populations we serve and our Health Plans are designed specifically to meet those needs.

Moreover, UnitedHealthcare understands that compassion and respect are essential components of a successful health care company. UnitedHealthcare 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.

Our Approach to Health Care

Innovative health care programs are the hallmark of UnitedHealthcare. Our personalized programs encourage the utilization of services. These programs, some of them developed with the aid of researchers and clinicians from academic medical centers, are designed to help our chronically ill members avoid hospitalizations and hospital emergency room visits — in short, to live healthy, productive lives.

The unique UnitedHealthcare Personal Care Model™ features direct member contact by UnitedHealthcare clinicians trained to foster an ongoing relationship between the Health Plan and members suffering from serious and chronic conditions. The goal is to use high-quality health care and practical solutions to improve members’ health and keep them in their communities with the resources necessary to maintain the highest possible functional status.

Designed to improve birth outcomes and reduce Neonatal Intensive Care Unit (NICU) admissions, UnitedHealthcare’s Healthy First Steps program uses an early identification to:

- Help overcome common social and psychological barriers to prenatal care;
- Increase member understanding of the importance of early prenatal care;
- Increase the mother’s self-efficacy by identifying and building a mother support system;
- Ensure appropriate postpartum and newborn care;
- Develop the physician/member partnership and relationship before and after delivery.

In addition to the usual Health Plan reminders to get preventive care services, UnitedHealthcare employs its proprietary Universal Tracking Database to identify members who have fallen behind in scheduling appointments and providers who are failing to focus on preventive care and optimal treatment.
Welcome to UnitedHealthcare Community Plan!

UnitedHealthcare Community Plan offers many plans in Arizona. UnitedHealthcare Community Plan’s Long Term Care plan services the vulnerable, elderly and chronically ill by offering enhanced medical coverage for both institutional and community residents, the Medicare and Medicaid population, through the collaboration of case managers, physicians, and other health care providers. UnitedHealthcare Community Plan plans are built on the foundation of comprehensive care management, providing an in-depth assessment and an innovative benefit package to maintain individuals in the least restrictive setting appropriate to maintain quality of life.

• UnitedHealthcare Community Plan – A Medicaid/Arizona Health Care Cost Containment System (AHCCCS) product in Maricopa, Apache, Coconino, Mohave, Pima, Yuma, La Paz, Santa Cruz, Yavapai, and Navajo Counties. Enrollees must be enrolled with ALTCS and assigned to UnitedHealthcare Community Plan. Contract Services are funded in part under contract with the State of Arizona.

UnitedHealthcare Community Plan products operate in all residential settings:

• In the nursing home – UnitedHealthcare Community Plan increases preventive care through a collaborative approach involving a UnitedHealthcare Community Plan Case Manager and teams of health care providers who work with nursing home staff to help maintain the health and well-being of enrollees.

• In the community – A Case Manager works with the family, the primary care physician, other health care providers, and community organizations to help ensure optimal use of available health care and other community resources.

UnitedHealthcare Community Plan Mission Statement

Helping people live healthier lives.

Vision

UnitedHealthcare Community Plan is a driving force in maximizing the health and well-being of America’s aging, vulnerable and chronically ill individuals. Our success is built on the foundation of:

• National Leadership – UnitedHealthcare Community Plan is the recognized leader in creating and shaping a full continuum of comprehensive services for the population we serve.

• Innovation – UnitedHealthcare Community Plan is revolutionizing the creation and delivery of programs and services that consistently provide individualized solutions to meet the unique and diverse needs of our clients.

• Reputation – UnitedHealthcare Community Plan is known as the employer, provider and partner of choice for those committed to serving aging, vulnerable and chronically ill individuals. Our culture represents integrity, collaboration and mutual respect for the people we serve and our employees.

• Demonstrated Results – UnitedHealthcare Community Plan provides value to our clients and partners by consistently delivering quality and customer-focused service. Our attention to results ensures the financial soundness of our company.

• Partnerships – UnitedHealthcare Community Plan has strong alliances with public and private sectors that support our mission and share our commitment to continuously improve the well-being of the people we serve.
VALUES

**Integrity**
Honor commitments
Never compromise ethics

**Compassion**
Walk in the shoes of the people we serve and those with whom we work

**Relationships**
Build trust through collaboration

**Innovation**
Invent the future, learn from the past

**Performance**
Demonstrate excellence in everything we do
Customer Call Center .................................................................................................................800-293-3740
Available Monday through Friday from 8 a.m. to 5 p.m.
Eligibility, Member and Claims Services ................................................................................800-293-3740
Provider Relations .......................................................................................................................800-377-2055
Main Phone .................................................................................................................................602-255-8188 or 800-377-2055
General Fax ..................................................................................................................................855-465-3075
Prior Notification Phone ..............................................................................................................602-255-8188 or 800-377-2055
Prior Notification Fax ......................................................................................................................800-278-2907

Case Management Offices
Apache County/Navajo County (Show Low)
Pebble Creek Plaza, Suite I ..........................................................................................................800-233-9867
2707 South White Mountain Road, Suite I ...................................................................................Fax: 928-537-5082
Show Low, Arizona 85901 .......................................................................................................Local: 928-537-1797

Coconino County (Flagstaff)
1016 W. University Ave, Suite 210 ..........................................................................................888-437-5249
Flagstaff, Arizona 86001 ............................................................................................................Fax: 928-226-1475

Maricopa County (Phoenix)
1 East Washington, Suite 800 ....................................................................................................800-377-2055
AZ009-800E ................................................................................................................................Fax: 855-465-3075
Phoenix, Arizona 85004 .............................................................................................................Local: 602-255-8913

Mohave County (Kingman)
2404 Stockton Hill Road, Suite D ............................................................................................800-598-3047
Kingman, Arizona 86401 ...........................................................................................................Fax: 928-753-2453 Local: 928-753-2403

Mohave County (Lake Havasu City)
1963 McCulloch, Suite 105 .......................................................................................................800-659-6886
Lake Havasu City, Arizona 86403 ............................................................................................Fax: 928-680-0343 Local: 928-680-6886

Pima County (Tucson)
6245 E. Broadway #650 ............................................................................................................Fax: 520-748-5019
AZ124-1000
Tucson, AZ 85711

Yavapai County (Prescott)
2825 N. Glassford Hill Rd, Suite B
Prescott Valley, AZ 86314

Yuma/La Paz County (Yuma)
3970 W. 24th St., Suite 204 ....................................................................................................Fax: 928-388-6810
Yuma, AZ 85364
Utilization Management and Prior Notification
Medical Management Department
1 East Washington, Suite 800 ....................................................................................... 800-377-2055
AZ009-800E.........................................................................................................Fax: 800-278-2907
Phoenix, AZ 85004

Quality Management
Quality Management Coordinator .................................................................................. 800-377-2055
1 East Washington, Suite 900 .................................................................................. Fax: 602-745-7950
AZ009-800E
Phoenix, AZ 85004

Member Services and Provider Claim Disputes
1 East Washington, Suite 800 ..................................................................................... 800-377-2055
AZ009-800E ........................................................................................................ Fax: 877-395-5993
Phoenix, AZ 85004

Claims Research Department
UnitedHealthcare Community Plan ............................................................................ 800-293-3740

Access to UnitedHealthcare Community Plan Website:
UHCCommunityPlan.com
Ch. 2 Member Services and Eligibility

The Customer Service Center provides assistance to enrollees and providers. The functions of Customer Service include:

- Answering benefit and claims questions
- Changing of primary care providers
- Verification of member eligibility
- Claims status and limited research
- Assistance with identifying participating providers
- Logging member complaints and appeals and forwarding to the site

The Customer Service Center can be reached at:
800-293-3740
Available Monday to Friday
8 a.m. to 5 p.m.

ALTCS Eligibility

All individuals on UnitedHealthcare Community Plan must meet eligibility requirements set forth by the state of Arizona to become eligible for benefits under the ALTCS program. UnitedHealthcare Community Plan is not involved in eligibility determination or enrollment/disenrollment.

In counties where multiple program contractors are available to provide ALTCS services, a member will have the opportunity to choose which program contractor they will be enrolled with to receive ALTCS services. The member and/or the member’s authorized representative will be provided with informational material from each program contractor to assist them in making a choice. If a member does not choose, they will be assigned to a program contractor by AHCCCS based on an auto-assignment.

Identification Cards

Each ALTCS member is issued an AHCCCS identification (ID) card when the member enrolls with UnitedHealthcare Community Plan. If a member presents for services without an AHCCCS ID card or loses their ID card, he or she may call the Customer Service Center at 800-293-3740 to request a new card.

The ID card contains the member’s name, ID number, date of birth, and group number.

Presentation by a person with an UnitedHealthcare Community Plan ID card may not be an absolute guarantee of eligibility at the point of service.

Verifying Member Enrollment and Eligibility

All providers should verify enrollment prior to rendering services. For up-to-date enrollment information, UnitedHealthcare Community Plan providers may use UHCCommunityPlan.com or call the Customer Service Center.

The number to call is:
800-293-3740
Available Monday to Friday
8 a.m. to 5 p.m.

For faster service, please have the following information ready when you call:

- Provider/Facility AHCCCS ID number
- Name of the caller and contact phone number
- Member’s name, AHCCCS ID number and date of birth

You can call AHCCCS at 602-417-7200 within Maricopa County or at 800-331-5090 outside Maricopa County, within Arizona. Or you can register to use the AHCCCS online website. More information is available at http://www.azahcccs.gov/commercial/AHCCCSonline.aspx.
UnitedHealthcare Community Plan Welcome Packet

Upon enrollment with UnitedHealthcare Community Plan, members will receive a Welcome Packet in the mail that includes:

- A welcome letter
- A Member Handbook, which includes:
  1. The member rights and responsibilities as defined in this chapter.
  2. Notice of Privacy Practices

Members’ Rights

Members have the right to:

- Access to care
- Respect and dignity
- Culturally competent care
- Privacy
- Information
- Communication
- File a complaint or grievance
- Consent/Refusal of treatment (medical care)

If members have any questions regarding cultural competency or concerns about specific providers, they are directed to contact their case manager or Member Services at 800-293-3740.

UnitedHealthcare Community Plan has no Policies Which Prevent the Provider from Advocating on Behalf of the Member:

UnitedHealthcare Community Plan will not prohibit a physician or health care provider, acting within the scope of his or her lawful practice, from advising, acting or advocating on behalf of the member about the member’s condition, risks and treatment options. We are committed to promoting dignity, quality of life, and appropriate standards for assuring quality care for all of our members. We believe that our members and their families deserve the best care and that they can enjoy an improved quality of life if given the opportunity to understand and access their rights.

ALTCS Enrollee Responsibilities

AHCCCS identifies the following as ALTCS enrollee responsibilities. UnitedHealthcare Community Plan enrollees and/or the enrollee’s authorized representative are informed of their responsibilities regarding ALTCS services. These responsibilities include but are not limited to the following:

1. Utilizing Services

   a) Ask questions if you do not understand your rights or plan of treatment.
   b) Keep your scheduled appointments.
   c) Cancel appointments in advance when you can’t keep them.
   d) Always contact your primary care provider (PCP) first for non-emergency medical needs.
   e) Be sure you have approval from your PCP before going to a specialist.
   f) Understand when you should and should not go to the emergency room.
   g) Know who to call if you need a ride to the PCP or other medically necessary service.

2. Giving Information

   a) Tell your PCP and your Case Manager about your current health and changes in your health.
   b) Tell Member Services and your Case Manager about changes in your Medicare, Medicare HMO or private insurance coverage, such as the addition or termination of other insurance coverage.
   c) Talk to your providers and your Case Manager about your health care needs and ask questions about the different ways your health care problems can be treated.
3. Follow Instructions

a) Work as a team with your PCP and Case Manager in deciding what health care is best for you.

b) Understand how the things you do can affect your health.

c) Do the best you can to stay healthy.

d) Treat providers and staff with respect.

Grievances and Complaints

As a provider, you may come across a member that wants to file a complaint or grievance with UnitedHealthcare Community Plan. You may assist or instruct the member on how to do so. We are providing you with a summary of the steps the member should take. For more information, this process is explained in the member handbook.

The member should first contact their Case Manager directly to assist in answering questions or resolving the issue. If the Case Manager was able to help, the complaint or grievance will be considered resolved and the member will not receive any further notification from UnitedHealthcare Community Plan. If the Case Manager cannot help the member to their satisfaction, the member may file a grievance or complaint with UnitedHealthcare Community Plan. This can be done either verbally (call 800-293-3740) and the caller tells the Customer Service representative they wish to file a grievance; or they may file in writing.

To file a grievance in writing they may submit a letter to the following address:

UnitedHealthcare Community Plan
Member Grievance and Appeal Manager
1 East Washington, Suite 800
AZ009-800E
Phoenix, AZ 85004

Members who call to file a complaint regarding a provider are encouraged to contact the provider first. If the member is not satisfied with the answer given by the provider, Member Services may intervene. If your office receives a call from a Member Services representative the intent is to clarify the situation and provide appropriate direction to the member.

Once UnitedHealthcare Community Plan receives the complaint, the Member Grievance Coordinator will investigate the issue and respond to the member.

Member Appeals

If the member was denied a requested service, the response will include how to appeal the decision. If the member is not satisfied with UnitedHealthcare Community Plan’s decision, the member may file an appeal. An appeal may be filed over the phone or in writing. All letters of appeal need to be sent to the address listed above.

After UnitedHealthcare Community Plan has completed its review of the member’s appeal, we will send a written decision letter that explains how we reached our decision. As a provider, you may file an appeal on behalf of the member if the member gives you that authority in writing and a copy of the authorization is sent to UnitedHealthcare Community Plan with the appeal. No punitive action will be taken against a provider who files an appeal on behalf of a member.

If the member is not satisfied with the decision of the appeal, the member may request a State Fair Hearing in writing within 30 days from the date of the appeal decision. UnitedHealthcare Community Plan will arrange the hearing. An Administrative Law Judge will conduct the hearing. The member may represent him or herself or use legal counsel, a relative, a friend or other representative if the member has given written consent. The Administrative Law Judge will issue a Recommended Decision to ALTCS who will review the decision. The member will receive a written decision from ALTCS.
Mail Order Pharmacy

UnitedHealthcare Community Plan offers mail order pharmacy services to its enrollees. To assist enrollees in arranging mail order pharmacy services, please advise the enrollee to contact Optum RX at 877-889-6510.

Primary Care Provider (PCP) Assignment

UnitedHealthcare Community Plan offers enrollees the opportunity to select an UnitedHealthcare Community Plan contracted PCP when more than one contracted PCP is available in the enrollee’s geographic service area. If the enrollee fails to elect a PCP, the case manager will assist the member in identifying an appropriate PCP at the time of the initial assessment visit. The enrollee is responsible for knowing the name of his or her assigned PCP. The Provider Services Department maintains a current list of all contracted PCPs by service area.

Pregnant enrollees will be allowed to choose an OB physician or health care provider as their PCP during the duration of the pregnancy and up to six weeks post-partum. They will then be automatically reassigned to their original PCP.

UnitedHealthcare Community Plan enrollees may be assigned to a PCP as follows:

- **Enrollee Request** – All enrollees are asked to choose who they want as a PCP. If the enrollee identifies a PCP, UnitedHealthcare Community Plan will assign that enrollee to the requested PCP.

- **Auto Assignment** – If an enrollee does not choose a PCP within 10 days, the case manager will assist the member in identifying an appropriate PCP at the time of the initial assessment visit.

- **Re-enrollments** – Enrollees that lost their ALTCS eligibility and have become eligible again will be reassigned to the previous PCP unless the enrollee requests a different PCP at the time of re-enrollment.

How to Reassign an Enrollee to Another PCP

PCPs may request an enrollee reassignment to another PCP. Allowable reasons include:

- If the enrollee behaves in an abusive manner to PCP or office staff;

- If the enrollee is non-compliant with UnitedHealthcare Community Plan policies and procedures;

- If the enrollee continually cancels or fails to keep scheduled appointments.

All requests must be submitted by the PCP in writing to the Member Services department and include the specific reason(s) for reassignment. The physician or health care provider is strongly encouraged to communicate his or her concerns to the enrollee before requesting reassignment.

Upon receipt of the request, the enrollee is referred to Case Management for assessment and intervention. A minimum of two weeks is required to complete the Case Management investigation. If the physician or health care provider/enrollee relationship remains problematic after Case Management intervention, the PCP may pursue reassignment.

If the UnitedHealthcare Community Plan Case Manager approves reassignment, the enrollee will be dis-enrolled from the originating PCPs practice effective the last day of the month that the request was received. Exceptions are granted on a case-by-case basis.

Member Services will notify the enrollee in writing of the PCP disenrollment. The enrollee will be allowed to select another PCP if deemed appropriate by the Case Manager. Enrollees who have had several previous PCP reassignments may be automatically assigned.
This chapter is intended to provide an overview of provider responsibilities. More information on provider responsibilities is located throughout this Provider Manual.

Responsibilities and Expectations

The responsibilities and expectations of UnitedHealthcare Community Plan contracted physicians and health care providers are as follows:

1. Follow the terms and conditions of the signed agreement with UnitedHealthcare Community Plan.

2. Submit full and complete credentialing and re-credentialing applications and supporting documentation to UnitedHealthcare Community Plan as requested and in a timely manner.

3. Maintain all required professional licenses and certifications.

4. Deliver services to UnitedHealthcare Community Plan enrollees in a non-discriminatory manner with regard to race, color, creed, religion, sex, sexual preference, a national origin, health status, income level, or on the basis that the enrollee is enrolled in the ALTCS/Medicaid program.

5. Comply with the Americans with Disabilities Act (ADA) and provide reasonable accommodations to enrollees when applicable.

6. Report any known or suspected cases of fraud and abuse.

7. Notify UnitedHealthcare Community Plan of any factor affecting the agreement with UnitedHealthcare Community Plan, such as change in licensure or credentialing status, change of address, or change in insurance coverage as per the provider agreement.

8. Submit encounter documents (for capitated services) and claims to UnitedHealthcare Community Plan in a timely and complete manner.

9. Verify enrollee eligibility and obtain any necessary authorization prior to initiation of services.

10. Maintain patient medical records and other record-keeping systems in a complete and legible manner, in accordance with applicable laws, regulations and rules, and retain such records for the duration established in the provider agreement. Medical records must be provided in a timely manner, in accordance with HIPAA, federal and state regulations, upon request. Enrollees have the right to obtain copies of their medical records. Medical records must be made available free of charge to UnitedHealthcare Community Plan, AHCCCS or Medicare for purposes of quality review or other administrative requirements.

11. Cooperate with UnitedHealthcare Community Plan and any authorized regulatory agency regarding quality management and utilization management programs.

12. If provider is an Emergency Services facility, services must be available on a 24-hour, seven-days-a-week basis. If the provider is a PCP, the PCP or an appropriate on-call physician must be available for services, consultation or prior approval activities on a 24-hour, seven-days-a-week basis.

13. Comply with all applicable federal, state and local laws, rules and regulations, including anti-kickback and self-referral laws and implementing regulations.

14. Maintain all insurance coverage required by the provider agreement.

15. Comply with federal and state laws regarding Advance Directives.

16. Comply with the drug formulary established by UnitedHealthcare Community Plan and follow UnitedHealthcare Community Plan’s exception authorization guidelines for dispensing of drugs not included in the formulary.
17. Comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, including Patient Health Information (PHI) privacy requirements.

18. Advocate on behalf of an enrollee when asked by the enrollee or when the provider recognizes an enrollee in need of advocacy assistance.

19. Advise or advocate on behalf of the member regarding the following:

- The member’s health status, medical care or treatment options, including any alternative treatment that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The enrollee’s right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatments.

20. Meet all applicable Americans with Disabilities Act (ADA) requirements when providing services to members with disabilities who may request special accommodations such as interpreters, alternative formats, or assistance with physical accessibility.

In addition, physicians and health care providers contracted to provide services to UnitedHealthcare Community Plan enrollees are responsible for the following:

1. Comply with the terms and conditions of the AHCCCS Minimum Subcontract Provisions, which is included in the UnitedHealthcare Community Plan provider agreement.

2. UnitedHealthcare Community Plan follows the regulations and policies as set forth in the AHCCCS Medical Policy Manual (AMPM). Providers are to comply with the standards as defined in the AMPM and all other applicable AHCCCS regulations.

3. Maintain a current AHCCCS Provider Identification Number and NPI number (if applicable).

4. Verify enrollee eligibility through AHCCCS and obtain any necessary authorization prior to initiation of services.

5. Recognize that Medicaid/AHCCCS/ALTCS and UnitedHealthcare Community Plan are, by law, the payer of last resort, and therefore assist UnitedHealthcare Community Plan in the identification and primary billing of other third-party payers including, but not limited to, the federal Medicare program.

6. Nursing home and assisted living facility providers are to comply with Enrollee Share of Cost, Enrollee Room and Board and patient trust fund accounting procedures and requirements as established by UnitedHealthcare Community Plan.
PCP as Medical Manager

Primary care physicians (PCPs) play a central role in our enrollees’ care. PCPs are responsible for the delivery of health care to their assigned enrollees. PCPs are accountable for ensuring proper documentation in medical records. Some of the responsibilities specific to PCPs are:

- PCPs must be contracted with UnitedHealthcare Community Plan if they have any enrollees that are UnitedHealthcare Community Plan primary.
- For EPSDT services to enrollees under age 21, as described in Chapter 10 of this Provider Manual.
- PCPs are responsible for care, including but not limited to, immunizations, history and physical assessments and examinations, disease-risk assessments, well-woman and well-child examinations.
- Patient education, including but not limited to, examination findings, symptoms or side effects of treatments or medications, medically necessary treatment options, health maintenance, disease-prevention counseling and education on the difference between urgent conditions and emergent conditions and what to do in those situations.
- PCPs must have coverage 24-hours-per-day, seven-days-per-week. PCPs must arrange for after hours and vacation/sick coverage. The covering provider must be registered with AHCCCS if the PCP or covering provider provides services to a UnitedHealthcare Community Plan member.
- Document and report members with excessive cancelled or missed appointments.
- Appropriate response time to telephone calls during office hours and after hours. After-hours response should either automatically forward calls to another number or identify the number in which the enrollee can call to reach the on-call provider. Phones should not ring more than five times and the hold time after answer should be less than five minutes.
- Maintain continuity of care by reducing duplication of diagnostic procedures including all medical records for services provided to the enrollee and forwarding these to the specialist.
- If the enrollee has a behavioral health diagnosis, the PCP must aid in care coordination with the enrollee’s Behavioral Health Case Manager.
- PCPs assigned to ventilator dependent patients must ensure each vent enrollee is evaluated annually by a pulmonologist to assess the prospects of weaning the enrollee from dependency on the ventilator.
- PCPs agree to make every effort to utilize contracted network providers.

Referrals and Prior Authorization

Contracted health care professionals are required to coordinate member care within the UnitedHealthcare Community Plan provider network. If possible, all UnitedHealthcare Community Plan member referrals should be directed to UnitedHealthcare Community Plan contracted providers. Referrals outside of the network are permitted, but only with prior authorization from UnitedHealthcare Community Plan.

The referral procedure and prior authorization procedure are particularly important to the UnitedHealthcare Community Plan managed care program. Understanding and adhering to these
procedures is essential for successful participation as a UnitedHealthcare Community Plan provider.

Prior authorization is one of the tools used by UnitedHealthcare Community Plan to monitor the medical necessity and cost-effectiveness of the health care members receive. Contracted and non-contracted health professionals, hospitals, and other providers are required to comply with UnitedHealthcare Community Plan’s prior authorization policies and procedures. Noncompliance may result in delay or denial of reimbursement.

UnitedHealthcare Community Plan requires practitioners and providers to obtain prior authorization before making referrals to certain specialists or providing certain procedures or services. Prior authorization allows for the evaluation of services for continuity of care, coverage under applicable program guidelines and policies, cost, and efficiency before services are rendered.

Because the PCP coordinates most services provided to a member, it is typically the PCP who initiates requests for prior authorization; however, specialists and ancillary providers may also request prior authorization for services within their specialty areas.

Specialists Responsibilities

A specialist is responsible for responding timely to a PCP referral for specialist intervention and to report back their results to the PCP in a timely manner. UnitedHealthcare Community Plan will measure compliance with, including but not limited to, medical-records keeping practices, appointment availability, staff competencies, professional standards, confidential exchange of enrollee information and timeliness of response and communication with the PCP. Specialists are also responsible for enrollee education and training, 24-hour availability coverage and proper eligibility verification, authorization and claims submission for services.

Confidentiality and Release of Medical Records

There are federal privacy standards, state laws and AHCCCS rules and regulations that pertain to the safeguarding and release of confidential enrollee information. Each provider and their employed staff are required to adhere to all rules and regulations pertaining to the confidentiality and safeguarding of PHI. Each provider is responsible for ensuring the appropriate release of confidential information in accordance with the federal, state and AHCCCS rules and regulations.

Appointment Standards

Contracted physicians and health care providers servicing UnitedHealthcare Community Plan enrollees are expected to adhere to appointment standards and waiting times established by AHCCCS. UnitedHealthcare Community Plan monitors quarterly provider compliance with Appointment Standards to ensure AHCCCS standards are met. UnitedHealthcare Community Plan will develop a Corrective Action Plan for providers that do not meet the appointment standards. The appointment standards* are as follows:

*For the purpose of this section, "urgent" is defined as an acute, but not necessarily life-threatening disorder, which, if not attended to, could endanger the enrollee’s health.
Primary Care Provider (PCP)
1. Emergency appointments same day or within 24 hours of the enrollee’s telephone call or other notification, or as medically appropriate.
2. Urgent care appointments within 2 days.
3. Routine care appointments within 21 days.

Specialty Referrals
1. Emergency appointments within 24 hours of referral.
2. Urgent care appointments within 3 days of referral.
3. Routine care appointments within 45 days of referral.

Behavioral Health Services
1. Emergency appointments within 24 hours of referral.
2. Routine care appointments within 30 days of referral.

Dental
1. Emergency appointments within 24 hours of referral.
2. Urgent care appointments within 3 days of referral.
3. Routine care appointments within 45 days of referral.

Maternity – Initial prenatal care appointments for pregnant enrollees as follows:
1. First Trimester appointments within 14 days of request.
2. Second Trimester appointments within 7 days of request.
3. Third Trimester appointments within 3 days of request.
4. High-risk pregnancies within 3 days of identification of high risk by UnitedHealthcare Community Plan or maternity care provider, or immediately if an emergency exists.

Waiting Times
As with the Appointment Standards, UnitedHealthcare Community Plan actively monitors provider compliance with Waiting Times to ensure AHCCCS standards are met. UnitedHealthcare Community Plan will develop a corrective action plan for providers that do not meet the waiting time standards. The waiting time standards are as follows:

Physician Services
Waiting times should not exceed 45 minutes except when the provider is unavailable due to an emergency.
Service Gap Reporting

AHCCCS requires that Home Care providers, Attendant Care, Personal Care, Homemaker services or Respite Care document and report any non-provision of services (NPS) to the appropriate program contractor. The reporting will be done in the AHCCCS required format. Completion of the NPS log will be submitted by the provider to UnitedHealthcare Community Plan by the 5th calendar day of the month.

The information submitted identifies enrollees where a gap in service occurred, how quickly replacement services were obtained and how the replacement services were obtained. Providers who do not have a copy of the Service Gap Contingency Plan policy should contact the Case Management department.

I. Instructions for Completing the NPS Log:
The NPS log form should be completed by the provider/agency and/or program contractor:

• When the authorized services are not provided as scheduled;
• When scheduled services are no longer available because a replacement cannot be found;
• When a request for DDD nonscheduled respite is made and not met.

Program contractors will determine what fields should be completed by the provider/agency and any additional instructions for the completion of the form. Program contractors will need to complete any fields that the provider/agency does not complete. Reporting timelines will be provided by the program contractors.

If you have any questions please call your respective ALTCS program contractor.

II. NPS Column # Instruction/Explanation

0. **Program Contractor ID Number** - Program contractor fills in column with identification number 110049.

1. **Provider Registration Number** - Provider’s AHCCCS Identification numbers. Column to be filled in by provider or program contractor. **When the provider is Self-Directed Attendant Care (SDAC) please use 000000 to represent all SDAC services. Do not use the SDAC worker's AHCCCS provider identification number (this was added 2/1/08).** Please ensure that this column is completed.

2. **Date Called In** – The date the agency was notified of the NPS. Use the following format 02/01/05.

3. **Time Called In** – The time the agency was notified. **Use military time** e.g., 08:00, 13:30, etc. Please round to the nearest 15-minute increment.

4. **NPS Date** – The date the NPS occurs. This date may be the same as the date in column 1 or the consumer may have waited to call. Use the following format: 11/01/04.

5. **Time Service Scheduled to Begin** – Insert the time the service was regularly scheduled to begin. **Use military time** e.g., 08:00, 13:30, etc. Please round to the nearest 15-minute increment.
6. **County Code** – The county of residence code from the following chart:

<table>
<thead>
<tr>
<th>County</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apache</td>
<td>01</td>
</tr>
<tr>
<td>Cochise</td>
<td>03</td>
</tr>
<tr>
<td>Coconino</td>
<td>05</td>
</tr>
<tr>
<td>Gila</td>
<td>07</td>
</tr>
<tr>
<td>Graham</td>
<td>09</td>
</tr>
<tr>
<td>Greenlee</td>
<td>11</td>
</tr>
<tr>
<td>La Paz</td>
<td>29</td>
</tr>
<tr>
<td>Maricopa</td>
<td>13</td>
</tr>
<tr>
<td>Mohave</td>
<td>15</td>
</tr>
<tr>
<td>Navajo</td>
<td>17</td>
</tr>
<tr>
<td>Pima</td>
<td>19</td>
</tr>
<tr>
<td>Pinal</td>
<td>21</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>23</td>
</tr>
<tr>
<td>Yavapai</td>
<td>25</td>
</tr>
<tr>
<td>Yuma</td>
<td>27</td>
</tr>
</tbody>
</table>

7. **Member’s Name** – List consumer’s name, last name, first name and middle initial – Jones, Mary J.

8. **Member’s Zip Code** – Member’s zip code – this column can be filled in either by the program contractor or the provider.

9. **Member’s AHCCCS ID** – List consumer’s AHCCCS Identification Number – A12345678.

10. **Select from the following authorized service type** – Select what service the consumer was to receive and list the corresponding alphabetical bullet in Column 10. A consumer may be receiving more than one service (i.e., personal care and homemaker). Please list member’s name twice and use a separate line to record the second service.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Letter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendant Care</td>
<td>A</td>
</tr>
<tr>
<td>Homemaker</td>
<td>B</td>
</tr>
<tr>
<td>Personal Care</td>
<td>C</td>
</tr>
<tr>
<td>Respite</td>
<td>D</td>
</tr>
</tbody>
</table>

11. **Member Service Preference Level at the time of notice** – Agencies shall obtain from the member/representative the Member Service Preference Level at the time the provider/agency either receives a call from a consumer advising of a NPS or the provider/agency contacts the member/representative. The Member Service Preference Level is a designation of how quickly the member chooses to have a service gap filled if the scheduled caregiver of that critical service is not available. The member may have indicated a lower preference level previously but immediate circumstances indicate a higher preference level now.

   Insert the Member Service Preference Level as indicated by the member/representative at the time the provider/agency makes contact with the member. Column to be filled in by agency/provider.

<table>
<thead>
<tr>
<th>Member Service Preference Level</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs services within two hours</td>
<td>1</td>
</tr>
<tr>
<td>Needs services today</td>
<td>2</td>
</tr>
<tr>
<td>Needs services within 48 hours</td>
<td>3</td>
</tr>
<tr>
<td>Can wait until next scheduled day</td>
<td>4</td>
</tr>
</tbody>
</table>
12. **Member Service Preference Level** at time of last Case Manager’s visit – Insert the Member Service Preference Level indicated by the member/representative during the initial or reassessment interviews. Column to be filled in by program contractors.

<table>
<thead>
<tr>
<th>Member Service Preference Level</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs services within two hours</td>
<td>1</td>
</tr>
<tr>
<td>Needs services today</td>
<td>2</td>
</tr>
<tr>
<td>Needs services within 48 hours</td>
<td>3</td>
</tr>
<tr>
<td>Can wait until next scheduled day</td>
<td>4</td>
</tr>
</tbody>
</table>

13. **Reason for the NPS** – List the reason the non-provision of services occurred. Use the corresponding numerical bullet only. Use number 9, only when a non-scheduled respite service has been requested and the agency does not have a caregiver available. Provide a brief explanation in Column 22, “Comments,” if “Other” is used.

<table>
<thead>
<tr>
<th>Reason for Non-Provision of Service</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver cancelled</td>
<td>1</td>
</tr>
<tr>
<td>Caregiver did not show</td>
<td>2</td>
</tr>
<tr>
<td>Caregiver left early</td>
<td>3</td>
</tr>
<tr>
<td>Caregiver refuses to go or return to an unsafe or threatening environment at the member’s residence</td>
<td>4</td>
</tr>
<tr>
<td>Caregiver quit</td>
<td>5</td>
</tr>
<tr>
<td>Member not available to receive services when caregiver arrives at the scheduled time</td>
<td>6</td>
</tr>
<tr>
<td>Replacement caregiver not available</td>
<td>7</td>
</tr>
<tr>
<td>Non-scheduled respite service request</td>
<td>8</td>
</tr>
<tr>
<td>Member refuses services</td>
<td>9</td>
</tr>
<tr>
<td>Member called to cancel/reschedule services</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
</tr>
</tbody>
</table>

14. **Explain how NPS was resolved** – List how the NPS was met on the day of the NPS. Use the corresponding alphabetical bullet only. Unpaid Community Organization could be the consumer’s church or civic organization. Unpaid Caregiver could be an unpaid family member, neighbor, friend, etc. who has been designated by the member/representative to assist in an emergency. If an unpaid caregiver is willing to stay with the member until the agency can get another caregiver to the home use “H.”

<table>
<thead>
<tr>
<th>Explain How NPS Was Resolved</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendant Care</td>
<td>A</td>
</tr>
<tr>
<td>Homemaker</td>
<td>B</td>
</tr>
<tr>
<td>Personal Care</td>
<td>C</td>
</tr>
<tr>
<td>Respite</td>
<td>D</td>
</tr>
<tr>
<td>Unpaid Caregiver</td>
<td>E</td>
</tr>
<tr>
<td>Unpaid Community Organization</td>
<td>F</td>
</tr>
<tr>
<td>Other</td>
<td>G</td>
</tr>
<tr>
<td>Unpaid/Paid Caregivers</td>
<td>H</td>
</tr>
</tbody>
</table>

**Note:**

1) If an “E,” “F” or “H” is recorded in Column 14, then Column 21 must be completed.

2) If “G” is used then an explanation must be included. Begin explanation(s) of “Other” in column 22, “Comments”. A “G” should not be used to indicate that no services were provided. If no services are provided leave the column blank.

15. **Original Hours Authorized** – The amount of hours authorized by the Case Manager for the date of the NPS being reported.
16. **Hours provided to resolve NPS on the day of the NPS** – Number of hours provided by all entries in Column 14 above to meet member’s needs. For example, Case Manager authorized eight hours for attendant care services; agency was able to get a replacement caregiver to provide six hours and unpaid caregiver provided two hours until replacement arrived so a total of eight hours should be recorded. Note: If Column 16 is less than the number of hours authorized in Column 15, then Column 20 must be completed.

17. **Length of time before services replaced** – Time to resolve NPS in service hours – e.g., the time between the agency/contractor notification and the delivery of service. Please record time to resolve NPS in hours – a half day as 12 hours; one day as 24 hours; the next once a week scheduled visit as 168 hours.

For example:

A. The agency was notified at 8:30 a.m. that the caregiver cancelled the 8 a.m. scheduled service. The Member Service Preference Level indicated by the member/representative at the time of the call was “1” – Within two hours. The agency was able to get a substitute caregiver to the member’s home by 9:30 a.m. Column 17 should record the length of time to resolve the NPS as one hour.

B. The agency was notified at 8:30 a.m. that the caregiver cancelled the 8 a.m. regularly-scheduled Tuesday services. The Member Service Preference Level indicated by the member/representative at the time of the call was 3 – Within 48 hours. The agency is able to have a substitute caregiver there at 8 a.m. Wednesday morning. Column 17 should record the length of time to resolve the NPS as 23.5 hours.

C. The agency was notified at 8:30 a.m. that the caregiver cancelled the 8 a.m. once-a-week Tuesday services. The Member Service Preference Level indicated by the member/representative at the time of the call was 4 – Next Scheduled Visit. Column 17 should record the length of time to resolve the NPS as 167.5 hours.

18. **Was Member Service Preference Level Timeline Met** – Place a Y (yes) or N (no) to indicate if the NPS was met within the timeline indicated by the Member Service Preference Level at the time of the notice in Column 11. The clock on the NPS begins when the provider is notified by the member/representative or caregiver that the caregiver either will not or has not arrived to provide services. **NOTE:** if an “N” is recorded in Column 18, then Column 19 must be filled out.

19. **If Member Service Preference Level Timeline Not Met** – List the reason the Member Service Preference Level timeline was not met. Use the corresponding numerical bullet. Provide a brief explanation if “Other” is used in column 22, “Comments”.

<table>
<thead>
<tr>
<th>If Member Service Preference Timelines Not Met, Explain Why</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reserved (Do Not Use)</td>
</tr>
<tr>
<td>Consumer Choice</td>
</tr>
<tr>
<td>Unable to find replacement</td>
</tr>
<tr>
<td>Not alerted of NPS</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>
20. **If total Authorized Hours not replaced, explain why** – List the reason the total authorized units not replaced. Use the corresponding numerical bullet. Provide a brief explanation if “Other” is used in column 22, “Comments.”

<table>
<thead>
<tr>
<th>Reason</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full replacement hours not needed</td>
<td>1</td>
</tr>
<tr>
<td>Consumer Choice</td>
<td>2</td>
</tr>
<tr>
<td>Unable to find replacement</td>
<td>3</td>
</tr>
<tr>
<td>Not alerted of NPS</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

21. **If Unpaid Caregiver used, explain why** – Use corresponding number to indicate the reason an unpaid caregiver was used. Note if there is an “E”, “F” or “H” used in Column 14 then Column 21 must be completed. For example, the agency is notified that the caregiver cancelled, the agency calls the member/representative to determine the Member Service Preference Level and discusses getting another caregiver out to the member. The member refuses and states they wish to use an unpaid caregiver. A number 1 would be recorded in Column 21. Provide a brief explanation if “Other” is used in column 22, “Comments.”

<table>
<thead>
<tr>
<th>Reason</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer Choice</td>
<td>1</td>
</tr>
<tr>
<td>No Agency Staff Available</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
</tbody>
</table>

**Interpreter Services**

UnitedHealthcare Community Plan provides oral interpreter services 24 hours per day to its enrollees free of charge. Services for more than 140 non-English languages and hearing impaired are available. If the UnitedHealthcare Community Plan enrollee needs interpreter services, AHCCCS and UnitedHealthcare Community Plan prefer you use a professional interpreter through the Language Line. The instructions to access the Language Line are below:

**Language Line Interpreters:**
- UnitedHealthcare Community Plan is contracted with the Language Line for Interpreter service.
- Please use the language line for our members who need an interpreter.

To access an interpreter contact Customer Service at 877-261-6608 please use “244162” as client ID, this will let us know you are using the Language Line for an UnitedHealthcare Community Plan member.

**Language Line Offers:**
- Over 22 years of experience with unmatched industry knowledge.
- Over 140 languages available 24-hours-a-day, seven-days-a-week.
- Over 2,000 interpreters, only company with medically certified interpreters in top 22 languages.
- 94 percent of all calls are handled by scheduled employee interpreters.

**To do a Sample Call:**
Language Line Services Demonstration Line 800-821-0301
Cultural Competency

As a physician or health care provider, UnitedHealthcare Community Plan reminds you to be culturally sensitive to the diverse population you serve. There are diverse cultural preferences that we ask providers to keep in mind when serving our enrollees. All services should be conducted in accordance with Title VI of the Civil Rights Act of 1964 and should be provided in a manner that respects the enrollee’s cultural heritage and appropriately utilizes natural supports in the enrollee’s community.

All providers shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, sex, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI. Providers shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, national origin or disability. (Federal regulations, State Executive order number 99-4 & AAC R9-22-513).

Some cultural preferences to remember include:

- Ask what language the enrollee prefers to help eliminate communication barriers and, when necessary, use the interpretation services available to you.
- Understand the enrollee’s religious and health care beliefs.
- Understand the role of the enrollee’s family and their decision-making process.
- Don’t assume the diets of similar countries are the same.

These are just a few reminders. Your UnitedHealthcare Community Plan Provider Advocate can provide additional education to you on cultural awareness. For more information on cultural competency, please refer to cultural competency links on UnitedHealthcare Community Plan’s website at UHCCommunityplan.com entitled Culturally Competent Patient Care: A Guide for Providers and Their Staff by Georgia Hall, PhD.

Some additional resources for information on Cultural Competency are:


www.LEP.gov – Promotes importance of language access to federal programs and federally assisted programs.

www.crosshealth.com – Quarterly newsletters on cultural competence topics for staff.

www.diversityrx.org – Promotes language and cultural competence to improve the quality of health care for minorities.

www.ncihc.org – Organization to promote culturally competent health care.

Member Advisory Councils

To promote a collaborative effort to enhance the service delivery system in local communities while maintaining an enrollee focus, UnitedHealthcare Community Plan has established a member advisory council in each of the geographic service areas. The council is chaired by the UnitedHealthcare Community Plan Executive Director or designee and meets quarterly. Enrollees and providers are encouraged to attend the advisory councils. The advisory councils allow enrollees and providers to give UnitedHealthcare Community Plan critical feedback on:

- The effectiveness of policies and programs related to the delivery of health care services to UnitedHealthcare Community Plan enrollees.

- Satisfaction survey results and quality improvement measures.

- Opinions on the quality and accessibility of UnitedHealthcare Community Plan’s networks.

- The usefulness of external communications, including the Enrollee Handbook, Provider Manual, enrollee and provider newsletters and other mailings.

Contact your Provider Relations Advocate for upcoming advisory council dates and locations. The advisory council is held quarterly and in all geographic service areas with UnitedHealthcare Community Plan members. Your provider relations advocate is always in attendance.

Provider Responsibility During Termination of Provider Agreement

If the physician or health care provider terminates their provider agreement without cause, the provider is required to continue to care and treat for the enrollees until the enrollee’s care has been transitioned to another provider or until the treatment course is completed.
UnitedHealthcare Community Plan Covered Services

UnitedHealthcare Community Plan follows the AHCCCS guidelines as set forth in the AHCCCS Medical Policy Manual (AMPM). You can view the entire manual on the AHCCCS website: www.azahcccs.gov. This chapter is an overview of covered and non-covered health care services, requirements and limitations, which are subject to change. Please refer to the AMPM for further details on the current ALTCS benefits.

Physicians and health care providers should contact the Customer Call Center or the enrollee’s Case Manager for additional eligibility, referral and provider authorization requirements. Further explanation of services can also be found in the Prior Authorization and Behavioral Health Services sections of this Provider Manual.

Physicians and health care providers that perform services for UnitedHealthcare Community Plan enrollees must have a valid AHCCCS ID number, NPI number if applicable, must be properly licensed according to state and federal regulations and must have documentation indicating compliance with local fire and sanitation codes and regulations.

All physicians and health care providers must ensure each enrollee’s privacy is protected, in accordance with the privacy requirements in 45 CFR parts 160 and 164 when providing coordination of services for enrollees with other entities.

All enrollees residing in a nursing facility or assisted living facility are assigned a Level of Care (LOC) by the UnitedHealthcare Community Plan Case Manager, who assists in determining the appropriate level and amounts of services for the enrollee. Providers that receive payment based on an enrollee’s LOC must bill accordingly.

Acute Care Health Services

1. Audiology
   - Adults 21 and older can receive medically necessary audiology services only for identification and evaluation of hearing loss unless the hearing loss is due to an accident or injury-related emergent condition.
   - Enrollees under 21 can receive medically necessary audiology services including the identification and evaluation of hearing loss and rehabilitation of the hearing loss through other than medical or surgical means (e.g. hearing aids).

2. Behavioral Health – refer to the Behavioral Health chapter in this Provider Manual

3. Children’s Rehabilitative Services – referred by UnitedHealthcare Community Plan and administered by the Arizona Department of Health Services

4. Chiropractic Services
   - Enrollees under 21 can receive medically necessary chiropractic services when prescribed by the enrollee’s PCP and approved by UnitedHealthcare Community Plan.
   - Qualified Medicare beneficiaries may receive chiropractic services if prescribed by the enrollee’s PCP.
5. Dental – Adults 21 and older can receive medical and surgical services furnished by a dentist only to the extent that such services may be performed under state law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician. For members 21-years-of-age and older, the services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. The covered services include examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Certain pre-transplant services (e.g. dental cleanings, fillings, restorations, extractions) and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head are also covered.

6. Dialysis – Medically necessary dialysis, supplies, diagnostic testing and medication for enrollees when provided by Medicare-certified hospitals or Medicare-certified end stage renal disease (ESRD) providers.

7. EPSDT Services – refer to the EPSDT chapter in this Provider Manual.

8. Emergency Medical Services – UnitedHealthcare Community Plan monitors emergency services utilization and will implement corrective action plans for providers with inappropriate utilization of these services. Emergency medical services include:
   • Medical services necessary to rule out an emergency condition;
   • Emergency transportation;
   • Enrollee access by telephone 24-hours-per-day, seven-days-per-week for advice by a physician, nurse practitioner or physician assistant.

9. Family Planning – For those who voluntarily choose to delay or prevent pregnancy, covered services include birth control pills, supplies and devices, and surgical procedures to cause sterility, delay or prevent pregnancy.


11. Hospital – Inpatient hospital services.

12. Immunizations
   • Adults may receive diphtheria-tetanus, influenza, pneumococcal, rubella, measles and hepatitis B immunizations;
   • Enrollees under 21: Refer to the EPSDT chapter in this Provider Manual.

13. Laboratory Services.

14. Maternity services – Includes pre-conception counseling, pregnancy identification, prenatal care, treatment of pregnancy-related conditions, labor and delivery services, and postpartum care for members. Members may select or be assigned to a PCP specializing in obstetrics.

15. Medical supplies, durable medical equipment, orthotic and prosthetic devices. Benefit limitations for orthotic and prosthetic devices apply to adults 21 and older.

16. Nutrition services, including medical foods, assessments and therapies.

17. Physician Services – Including medical assessments, treatments and surgical services.

18. Podiatry Services – For adults 21 and older, foot and ankle services provided by a podiatrist are no longer covered. Those services may be reimbursed if rendered by another clinician such as a physician, NP, or PA.

19. Post-Stabilization Care Services.

20. Prescription Medications.
21. Primary Care Provider (PCP) – A physician, nurse practitioner or physician assistant assigned to the enrollee. PCP’s assigned to enrollees that have UnitedHealthcare Community Plan as primary must be contracted with UnitedHealthcare Community Plan. All PCP’s are responsible for the following activities:

- Supervision, coordination and provision of care to each assigned enrollee;
- Initiation of referrals for medically necessary specialty care;
- Maintaining continuity of care for each assigned enrollee;
- Maintaining the enrollee’s medical record, including documentation of all services provided to the enrollee by the PCP, as well as specialty or referral services;
- Making every effort to refer enrollees within the UnitedHealthcare Community Plan network.

22. Radiology and Medical Imaging.

23. Therapies including: occupational, physical, respiratory, auditory and speech. Limitations apply.

24. Transportation – All providers that transport UnitedHealthcare Community Plan enrollees must have the minimum liability insurance amounts as mentioned in the provider agreement. Medically necessary non-emergent transportation (car, wheelchair, van or stretcher van) requires prior authorization. Emergency transportation does not require prior authorization.

25. Triage, Screening and Evaluations – when provided by acute care hospitals, IHS facilities and urgent care centers to determine whether or not an emergency exists, assess the severity of the enrollee’s medical condition and determine services necessary to alleviate or stabilize the emergent condition.

Behavioral Health Services

Behavioral Health services are provided in collaboration with the enrollee, family representative and entities involved in the enrollee’s care. See the Behavioral Health chapter of this Provider Manual for more details.

1. Behavior management (behavioral health personal assistance, family support, peer support).
2. Behavioral health case management services.
3. Emergency behavioral health services.
4. Emergency and non-emergency transportation.
5. Evaluation and diagnosis.
6. Individual, group and family therapy and counseling.
7. Inpatient hospital.
8. Inpatient psychiatric facilities – Level 1 residential treatment centers and sub-acute facilities.
9. Laboratory and radiology services for psychotropic medication regulation and diagnosis.
10. Partial care – supervised day program, therapeutic day program and medical day program.
11. Psychosocial rehabilitation – living skills training; health promotion; pre-job training, education and development; job coaching and employment support.
12. Psychotropic medication, adjustment and monitoring.
Long Term Care (LTC) Services

The Case Manager will evaluate the enrollee’s health care needs to determine the appropriate residential setting, Level of Care (LOC) and services necessary to safely maintain the enrollee in the least restrictive environment. All LTC services require prior notification by the UnitedHealthcare Community Plan Case Manager.

All facility settings require the appropriate registration, licensure and insurance liability coverage. All providers are required to send copies of updated licenses and certificates upon renewal. Failure to provide this information may result in non-payment of rendered services and termination of your UnitedHealthcare Community Plan Agreement.

Case Managers will conduct on-site assessments of enrollees to ensure the appropriateness of the caregiver and of the type and amount of services being rendered to the UnitedHealthcare Community Plan enrollee. If UnitedHealthcare Community Plan has been made aware that a provider’s performance is unsatisfactory, it will contact the provider with the findings and care issues. The provider is responsible to address the issues and follow up with UnitedHealthcare Community Plan promptly. If a Quality Management issue becomes evident, UnitedHealthcare Community Plan will follow appropriate procedures to ensure the highest quality of care is provided to the enrollee.

Enrollees residing in nursing facilities or assisted living facility settings are responsible for the Enrollee Share of Cost (MSOC) or Room and Board (R&B) payment as applicable. There are three long-term care settings:

1. Nursing Facility – Case Management enrollee evaluations are completed every 180 days or as enrollee conditions change. Nursing facility placements must be prior authorized by the Case Manager.
   - Nursing facilities, including skilled nursing.
   - Behavioral Health Level 1.
   - Inpatient Psychiatric Residential, only for enrollees under 21 years of age.
   - Institution for Mental Disease.

2. Assisted Living Facility – Case Management enrollee evaluations are completed every 90 days or as enrollee conditions change. See “HCBS Alternative Residential Settings” of this chapter for more details. In some instances, an enrollee may be eligible to receive HCBS services while residing in an Assisted Living Facility. The Case Manager will evaluate the enrollee’s health care needs and determine if an HCBS services is appropriate. Assisted Living Facility placement must be prior authorized by the Case Manager.

3. Home and Community Base Services (HCBS) – Case Management enrollee evaluations are completed every 90 days or as enrollee conditions change. Enrollees residing in a private home or apartment may receive the following services based upon the Case Manager’s evaluation and authorization of services:
   - Adult Day Health Care – includes supervision, medication assistance, recreations and socialization, personal living skills training, health monitoring and preventive, therapeutic and restorative services. This service may be available to enrollees residing in ALTCS approved alternative residential settings upon the Case Managers evaluation and approval for the service.
• **Attendant Care** – includes supervision, bathing assistance, food preparation and feeding assistance, housekeeping services, medication reminders, recreation and socialization.

• **Behavioral Management Services** – See the Behavioral Health chapter of this Provider Manual.

• **Community Transition Service** – The Community Transition Service is a fund to assist ALTCS-institutionalized members to reintegrate into the community by providing financial assistance to move from an ALTCS Long Term Care (LTC) institutional setting to their own home.

• **Durable Medical Equipment** – Custom and standard items require an order by the enrollee’s physician and must be prior authorized by the enrollee’s UnitedHealthcare Community Plan Case Manager and/or the Prior Authorization Department. This service is limited to a one-time benefit per five years per member.

• **Emergency Alert System** – Monitoring devices for enrollee’s who live alone, are at risk of emergent care and are unable to access emergency assistance. Emergency alert system equipment may not be provided without orders from the member’s PCP. A physician order is also required to discontinue the provision of the Emergency Alert System.

• **Group Respite** – An alternative to adult day health care.

• **Habilitation** – Provision of training independent living skills or special developmental skills: sensory-motor development; orientation and mobility and behavior intervention. Physical, occupational or speech therapies may be provided as a part of or in conjunction with other habilitation services.

• **Home Delivered Meals** – Provides nutritious food to enrollees who live in their own home but are in jeopardy of not eating adequate amounts of nutritious food to maintain good health. Only one meal may be approved for an enrollee on any given day. Provider of home-delivered meals, and those employed, must have applicable food handling/preparation permits.
  
  - **Menus:** Must be planned for a minimum of four consecutive weeks and rotated three times before changing menus, taking seasonal foods into consideration; must be available for audit at the providers place of business for at least one year following meal services; must be available in the predominant languages of the group serviced, with reflection of ethnic choices; must be approved by a registered dietician prior to posting – any possible substitutions must be included.
  
  - **Meals:** Must reflect 1/3 of the current recommended daily allowance of nutrients dietary recommendations for sugar, salt and fat intake must be maintained; must be delivered in a safe and sanitary manner directly to the enrollee; frozen meals may be provided in advance for days when no delivery is available; enrollee must have the ability to store three meals; must be prepared therapeutically in accordance with the PCP order if a special diet is ordered; must be signed for upon delivery.
  
  - **Other:** Case records must be maintained confidentially; services not provided are documented with reasoning; printed educational materials must be delivered to enrollees with meals at least two times per quarter; provider must respond to consultant concerns and initiate corrective action within three weeks.
• **Home/Environmental Modifications** – Allows modifications to enrollee’s existing residences to enable an enrollee to function safely and as independently as possible in the community. UnitedHealthcare Community Plan Case Managers will conduct on site assessments to determine the appropriateness of an environmental modification or repair.

• **Home Health Services** – Includes home health aides, home health skilled nursing, private-duty nurses for ventilator dependent enrollees only, medically necessary supplies and therapy services. See “Medical Supplies Included in FFS Home Health Nursing Visits” for supplies that are included in the agencies Fee-For-Service (FFS) rate, at the end of the chapter.

• **Home Health Aide** – Provides nursing-related services under the direction of a registered nurse or physician. These services must be ordered by the PCP and authorized by the Case Manager. Home Health Aides must have current certification through the Arizona Board of Nursing, CPR and First Aid. A Home Health Aide visit may include one or more of the following:
  - Assessment of the enrollee’s health or functional level.
  - Monitoring and documentation of vital signs.
  - Assistance with contingency or osmotic programs.
  - Assistance with self-administration of medications.
  - Assistance with feeding.
  - Assistance with ambulation, transfer, range of motion and use of equipment.
  - Assistance with Activities of Daily Living.
  - Enrollee or family training of health care tasks.

• **Home Health Nurse** – Provides skilled nursing services ordered by the PCP and must be provided by a licensed nurse under the supervision of a physician. These services can only be provided on an intermittent basis. These services are considered as skilled.

If a licensed/Medicare certified home health agency is not available in an enrollee’s community, does not have adequate staff, or will not provide services through UnitedHealthcare Community Plan, a licensed home health agency that is non-Medicare certified or an independent RN may provide skilled nursing services. RNs providing these services will be required to provide documentation of services performed via PCP orders. UnitedHealthcare Community Plan will monitor the service deliver and quality of care.

Skilled nursing assessments and care for enrollees with pressure sores, surgical wounds, tube feedings, etc., must be provided by a Medicare-certified home health agency or independent nurse. Written monthly reports must be submitted to the PCP and UnitedHealthcare Community Plan Case Manager. Skin assessments must be performed at least monthly for enrollees prone to breakdown of skin integrity due to their health status or care needs.

• **Private Duty Nurse** – Home Health Private Duty Nurse services are provided on a continuous basis to avoid hospitalization or institutionalization when care cannot be safely managed intermittently. Private Duty services must be ordered by the PCP and authorized by UnitedHealthcare Community Plan. If a LPN provides services, a physician must provide supervision. Home Health Private Duty Nursing services are only available to ventilator dependent enrollees.
• **Homemaker Services** – May be provided to preserve or improve upon the safety and sanitation of an enrollee’s living condition, nutritional value of meals and to maintain or increase the enrollee’s self-sufficiency. A homemaker is only to provide services that pertain to the enrollee. A homemaker may clean the enrollee’s living space, such as his or her bedroom; conduct meal planning, shopping, and food preparation with clean up; and clean and put away the enrollee’s laundry.

• **Home Maintenance Program** – If an enrollee’s restoration potential is evaluated as insignificant or at a plateau, a Home Maintenance Program can be initiated. A licensed therapist, the enrollee, family, caregiver or non-skilled personnel is trained to help to maintain the enrollee’s functioning level. UnitedHealthcare Community Plan will authorize the initial establishment of the Home Maintenance Program via a licensed therapist if the service is determined appropriate by the PCP, UnitedHealthcare Community Plan Medical Director, and UnitedHealthcare Community Plan Utilization Management.

• **Hospice** – Includes physician services, nursing services, medication for the terminal illness, therapies, aid services, homemaker services, medical social services, medical supplies and appliances, short-term respite and counseling including bereavement and support. The enrollee’s physician must certify that the enrollee is terminally ill with a prognosis of six (6) months or less, and enrollee desires palliative versus curative treatment. Hospice is a prior-authorized service. If the enrollee is receiving services under Medicare, the services do not require PCP orders or UnitedHealthcare Community Plan Case Management prior authorization. However, the UnitedHealthcare Community Plan Case Manager is responsible to monitor the enrollee’s care, therefore the hospice provider must notify the UnitedHealthcare Community Plan Case Manager of the hospice election. Hospice services must be provided through a Medicare-certified agency. If the enrollee has Medicare, hospice benefits must be chosen instead of regular Medicare benefits.

• **Partial Care** – Structured, coordinated programs designed to provide therapeutic activities that promote coping, problem solving, and socialization skills.

• **Personal Care** – Includes bathing assistance, food preparation and feeding assistance, homemaker services, medication reminders, and recreation and socialization. Personal Care services may assist with bathing, toileting, dressing, nail care and feeding; assistance with transferring, ambulating and use of special equipment; and conduct training of family/caregivers.

• **Respite Care** – Is provided in both inpatient and outpatient settings for a short-term period to relieve the family. Respite services can be available up to 24-hours-a-day and is limited to 600 hours per fiscal year up to 25 days.
HCBS Alternative Residential Settings

Enrollees residing in these settings are responsible for their room and board payment at the beginning of each month. The room and board amount is determined by UnitedHealthcare Community Plan in accordance with AHCCCS guidelines.

1. Alzheimer’s Treatment Assisted Living.

   - “AFC” or Adult Foster Care – up to four residents in the home. The sponsors, or homeowners, reside in the home with the residents.
   - “ALH” or Assisted Living Home (formerly Adult Care Home) – up to 10 residents in the home. Owners of ALH’s typically do not reside in the residence. ALH’s must be staffed 24 hours per day, seven days per week.
   - “ALC” or Assisted Living Center – more than 10 residents in the center. ALC’s must be staffed 24 hours per day, seven days per week. Enrollees residing in ALC’s must be offered the choice of single occupancy rooms. If no single occupancy rooms are available at the time of move-in, or in situations where an enrollee is offered a single occupancy room and declines but later requests to move into a single occupancy room, the enrollee must be placed on a wait list for a single occupancy room and may not be passed over by other residents (regardless of payor source) on the wait list. ALC’s that have varying sizes and layouts for single occupancy rooms may designate a room size/layout for ALTCS enrollees, in which if a single occupancy room size/layout that is not designated becomes available, the ALC is not required to place the ALTCS enrollee in that specific unit.

3. Adult Development Home – licensed by DES (Department of Economic Security) – up to three adults (18 or older) in the home

4. Adult Therapeutic Foster Home – for behavioral health enrollees only – up to three adults in the home

5. Behavioral Health Level II (Residential Treatment Center) – licensed by ADHS – 24-hour supervision and counseling or other therapeutic activities for individuals who do not require the intensity of treatment services or on-site medical services found in a Level 1 behavioral health facility

6. Behavioral Health Level III (Residential Treatment Center) – licensed by ADHS – 24-hour supervision and supportive protective oversight, behavior management or psycho-social rehabilitation and assure that enrollees receive required medications, obtain needed treatment and have transportation to outside treatment agencies if necessary. Life skills training, social and recreational activities may be provided directly or by referral to outside treatment agencies.

7. Child Development Foster Home – licensed by DES – up to three children in the home.

8. Group Home for Developmentally Disabled – licensed by DES – up to six adults in the home.


10. Traumatic Brain Injury Treatment Facility – licensed by ADHS.
Therapeutic Leave and Bed Hold

UnitedHealthcare Community Plan enrollees residing in skilled nursing facilities may receive up to 12 days per AHCCCS contract year (beginning October 1) while the enrollee is hospitalized or otherwise not occupying a bed in the skilled nursing facility and is expected to return to the facility, in accordance with UnitedHealthcare Community Plan’s Therapeutic Leave/Bed Hold Policy. Of the 12 days allowed, no more than nine days shall be for Therapeutic Leave. All requests for payment of Therapeutic Leave and Bed Hold days must be prior authorized by the Case Manager.

Enrollees less than 21-years-of-age may use any combination of Bed Hold and Therapeutic Leave per AHCCCS contract year with a limit of 21 days per year. The total days may include Therapeutic Leave and Bed Hold days in multiple facilities.

Medical/Acute Care Only Services

Medical/acute care services and case management services are provided to those enrollees eligible for ALTCS, but are residing in an uncertified or unauthorized facility, refuse long-term care services, are awaiting disenrollment from the ALTCS program, or have not received long-term care services for more than 30 days. These enrollees do not qualify for full long-term care benefits. Services provided will be only those allowable under the auspices of AHCCCS ambulatory plans and case management services (e.g. DME, medically necessary transportation, physician services, prescriptions, laboratory, x-rays, behavioral health, outpatient services, inpatient acute services). These services do not include nursing facility placement, assisted living placement or home and community-based services.

Emergency Services

A medical emergency is something that happens suddenly and with very severe and serious symptoms. Without immediate medical attention, an emergency could place an enrollee’s health in serious danger. Minor problems like a cold, rash or small cuts and bruises are not considered an emergency and can usually be treated by scheduling an appointment with the enrollee’s PCP.

Emergency services are covered for all UnitedHealthcare Community Plan enrollees. However, providers should educate the members regarding appropriate and inappropriate use of the emergency room. Non-emergency services should be treated by the PCP or in an urgent care setting. Non-emergency services, such as: sprains/strains, stomach aches, ear aches, fever, cough and colds, sore throats, should be treated by the PCP.

For a list of urgent care centers, contact Customer Services at 800-293-3740.
In the case of a true emergency, call 9-1-1 for help.

If one of the following happens, call 9-1-1 or take the enrollee to the nearest hospital emergency room immediately:

- Danger of losing life or limb
- Loss of speech
- Chest pains
- Unconsciousness
- Poisoning or overdose of medicine or drugs
- Car accident
- Choking or problems breathing
- Suddenly not able to move
- Heavy bleeding
- Criminal attack (e.g. mugging)
- Fainting

If you are not sure if the symptoms are life threatening, you can call the enrollee’s PCP or case manager.

Emergency transportation is available 24-hours-a-day, seven-days-a-week.

Non-Covered Services

Services not covered by ALTCS include, but are not limited to:

1. Services provided by non-approved physicians or health care providers.
2. Services or items furnished solely for beauty or cosmetic reasons.
3. For persons 21 or older, hearing aids, eye exams for glasses/lenses, dentures, and non-emergency dental services, unless deemed medically necessary and approved by the medical director.
4. Services defined by AHCCCS as experimental or provided solely for the purpose of research.
5. Sex-change operations.
7. Care not deemed medically necessary by AHCCCS, UnitedHealthcare Community Plan or the physician, and/or care not covered under ALTCS.
8. Medical services provided to an enrollee who is an inmate or who is in the care of a state mental health center.
9. Man-made hearts or xenografts.
10. Organ transplants, except those identified under the “Covered Services” chapter of this Provider Manual or stated in ALTCS benefits.
11. Services provided in a center or facility in an area of a center or facility that is not Medicare/Medicaid certified for such services.
12. Room and Board in AFC’s, ALH’s, ALC’s or other alternative residential settings.
13. HCBS services that are not approved by the UnitedHealthcare Community Plan Case Manager.
14. For adults 21 and older, foot and ankle services provided by a podiatrist.
15. Well visits/well exams for adult members 21 years of age and older have been reinstated as a covered service. Well visits, such as, but not limited to, well woman exams, breast exams, and prostate exams are covered for members 21 years of age and older. For members under 21 years of age, AHCCCS continues to cover medically necessary services under the EPSDT Program.
**Medical Supplies Included in FFS Home Health Nursing Visits**

In accordance with Chapter 1240 of the AMPM (AHCCCS Medical Policies Manual), the following supplies are included in the AHCCCS Fee-For-Service (FFS) Home Health Nurse visit rate. DME equipment should not be included in the visit rate. This list is not all-inclusive and its purpose is a general reference only.

- Adhesive spray
- Adhesive tape
- Antiseptics
- Bandage, cling type 6”
- Colostomy care
- Cotton balls, non-sterile
- Cotton balls, sterile
- Diabetic daily care
- Diabetic Diagnostics and tape, cloth 2”x10 yds
- Dressing, N-Adhering with adhesive 2x3”
- Dressing, transparent
- Gauze bandage roll 1”x10yds Tape, cloth 2”x10yds
- Gauze pads, sterile
- Gauze pads, sterile 4 x 4
- Gauze pads, sterile with gel 1/2” x 72”
- Gauze pads, sterile with gel 6” x 36”
- Gauze sponges, non-sterile 4 x 4
- Gloves, plastic disposable
- Glucose care starter kit
- Glucose reagent strips
- Hydrogen peroxide
- Iodoform packing 1/2’ x 5yds
- Isopropyl alcohol swabs
- Lancets
- Lubricating jelly, 1 oz
- Packaging gauze, plain 1/4” x 5yds
- Petroleum jelly, 1 oz
- Petroleum jelly gauze 1” x 8”
- Syringes
- Syringes/needles
- Tape, paper 1” x 5yds
- Tape, plastic 1” x 5yds
- Tape, standard adhesive 2” x 5yds
- Tape, standard adhesive 11/2” x 10yds
- Tape, waterproof adhesive 1” x 5yds
- Tape, waterproof adhesive 11/2” x 5yds
- Tape, waterproof adhesive 1”
- Urine test strips
- Wood applicator with cotton tips
Making a Referral for Behavioral Health Services

If an UnitedHealthcare Community Plan provider or the enrollee identifies a need for Behavioral Health services, they should contact the enrollee’s Case Manager directly to discuss the referral. If the provider does not know the Case Manager’s name, they can call the UnitedHealthcare Community Plan Customer Service Center at 800-377-2055. If the Case Manager’s name is known but not their phone number, call the main UnitedHealthcare Community Plan number at 602-255-8908 or 800-293-3740 and ask to be connected to the Case Manager’s office phone number.

UnitedHealthcare Community Plan provides a wide range of medically necessary behavioral health services, in accordance with AHCCCS policies. Covered behavioral health services include:

- Behavior Management (personal care, family support/home care training, peer support)
- Behavioral Health Case Management Services (with limitations)
- Behavioral Health Nursing Services
- Emergency Behavioral Health Care
- Emergency and Non-Emergency Transportation
- Evaluation and Assessment
- Individual, Group and Family Therapy and Counseling
- Inpatient Hospital Services - (Contractors may provide services in alternative inpatient settings that are licensed by ADHS/DLS/OBHL, in lieu of services in an inpatient hospital. These alternative settings must be lower cost than traditional inpatient settings.
- Behavioral Health Inpatient Facilities
- Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
- Partial Care (supervised day program, therapeutic day program and medical day program)
- Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services)
- Psychotropic Medication
- Psychotropic Medication Adjustment and Monitoring
- Respite Care (with limitations)
- Substance Abuse Transitional Agency Services
- Screening
- Home Care Training to Home Care Client

Long Term Care Placement Services for Persons with Behavioral Health Disorders and or Traumatic Brain Injuries.

- Behavioral Health Residential Facility
- Traumatic Brain Injury Treatment Facility
- Institution for Mental Disease (IMD)
- Group Home for Developmentally Disabled (A Specific Licensed DD Group Home providing services for Elderly/PD ALTCS members must only provide services to persons who are not in the DES-DDD ALTCS Program.)

Other services and settings, if approved by CMS and/or the Director of AHCCCS, may be added as appropriate. Exclusions and limitations of ALTCS covered services are discussed in AHCCCS and ALTCS Rules and the AMPM.
Role of the UnitedHealthcare Community Plan Case Manager in Behavioral Health Services

The UnitedHealthcare Community Plan Case Manager plays a central role in coordinating services within UnitedHealthcare Community Plan’s network to ensure a smooth flow of services and maximum accessibility to services.

UnitedHealthcare Community Plan’s approach to behavioral health is designed to ensure that eligible enrollees receive timely and necessary behavioral health services in the least restrictive environment, as well as eliminate barriers to care delivery that may prohibit individuals from receiving needed care. These services are provided by coordinating a service plan through collaboration with the enrollee, their family, significant other or legally authorized decision-maker, along with the enrollee’s PCP, Case Manager and any community resources that may be serving the enrollee.

The UnitedHealthcare Community Plan Case Manager is responsible to ensure that providers are aware of the member’s ongoing behavioral health plan. If you have any questions or concerns, please feel free to call the Case Manager at any time. In order to enhance your awareness of the behavioral health services your member is receiving and effectively coordinate his or her care, the Case Manager will send you regular correspondence that includes:

1. Name of the behavioral health provider and methods to contact.
2. List of all current medications so that you are aware of what the behavioral health provider is prescribing.
3. Name of any other provider significantly involved in the member’s behavioral health care.

In turn, the behavioral health provider will also receive the same correspondence, indicating the list of current medications and the name of the PCP and methods to contact.

Role of the Non Behavioral Health Care Provider

Primary Care Providers and other providers should play an active role in the enrollee’s behavioral health treatment. One of the most important things to remember is that no matter the circumstances, the enrollee and their family must be a part of the treatment planning process. Discussing with the enrollee and their family regarding how they are doing in treatment can reinforce the importance of continuing treatment and also provide them the opportunity to discuss issues. Another key to success is to be aware of what types of treatment (both in terms of services and medications) the enrollee is receiving. This will help support the behavioral health treatment plan.

Non behavioral health providers will receive regular correspondence from the Case Manager concerning psychotropic medications the enrollee is prescribed. This information should be filed in the enrollee’s medical record for easy reference. The PCP should establish a separate record for behavioral health information. Our Quality Management program incorporates monitoring of the PCP’s referral to, coordination of care with, and transfer of care to behavioral health providers.

Initial Behavioral Health Evaluation Consultation

After the referral has been made, the UnitedHealthcare Community Plan Case Manager will ensure that the enrollee receives a behavioral health evaluation consultation. A behavioral health evaluation is the assessment of an enrollee’s medical, psychological and psychiatric history and social needs to establish a treatment plan for all medically necessary services. This evaluation consultation with the UnitedHealthcare Community Plan case manager must be performed by a behavioral health professional.
In accordance with R9-20-101, a behavioral health professional is, including but not limited to:

- Arizona Licensed: A licensed psychologist, a registered nurse with at least one year of full-time behavioral health work experience, or a behavioral health medical practitioner, or
- Arizona Certified: A social worker, counselor, marriage and family therapist or substance abuse counselor certified according to A.R.S. Title 32, Chapter 33, Article 6.

Ongoing Behavioral Health Evaluation Consultation

To ensure that the enrollee is being provided effective behavioral health care, a quarterly review is completed between the Case Manager and the licensed behavioral health professional assigned to the enrollee. The process documents the ongoing goals for treatment. In addition, enrollees who are in special placements, such as a behavioral health group home or specialized behavioral health care unit in skilled nursing facility, receive case management from a person trained in high acuity behavioral health care services. The Medical Director for UnitedHealthcare Community Plan is available to help Case Managers with complex behavioral health care situations and provides a standing case review time schedule to evaluate and direct the care for members receiving or needing behavioral health treatment.

Psychotropic Medication Management

Enrollees who require psychotropic medications that cannot be managed by a PCP, will be provided services from either a psychiatrist or a nurse practitioner with psychiatric care experience.

Behavioral Health Services Appointment Availability Standards

Enrollees in an emergency will be scheduled an appointment within 24 hours. Routine care appointments are within 30 days of referral.

Behavioral Health Crisis Services

During business hours, it is best to first try contact the Case Manager. If the case manager cannot be reached, or if it is after business hours the following are the crisis contact numbers, by county:

<table>
<thead>
<tr>
<th>County</th>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maricopa – Mobile Crisis</td>
<td>EMPACT</td>
<td>480-784-1500</td>
</tr>
<tr>
<td>Coconino County</td>
<td>Guidance Center</td>
<td>928-537-1899</td>
</tr>
<tr>
<td>Mohave – Lake Havasu City</td>
<td>Mohave Mental Health</td>
<td>928-855-3432</td>
</tr>
<tr>
<td>Mohave – Kingman</td>
<td>Mohave Mental Health</td>
<td>928-757-8111</td>
</tr>
<tr>
<td>Mohave – Bullhead City</td>
<td>Mohave Mental Health</td>
<td>928-758-5905</td>
</tr>
<tr>
<td>Navajo and Apache Counties</td>
<td>Community Counseling</td>
<td>928-537-2951</td>
</tr>
<tr>
<td>Pima County</td>
<td>The Crisis Response</td>
<td>520-622-6000</td>
</tr>
<tr>
<td>Santa Cruz County</td>
<td>Nurse Wise</td>
<td>866-495-6735</td>
</tr>
<tr>
<td>Yuma and LaPaz Counties</td>
<td>Nurse Wise</td>
<td>866-495-6735</td>
</tr>
<tr>
<td>Yavapai County</td>
<td>Crisis Line</td>
<td>877-756-4090</td>
</tr>
</tbody>
</table>
Specialized Behavioral Health Case Management

In most instances enrollees requiring behavioral health services can easily be assisted by regular case managers. In certain circumstances, the enrollee may require the services of Case Manager trained in behavioral health services.

Specialized Behavioral Health Case Managers have extensive knowledge in dealing with persons with serious mental illnesses; traumatic brain injury and/or cognitive disorders that can cause aggressive behaviors.

Referrals to specialized behavioral health case management are decided on a case-by-case basis and are reserved for those enrollees whose behaviors seriously interfere with their ability to live in a long-term care setting or to effectively utilize long-term care services. Enrollees who receive specialized behavioral health case management have aggressive behaviors or behaviors that can cause harm to themselves and the harm or aggression is a result of a mental illness, brain injury or cognitive impairment, including some forms of dementia.
Ch. 6 Utilization Management

UnitedHealthcare Community Plan’s Utilization Management Program encompasses activities directed toward prospective, retrospective and concurrent utilization review. Prospective review (prior authorization) determines the medical necessity and appropriateness of the service before it is provided. Concurrent review occurs periodically throughout an enrollee’s inpatient stay. Retrospective review often involves aggregate and provider specific assessment of the appropriateness of medical services after the services have been provided.

Concurrent Review

UnitedHealthcare Community Plan conducts concurrent utilization review on each UnitedHealthcare Community Plan primary enrollee who is admitted to an inpatient facility and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the enrollee’s medical record assesses medical necessity for the admission and appropriateness of the level of care. Admission certification is conducted within 24 hours after the admission. Continued stay reviews are conducted before the expiration of the assigned length of stay. Discharge planning is coordinated with case management. For UnitedHealthcare Community Plan members who have another primary insurance payor that is not a UnitedHealthcare Community Plan, Utilization Management (UM) coordinates discharge planning with case management.

Discharge Planning Coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of re-admissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the enrollee and involving the enrollee, family and the UnitedHealthcare Community Plan Case Manager in implementing the plan.

The UnitedHealthcare Community Plan concurrent review nurse works peripherally with the hospital discharge team and attending physicians to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but not be limited to:

- Assuring early discharge planning.
- Facilitating or attending discharge planning meetings for enrollees with complex and/or multiple discharge needs.
- Providing hospital staff and attending physician with names of contracted UnitedHealthcare Community Plan providers.
- Informing hospital staff and attending physician of covered benefits as indicated.
Physician Medical Review

The UnitedHealthcare Community Plan Medical Director conducts medical review for each case with the potential for an adverse decision. The UnitedHealthcare Community Plan concurrent review nurse or the prior authorization nurse review the documentation for evidence of medical necessity according to established criteria.

When the criteria are not met, the case is referred to the Medical Director. The medical director reviews the documentation, discusses the case with the nurse and may call the attending or referring physician for more information. The requesting physician may be asked to submit additional information. Based on the discussion with the physician or additional documentation submitted, the medical director will decide to approve, deny, modify, reduce, suspend or terminate an existing or pending service.

Utilization Management decisions are based only upon appropriateness of care and service. UnitedHealthcare Community Plan does not reward practitioners or other individuals involved in utilization review, for issuing denials of coverage or service. The decision to deny a service request will only be made by the medical director.

For inpatient denials, attending physician and hospital are notified in writing. The attending or referring physician may dispute the finding of the medical director by phone informally or formally in writing. If the finding of the medical director is disputed, a formal grievance may be filed according to the established UnitedHealthcare Community Plan grievance procedure.

For denial of outpatient authorizations, the referring physician, the PCP (if not the referring physician) and the enrollee are notified in writing. An expedited appeal may be initiated by the enrollee or by the practitioner acting on behalf of the enrollee for any treatment denial, suspension or reduction in services. See the “Claims Disputes and Appeals” chapter of this Provider Manual for more information.
Ch. 7  Prior Authorization

UnitedHealthcare Community Plan has streamlined its prior authorization requirements across all UnitedHealthcare Community Plan products to provide enrollee’s with easier access to health care, to allow health care providers greater freedom for determining and implementing treatments plans and to enhance the enrollees and health care providers experience with UnitedHealthcare Community Plan. The requirements are outlined in the “Authorization Guide to In-Network Providers.” You can access a copy of the “Authorization Guide to In-Network Providers” at UHCCommunityPlan.com. UnitedHealthcare Community Plan may be the enrollee’s primary payer, in which case, prior authorization may be required on some services or UnitedHealthcare Community Plan may be the secondary payer, in which case, UnitedHealthcare Community Plan is responsible for member copays and deductibles and prior authorization is not required. You may not balance bill an UnitedHealthcare Community Plan member per AHCCCS guidelines.

Prior authorization services can be obtained from UnitedHealthcare Community Plan from one of four sources:

1. UnitedHealthcare Community Plan Utilization Management (Prior Authorization) Department: (Phone: 602-255-8788; toll-free 800-377-2055; Fax: 800-278-2907)
The Prior Authorization department may approve:
   • Elective admissions.
   • Durable medical equipment over $500.
   • Prosthetic and orthotic devices over $500.
   • Professional services: PN is not required for contracted providers.
   • Rehabilitative services.

For UnitedHealthcare Community Plan enrollees, the general rule of thumb is if the primary payer reimburses the provider, UnitedHealthcare Community Plan does not require prior authorization for the enrollee’s copay and deductibles. If the provider cannot secure payment from the primary carrier, and the service is such that UnitedHealthcare Community Plan would normally require prior authorization in a situation where UnitedHealthcare Community Plan is primary, the provider needs to obtain prior authorization from UnitedHealthcare Community Plan prior to rendering the service.

If the enrollee has UnitedHealthcare Community Plan for their Medicare and AHCCCS providers, (dual enrollee), only one prior authorization request needs to be submitted to the UnitedHealthcare Community Plan Medicare line of business. UnitedHealthcare Community Plan will pay off the UnitedHealthcare Community Plan Medicare authorization. Requests that are not approved by UnitedHealthcare Community Plan Medicare programs are referred to UnitedHealthcare Community Plan for AHCCCS benefit determination.

2. The UnitedHealthcare Community Plan Case Manager:
The UnitedHealthcare Community Plan Case Manager may approve:
   • Home Health nursing services
   • Home and community-based services
   • Respite care
   • Residential placement in a nursing facility (needs to be approved by Medical Director)
   • Home modifications (needs to be approved by Director of Case management and Medical Director)
3. Optum Rx: (877-305-8952). UnitedHealthcare Community Plan utilizes a pharmacy benefit manager (PBM), for coordination and administration of the plan’s formulary. The PBM may approve:
   • Non-formulary medications.
   • Quantity limit overrides.
   • Early renewals.

4. UnitedHealthcare Dental also known as Dental Benefit Providers (DBP):
UnitedHealthcare Dental provides prior authorization on dental services and claims processing. UnitedHealthcare Community Plan is responsible for providing dental care to all members under the age of 21 with all medically necessary dental coverage for emergency dental services, dental screening and preventive services.

### Important Telephone Numbers

<table>
<thead>
<tr>
<th>Call to Inquire About</th>
<th>Telephone Number</th>
<th>Hours of Operation</th>
</tr>
</thead>
</table>
| UnitedHealthcare Dental IVR Provider Services and Interactive Voice Response | 877-816-3596     | Provider Services
8 AM to 11 PM EST
Mon–Fri
IVR = 24 Hours:
365 days |
| UnitedHealthcare Community Plan Prior Authorization Number | 602-255-8188     | Mon–Fri
8:00 AM to 5:00 PM Arizona Time |

### Deadlines for Requesting Authorization from UnitedHealthcare Community Plan

It is UnitedHealthcare Community Plan’s policy that all requests for prior authorization must be made prior to the service being rendered.

UnitedHealthcare Community Plan covers emergency medical services for members when there is a demonstrated need, and/or after triage, emergency medical services assessment indicates an emergency condition. Providers are not required to obtain prior authorization for emergency services.

### UnitedHealthcare Community Plan’s Time Frames for Responding to Authorization

It is the policy of UnitedHealthcare Community Plan to respond to routine requests with an approved, pended or denied status within 14 calendar days of receipt. The prior authorization may be pended for further review if inadequate information accompanies the request. If the supporting documentation for a pended authorization is not received in a timely manner, the authorization request will be denied.

Urgent service requests will be decided within three business days after receipt of the clinical information needed by UnitedHealthcare Community Plan staff to render an appropriate decision. Urgent or stat requests should be limited to those conditions or situations where an enrollee’s health or well-being is in jeopardy. Stat or urgent requests should not be made as a result of the timing of the request in relation to the scheduled service.
Approved Requests

Approved authorization requests are faxed to the requesting provider for all outpatient services and elective admissions.

- The approved authorization will remain effective for 60 days from the date of issue unless otherwise indicated on the approval.
- The authorization approval is only effective for the services approved on the request and for the identified date range.
- All approvals are contingent upon the enrollee’s eligibility status on the date the service is provided.
- Prior authorization is not a guarantee of payment.
- For services not included under the approved request, the provider must contact UnitedHealthcare Community Plan to amend the original request and receive a new authorization.

UnitedHealthcare Community Plan follows physician referral requirements and conditions defined in the Social Security Act, sections 1903, 1877, and as defined in 42 CFR parts 411, 424, 425 and 455. Enrollees may seek a second opinion within the UnitedHealthcare Community Plan network of providers.

Prior authorization is not a guarantee of payment. UnitedHealthcare Community Plan reserves the right to request medical records and/or other documentation to substantiate any charges billed to UnitedHealthcare Community Plan. Payment is based upon enrollee eligibility at the time of service and substantiating documentation of appropriateness of the care, service, or treatment. If the claim and documentation review fails to establish medical necessity and/or appropriateness of the care, service, or treatment payment will be denied.

Denied Requests

All requests submitted to the UnitedHealthcare Community Plan prior authorization department which do not meet criteria, are referred to the medical director for review. Only the Medical Director may make a decision to deny a request. Criteria include eligibility, contracted provider or AHCCCS ID number, covered benefit, and medical necessity. Professionally recognized criteria are utilized in determining medical necessity.

Denied requests will generate denial authorizations to be sent to the requesting provider and the UnitedHealthcare Community Plan enrollee within 3 business days of the decision. The denial authorization will be faxed to the requesting provider, if the provider’s fax number is indicated on the request form. Enrollee appeal and grievance rights, including denial rule references, are included with the enrollee’s denial authorization.

If the enrollee files a written request for an appeal within 15 days of the date of notice, UnitedHealthcare Community Plan will continue to provide the current level of service during the appeal. For additional information, refer to the “Claims Disputes and Appeals” chapter of this Provider Manual.

UnitedHealthcare Community Plan Sample Prior Authorization Request Forms

The following are copies of the Prior Authorization Request Forms general prior authorizations and therapy that are utilized by UnitedHealthcare Community Plan. Complete the appropriate form in its entirety and fax to the fax number listed on the form.
# Long Term Care Prior Authorization Request

**Phone**: 1 (800) 377-2055 OR 1 (602) 255-8188 (M-F 8am to 5pm)  
**Fax**: 1 (800) 278-2907 (M-F 8am to 5pm)  
**For After Hours Urgent Prior Authorization please call**: 1 (800) 377-2055 or 1(602)787-3305  
**PBM-Medication Notification Phone**: 1(800) 788-7871

***Use the Therapy Prior Authorization Request Form for ALL Therapy Requests***

## Patient Information

<table>
<thead>
<tr>
<th><strong>Date</strong></th>
<th><strong>Requesting Provider</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Patient’s Last Name</strong></th>
<th><strong>First Name</strong></th>
<th><strong>DOB</strong></th>
<th><strong>AHCCCS ID #</strong></th>
</tr>
</thead>
</table>

Is Medicare or other payer the Primary Payer?  
**Yes** If Yes, **Prior Authorization is not required from UHC Community Plan LTC for outpatient services when you have secured payment from Medicare or other party liability.**  
**No** If No, please complete the rest of this form.

- **Routine (14 calendar days)**  
- **Urgent (3 business days)** *This means the standard (routine) timeframe could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function.*

***Attach supportive medical documentation, labs and drug history as necessary***

**Primary Care Provider:**  
**AHCCCS ID #**  
**Phone:**  
**Fax:**  
Is the PCP referring?  
**Yes**  
**No**

## Servicing Provider Information

<table>
<thead>
<tr>
<th><strong>Service Provider (First and Last Name)</strong></th>
<th><strong>AHCCCS #</strong></th>
<th><strong>Phone</strong></th>
<th><strong>Fax</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Service Facility Name/Address</strong></th>
<th><strong>AHCCCS #</strong></th>
<th><strong>NPI #</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Date of Service (if scheduled)</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>DX Codes</strong></th>
<th><strong>(Must be completed)</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>DX Description</strong></th>
</tr>
</thead>
</table>

History:  
- **1st Time Consult**  
- **Follow-up**  
- **Procedure / Service / Surgery** *(Check all that apply)*

<table>
<thead>
<tr>
<th><strong>CPT/HCPCS Codes</strong></th>
<th><strong>Outpatient</strong></th>
<th><strong>Inpatient</strong></th>
</tr>
</thead>
</table>

When UHC Community Plan LTC is the primary payer, **SPECIALISTS must have an authorization PRIOR to ANY services being rendered. Elective Surgery Requests REQUIRE a 5-day notification. Prior authorization is not a guarantee of payment. Failure to do so may result in a denial and NON-PAYMENT for services.**  
**Member eligibility must be determined on date of services**

## This Section for UHC Community Plan LTC Use Only

<table>
<thead>
<tr>
<th><strong>Date:</strong></th>
<th><strong>Comments:</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Authorization:</strong></th>
<th><strong>Approved</strong></th>
<th><strong>Denied</strong></th>
<th><strong>Duplicate Request</strong></th>
<th><strong>Entered</strong></th>
<th><strong>Date</strong></th>
</tr>
</thead>
</table>

- **COB Required – UHC Community Plan LTC is not primary and will not pay balance of allowable without EOB from primary carrier**

- **Benefit does not require prior authorization by Utilization Management**

<table>
<thead>
<tr>
<th><strong>Authorization Staff Signature</strong></th>
<th><strong>Date</strong></th>
</tr>
</thead>
</table>
LONG TERM CARE THERAPY PRIOR AUTHORIZATION REQUEST

Phone 1 (800) 377-2055 OR 1 (602) 255-8188 Fax 1 (800) 278-2907

To: _______________________________ Fax: _______________________________

Member’s Name: _____________________ ID # ______________________________

Ordering Physician: ___________________ Physician Phone: ____________________

Fax: _______________________________ Fax: _______________________________

DX Description: ______________________ DX Code (ICD-9) ___________________ Onset Date: ________________

☐ Routine (14 days) ☐ Urgent (3 business days) This means using the standard (routine) timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

Please include a copy of the initial evaluation, clinical notes and physician orders
(Further visits will be based on guidelines in the ALTCS Provider Manual and must show a reasonable expectation of improvement in a predictable time frame).

☐ Physical ☐ Occupational ☐ Speech ☐ Nutritional ☐ Respiratory ☐ Psych Services

Requested sessions: ________________ Total of days per week: ________________ Number of weeks: ________________

Date of service for requested auth: ________________ to ________________

CPT Code: __________________________ # of units per session: __________________

CPT Code: __________________________ # of units per session: __________________

CPT Code: __________________________ # of units per session: __________________

CPT Code: __________________________ # of units per session: __________________

Comments: __________________________

Therapists Name: ______________________ Facility: _______________________

Phone Number: _______________________ Fax Number: _____________________

Facility / Provider ID Number: __________________________

THIS SECTION FOR UHC COMMUNITY PLAN LTC USE ONLY

Date: _________________________ Comments: _____________________________

Authorization: ☐ Approved ☐ Denied ☐ Duplicate Request Entered ________________ Date ________________

☐ COB Required – UHC Community Plan LTC is not primary and will not pay balance of allowable without EOB from primary carrier

☐ Benefit does not require prior authorization by Utilization Management

Authorization Staff Signature _________________________ Date ________________
Case Management Coordination

UnitedHealthcare Community Plan makes every effort to foster an enrollee-centered approach while promoting enrollee independence, individuality, dignity, privacy, respect and choice. The UnitedHealthcare Community Plan approach to Case Management is designed to ensure that eligible enrollees receive timely and medically necessary health care services in the least restrictive setting as well as eliminate barriers to health care delivery that may prohibit individuals from receiving needed care.

UnitedHealthcare Community Plan’s case managers play a central role in the member’s plan of care. They are responsible for initiation, coordination and monitoring of long-term care services, including institutional placements, Home and Community-Based Services (HCBS), Assisted Living Facility (ALF) services in the community setting, acute care, behavioral health services, discharge planning as well as other ancillary needs and support services to establish a comprehensive plan of care. The review with the member and/or their representative is designed to result in a mutually agreed upon, appropriate and cost-effective service plan that meets the medical, functional, social and behavioral health needs of the member in the most integrated setting that may increase the member’s level of functioning, health status and all around quality of life. Case management begins with a respect for the member and member’s family/representative preferences, interests, needs, cultural considerations, language and belief system.

Case managers are expected to use a holistic approach regarding the member assessment and needs taking into account not only ALTCS covered services but also other needed community resources as applicable. Case managers are expected to:

- Respect the member’s rights;
- Provided adequate information and training to assist the member/representative/family in making informed decisions and choices;
- Provide a continuum of services options that support the expectations and agreements established through the care plan process;
- Facilitate access to non-ALTCS covered services available throughout the community;
- Educate the member/representative/family on how to report unplanned gaps or other problems with service delivery to the program contractor in order that unmet needs can be addressed as quickly as possible;
- Advocate for the member/family/representative and others as the need occurs;
- Allow the member/representative/family to identify their role in interacting with the service system;
- Provide members with flexible and creative service delivery options;
- Provide necessary information to providers about any changes in member’s functioning to assist the provider in planning, delivering, and monitoring services;
- Provide coordination across all facets of the service system in order to maximize the efficient use of resources and minimize any negative impact to the member.
When to Contact the UnitedHealthcare Community Plan Case Manager

Providers must contact the UnitedHealthcare Community Plan Case Manager should any of the following conditions occur:

- Inability to contact member
- Inability to provide services
- Change in the enrollee’s condition
- Enrollee unexpectedly leaves their place of residence or without notification
- Death of the enrollee
- Enrollee is transferred to the hospital
- Enrollee suffers a fall
- Skin integrity issues
- Behavioral health issues
- Hospice election
- Bed hold and therapeutic leave requests (Skilled Nursing Facilities only)
- Enrollee needs dental or vision services
- Enrollee needs therapies including PT/OT/SP/RT
Ch. 9 Quality Management

Overview
UnitedHealthcare Community Plan utilizes the Continuous Quality Improvement (CQI) approach for processing quality management information. CQI has the potential to positively impact every aspect of UnitedHealthcare Community Plan’s health care delivery of services. It is used to accomplish goals such as improving member outcomes and processes. CQI encourages all functional areas to see beyond their own immediate tasks and to be aware of the larger work process of which they are a part. It keeps the team focused on shared goals. By its very definition, CQI is an ongoing organization wide framework in which UnitedHealthcare Community Plan and its employees are committed to and involved in monitoring and evaluating all aspects of service rendered in order to continuously improve them. To put into daily practice the spirit of CQI, UnitedHealthcare Community Plan utilizes the APIE (Assess, Plan, Implement and Evaluate) model to develop the structural framework of its QM Program.

Figure One: An illustration of the APIE Model as it applies to UnitedHealthcare Community Plan QM Plan’s continuous quality improvement process.

Process for QM Provider Profiling
UnitedHealthcare Community Plan monitors the quality of care provided to our members by our contracted providers. QM monitoring and evaluation activities are a continuous ongoing process. Whenever possible, UnitedHealthcare Community Plan will align QM activities with those of AHCCCS, CMS, ADHS, and other program contractors. This is done to focus our providers’ quality improvement activities on areas of state and nationwide importance and to reduce duplication of service.

There are several steps used by UnitedHealthcare Community Plan in the QM provider profiling process. They are as follows:

Step One: Data Collection for Provider QM Profiling
There are four methods used to evaluate contracted providers:

- Provision of care monitoring (e.g. mortality reviews, site reviews, acute care review, member satisfaction surveys, and grievances/concerns trending).
- Regulatory agency findings, when applicable.
- Disease management compliance rates, when applicable.
- Member trust fund monitoring, when applicable.
- Medical records monitoring, when applicable.

Provisions of Care Monitoring:
Documentation reviews and/or onsite visits are coordinated to assure member issues are dealt with in a time-appropriate manner based upon the nature of the issue and the geographical location of the provider. For some provision of care reviews there are selection criterion. Not every case triggered for review by the selected criteria will prove to be a problem. These reviews also give UnitedHealthcare Community Plan an opportunity to identify areas of good performance.
Each provision of care review has a data collection tool to evaluate key indicators of the care. Each key indicator of care has points attached. The points are totaled and a final score is given, the best possible score being 100 points.

Upon completion of onsite investigations, identified problems are shared with the facility director/manager. UnitedHealthcare Community Plan will attempt to resolve problems through education and technical support whenever possible.

- **Mortalities**
  Mortalities review selection criteria includes: relative expectation of death and discretion of the Medical Director. Reviews for facilities and attending physicians are conducted by licensed professionals and results reviewed with the medical director.

- **Acute Care Site Reviews**
  This review is specific to home health agencies and is done by the UnitedHealthcare Community Plan QM Specialist every three years. Please refer to the Home Health Monitoring Section of this document and the QM Manual.

- **QM Site Monitoring Service**
  Sites are monitored at least annually to collect data indicative of quality and/or delivery of service. Depending upon the provider type and nature of the review, the reviews can be conducted by UnitedHealthcare Community Plan QM Specialists, other UnitedHealthcare Community Plan staff as appropriate or delegated to an external agency (e.g. Foundation for Senior Living).

  If significant problems are identified, or a provider and/or service site scores 85 percent or lower on an audit an Improvement Action Plan (IAP) will be requested of the service provider. The action plan should address the following:

  - Specify the type of problem(s) that require action.
  - Person(s) or body (e.g., committee) responsible for making the final determination regarding quality issues.
  - Type(s) of member/provider actions to be taken (e.g., education, monitoring, process changes, etc).
  - How the effectiveness of the plan will be evaluated.
  - Method(s) of communication of findings and resulting changes to staff and providers.
  - Method(s) of communication of pertinent information to AHCCCS and/or other agencies.

The effectiveness of the improvement actions taken by providers is determined during subsequent monitoring visits by the QM and/or CM staff. Intensive monitoring reviews can occur weekly, monthly or quarterly depending on the pattern and scope of the deficiencies noted during an onsite review.

It is the goal of the QM staff to provide education and support to providers to develop changes in their policies, procedures and internal monitoring to effect lasting improvement in areas found to be deficient. If a pattern of deficiency is noted that impacts several members, a decision can be made within the health plan to limit future admissions or referrals to the provider until corrective action has been completed and the provider has demonstrated that identified issues have all been resolved.
• **Member Satisfaction**  
Periodically a survey may be mailed by Member Services to the members/family. Member satisfaction with the care being provided by our network providers affords feedback. From this feedback, areas for improvement can be determined. Should the survey be provider-specific, the results of the surveys will be shared with the provider for inclusion in their QM efforts.

• **Complaints and Concerns (QOC)**  
Concern reports are received as problems are identified. All concern reports are investigated. Clinical quality of care issues will be investigated by licensed personnel. Aggregating concerns and complaints help to identify problems within the provider network. A quarterly summary by provider is run for all complaints. This aggregated complaint data is reviewed for trends by the QM Specialist and QM Committee. If a trend is noted, the QM Committee will determine what further actions are needed to address the trend.

**Regulatory Agency Findings**

• **ADHS Annual Survey and ADHS Deficiency Reports**  
The annual ADHS survey and deficiency report results are compared to issues identified by our provision of care monitoring.

• **Medicare Compare**  
CMS’ website [www.cms.gov](http://www.cms.gov) posts quarterly reports showing the CMS Nursing Home Quality Initiatives. Selected quality measure rates will be ranked by provider. Reports are run by the facility along with the contracted providers’ state and federal survey results to use in identification of trends.

**Disease Management Compliance Rates**

• **Provider Specific**  
The annual objective/goal for measures, established by AHCCCS, will be used as the benchmark. Those providers falling below the goal may require intervention by the medical director, EPSDT coordinator or QM Nurse as indicated.

Flu Vaccine Compliance Rate:  
- Nursing Facility........................................75%  
- HCBS....................................................50%

Diabetic Care Compliance Rate:  
- Annual HgA1c........................................80%  
- Annual Lipids..........................................72%  
- Annual Dilated Eye..................................60%  
- EPSDT Participation...............................55%

**Medical Records Monitoring**  
Primary Care Providers and Obstetricians/Gynecologist will have a medical record audit at least every three years in conjunction with the re-credentialing process. Specialists with 50 or more referrals per contract year will also have a medical record audit at least every three years.

**Peer Review**  
The UnitedHealthcare Community Plan Provider Advisory Committee (PAC) Peer Review Committee meets, (at minimum) quarterly, or more frequently, to improve the quality of medical care provided to members by practitioners or providers. The scope of PAC includes cases where there is evidence of a quality deficiency in the care or services provided, or the omission of care or services by a participating or non-participating health care professional or provider.
The PAC is comprised of the UnitedHealthcare Community Plan Medical Director (chairperson), contracted providers/physician members from the community, the Director of Quality Management, and specialty providers if an issue requires their presence. If a behavioral health specialty is being reviewed, a behavioral health provider will be a part of the review process. UnitedHealthcare Community Plan will use peers of the same or similar specialty through external consultation should that specialty not be represented on the committee. Committee members involved in the quality of care issue being discussed are not involved in the discussion of the case.

The Peer Review process compares the health care professional or provider’s performance with that of peers or with community standards. The committee will recommend if any further follow up action is indicated. Minutes are maintained and kept confidential. Any provider may file a grievance as the result of a peer review decision with the Medical Director. A provider who is adversely affected by a committee’s decision/action may file a formal appeal.

It is the responsibility of the Medical Director to report to the appropriate licensing board any concerns regarding UnitedHealthcare Community Plan network practitioners.

**Member Fraud Investigation**

Reports of alleged abuse against UnitedHealthcare Community Plan members require immediate action to ensure the member’s safety. Member safety is the first concern when a potential/actual case of abuse has been identified. UnitedHealthcare Community Plan and their providers will take all actions necessary to secure our members’ safety. Members’ risk status within the facility/home in question will determine the time frame for initiation of the concern report investigation.

Providers will be encouraged to self-report cases of alleged abuse to the appropriate regulatory agencies or boards (e.g. Arizona Department of Health Services (ADHS), Adult Protective Services (APS)/Child Protective Services (CPS), law enforcement agency, Board of Nursing, Board of Medical Examiners (BOMEX), etc.). Failure of providers to self-report will result in UnitedHealthcare Community Plan notifying the appropriate authorities.

**Reporting Cases of Fraud**

All providers are required to abide by applicable law, rules, and regulations and to maintain and furnish required records and documents as required by law, rules and regulations.

Contracts are not awarded or renewed for any provider terminated from Medicare, Medicaid or debarred from the Department of Health and Human Services.

**Detection and Prevention Tips**

Providers are encouraged to visit HHS Office of Inspector General’s website at [https://oig.hhs.gov/](https://oig.hhs.gov/) for information on detection and prevention of fraud.

**Reporting**

Pursuant to R9-22-511 “all contractors, providers, and non-providers shall advise the AHCCCS Office of Inspector General, immediately, in writing, of any cases of suspected fraud or abuse.” Referrals can be made at: [http://www.azahcccs.gov/fraud/reporting/reporting.aspx](http://www.azahcccs.gov/fraud/reporting/reporting.aspx).

Providers are encouraged to view the on-line video at this link “Fraud Awareness for Providers.” [http://www.azahcccs.gov/fraud/default.aspx](http://www.azahcccs.gov/fraud/default.aspx).

Providers are encouraged to make a self-referral if fraud is detected within their organization or if they should suspect UnitedHealthcare Community Plan member of defrauding Medicaid or Medicare.
Member and Provider Rights and Responsibilities

Advance Directives
Members must be informed of their right to determine their end of life care through education on advance directives. During the initial visit or PCP visit, members must be explained in layman’s terms an explanation of: Cardiopulmonary Resuscitation (CPR), artificial hydration and nutrition, intubation, and comfort measures. Documentation supporting the member education must be recorded in the member’s medical records. Signed copies of advanced directives should be kept in the member’s medical records and accompany the member when transferring care.

UnitedHealthcare Community Plan case managers also provide the members with Aging with Dignity Pamphlet, “Five Wishes.” This pamphlet is also available in Spanish. “Five Wishes” discusses selecting the right person to be their power of attorney, what to do when they change their mind, the kind of treatment they want, comfort measures, how they wish to be treated, and what they want their loved ones to know. When completed, “Five Wishes” includes the member signature, witness statement and a notary seal.

Availability and Accessibility of Services
Members have the right to have availability and accessibility of services equal to or better than community norms. Network Operations staff assesses access to service. This is accomplished through quarterly provider office visits and regional conferences. When an area is found to be in need of additional services, Network Operations develops an outreach program to encourage providers to join the UnitedHealthcare Community Plan provider network.

Appointment availability of services accessibility of care is monitored to assure that members can access needed care. Care is provided within the network whenever possible. If a service is unavailable within our network, the member is referred out of the area and transportation is provided. When a medically necessary service is provided outside the geographical area or network, it will be provided by non-contracted UnitedHealthcare Community Plan providers or by UnitedHealthcare Community Plan affiliated providers.

Providers contracted with UnitedHealthcare Community Plan are required to maintain member accessibility within specified time limits outlined in their contract. This is monitored through the trending of member concerns related to availability of providers.

Cultural Competency
UnitedHealthcare Community Plan recognizes cultural competency as a necessary component of member rights. It is our desire to integrate cultural competency into all systems of UnitedHealthcare Community Plan including quality improvement efforts.


Re-credentialing
Individual Providers
All licensed individual providers (LIPs) are re-credentialed every three years. Six months prior to the re-credential due date, Corporate Credentialing will identify LIPs due for re credentialing. A re-credentialing application is initiated and sent to the LIP. UnitedHealthcare Community Plan’s QM department will review all providers due for re-credentialing for information regarding quality of care issues (e.g. outcomes of provision of service monitoring, grievances and complaints, utilization and member satisfaction survey results, when available).
Organizational Providers
UnitedHealthcare Community Plan Corporate Credentialing will perform an assessment of each organizational provider (e.g. hospitals, home health agencies, skilled nursing facilities and free standing surgical center) prior to initiating a participation agreement to confirm that the organizational provider is in good standing with state and federal regulatory bodies, has been reviewed and approved by an acceptable accrediting body and, if not accredited, has successfully completed a site assessment.

The Primary Source Verification (PSV) process for organizational providers includes:

- Verification of state licensure, if applicable.
- Absence of exclusion or debarment from participation in Medicare, Medicaid, or other state or federal health care programs, including the Office of Inspector General (OIG) and General Services Administration (GSA), warranting denial of participation status through a review of the Healthcare Integrity and Protection Data Bank (HIPDB) report.
- Absence of a history of sanctions or other actions warranting denial of participation status through a review of the HIPDB report.
- Verification of valid accreditation or certification.
- If the organizational provider is not accredited or certified by a recognized agency, a site review of the organizational provider is required. Results must be found satisfactory. The assigned Corporate Credentialing Specialist submits request to the UnitedHealthcare Community Plan Credentialing Coordinator or designee for completion of the Site Visit assessment.

Upon completion of the PSV process, the Corporate Credentialing specialist assures receipt of the Site Visit assessment and exception approval for deviated liability from the Site Credentialing coordinator or designee, if applicable. Upon completion of the PSV process, the credentialing specialist assures receipt of the visit assessment, quality management documentation for all subsequent three-year cycle reviews and exception approval for deviated liability.
EPSDT is a federally mandated program specifying medical standards of care for primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems. EPSDT services are defined as Early and Periodic Screening, Diagnosis and Treatment services for enrollees under the age of 21 years. Arizona law (A.R.S Statute 36-135) requires physicians to report all immunizations given to children in the age group at least monthly. More information can be accessed at www.azdhs.gov/phs/asiis/.

**Early** – As early as possible in the child’s life, or as soon after the enrollee’s eligibility with UnitedHealthcare Community Plan has been established.

**Periodic** – Intervals established by the AHCCCS Administration for screening to assure that a condition, illness, or injury is not incipient or present.

**Screening** – Regularly scheduled examination and evaluation of the general physical and behavioral health, growth, development and nutritional status of infants, children and youth and the identification of those in need of a more definitive evaluation. Screening and diagnosis are not synonymous.

**Diagnosis** – Determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental and psychological examination, laboratory tests, and X-rays, when appropriate.

**Treatment** – Type of health care or services recognized to prevent or ameliorate a condition, illness, and injury or to prevent or correct abnormalities detected by screening or diagnostic procedures. Services must be recognized under the State Plan and Title XIX of the Social Security Act.

### EPSDT Screening Components

1. UnitedHealthcare Community Plan EPSDT requirements will be conducted according to the time frame identified in the EPSDT periodicity schedule, and inter-periodic screenings as appropriate for all enrollees under the age of 21 years. The physician or health care provider shall perform the following:
   - A comprehensive health and developmental history (including physical, nutritional and behavioral health assessment).
   - A comprehensive disrobed physical exam.
   - Appropriate immunizations according to age and health history.
   - Laboratory tests (including blood lead screening assessment appropriate to age and risk, tuberculosis screening appropriate to age and risk, anemia testing, and if appropriate, diagnostic testing for sickle cell trait).
   - Health education.
   - Appropriate dental screening.
   - Appropriate vision, hearing and speech testing.

2. Diagnosis and medically necessary treatment or referral to an appropriate community resource.
Physical Examinations

EPSDT services will be provided according to community standards of practice and the EPSDT periodicity schedule. AHCCCS EPSDT tracking forms will be used to document services provided and physician compliance with standards.

The physical examination is a comprehensive, disrobed examination performed according to acceptable medical practice. The provider should consider the age of the enrollees when conducting the physical examination. The provider will initiate appropriate referrals according to their findings.

The purpose of the EPSDT physical examination is to:

• Evaluate the form, structure, and function of particular body region and systems.
• Determine if these region(s) and systems are normal for the child’s age and background.
• Discover those diseases and health problems for which no standard screening test has been developed, including evidence of child abuse and/or neglect.

The complete physical examination and screenings will include a developmental/behavioral health screening, comprehensive history, dental screening and appropriate vision testing, hearing testing, laboratory tests, dental screenings, laboratory tests and immunizations. EPSDT providers must document immunizations into ASIIS and enroll every year in the Vaccine for Children program. Examination with further guidance on obtaining necessary dental care, accurate measurement of height and weight and appropriate lab tests according to age and risk. Use of a growth chart developed by the National Center of Health Statistics (NCHS) is recommended for each EPSDT enrollee. The Centers for Disease Control and Prevention (CDC) website provides access to both growth charts and Body Mass Index (BMI) calculation tools. Charts for estimating BMI measurements are also found in Appendix I of the AHCCCS Medical Policy Manual.

Developmental Assessment

The developmental assessment is designed to determine whether a child’s developmental progress falls within a normal range of achievement according to age and cultural background. Screening for developmental assessment will be done at each EPSDT visit. The assessment will include obtaining a relevant developmental history, assuring accurate and informative observation of enrollees and attending to parental concerns. Emphasis will be placed on monitoring development within the context of the enrollee’s overall well-being, rather than viewing development in isolation during a testing session. An objective developmental test must be administered as a ‘second-stage’ screening instrument when the history and/or physical examination are suspicious.

The following elements will be assessed:

• Gross motor development, focusing on strength, balance, locomotion.
• Fine motor development, focusing on eye-hand coordination.
• Communication skills or language development, focusing on expression, comprehension and speech articulation.
• Self-help and self-care skills.
• Social-emotional development, focusing on the ability to engage in social interaction with other children, adolescents, parents and other adults.
• Cognitive skills, focusing on problem solving or reasoning.
Throughout school age, focus on:

- Visual-motor integration.
- Visual-special organization, visual.
- Sequential memory.
- Attention skills, auditory processing skills.
- Auditory sequential memory.

For adolescents, focus on:

- Potential presence of learning disabilities.
- Peer relationships.
- Psychological/psychiatric problems.
- Vocational skills.

Anytime the enrollee’s assessment falls out of the normal range of achievement according to age and cultural background, the provider will refer the enrollee to the appropriate specialist, state program or community resource for follow up evaluation, diagnosis and treatment.

**Nutritional Assessment**

EPSDT covers assessment of nutritional status by the EPSDT provider as specified in the EPSDT periodicity schedule as part of the EPSDT screenings and on an inter-periodic basis as determined necessary by the enrollee’s PCP. Assessments are accomplished through questions regarding dietary practices, assessment of overall health, measurement of height and weight, review of body mass index (BMI) scores and environmental factors.

Nutritional assessments by a registered dietitian require an order by the PCP and completion of prior authorization protocol.

UnitedHealthcare Community Plan covers supplemental nutritional feedings, provided on either an enteral, parenteral or oral basis, when determined medically necessary. Medical necessity is determined on an individual basis by the Medical Director. Documentation must be present of unsuccessful trials in utilizing alternatives such as blenderized foods when making the determination of medical necessity of supplemental nutritional feedings.

When requesting authorization for commercial oral nutritional supplements the provider must use the AHCCCS approved form, “Certificate of Medical Necessity for Commercial Oral Nutritional Supplements.” The provider must document that the PCP or attending physician has provided nutritional counseling as part of the EPSDT service and specify alternatives that were tried in an effort to boost caloric intake and/or change food consistencies. In addition, documentation that at least two of the following criteria have been met must also be present when determining medical necessity:

- The enrollee is at or below the 10th percentile on the appropriate growth chart for their age and gender for three months or more.
- The enrollee has reached a plateau in growth and/or nutritional status for more than six months (prepubescent).
- The enrollee has already demonstrated a medically significant decline in weight within the last three months (prior to the assessment).
- The enrollee is able to consume/eat no more than 25 percent of nutritional requirements from age-appropriate food sources.
- Absorption problems as evidenced by emesis, diarrhea, dehydration, and/or weight loss, and intolerance to milk or formula products have been ruled out.
- The enrollee requires nutritional supplements on a temporary basis due to an emergent condition; e.g. post-hospitalization. (PA is not required for the first 30 days).
• Enrollee receiving supplemental nutritional feeding will be referred to case management for follow up, coordination with the PCP providing information and assistance as needed to ensure appropriate referrals for home health education regarding weaning from supplemental feedings.

**Tuberculin Testing**

Tuberculin skin testing is to be provided as appropriate to age and risk. Children at increased risk of tuberculosis (TB) include:

• Any child born outside the United States in developing countries.
• Any child with any medical condition which would increase the incidence of TB infection such as HIV infection, chemotherapy treatment, diabetes, renal disease or treatment which suppresses the immune system.
• Any child living in a household with
  – Anyone confirmed or suspected case of TB;
  – An HIV-infected person or the child is infected with HIV;
  – Anyone in jail or prison during the last five years;
  – Anyone traveling/immigrating from or with significant contact with indigenous persons from endemic countries.

**Blood Lead Screening**

EPSDT covers blood lead screening. All children are considered at risk and must be screened for lead poisoning. All children must receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 24 months and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test result equal to or greater than 10ug/dl obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample. A verbal risk assessment must be completed at each EPSDT visit for children ages 6 months through 72 months (6 years) to assist in determining risk. Appropriate follow-up must be provided.

**Immunizations**

EPSDT covers all child and adolescent immunizations as specified in the EPSDT periodicity schedule. Each appropriate immunization must be provided to bring, and maintain, each EPSDT enrollee’s immunization status up-to-date. Physicians or health care providers must coordinate with the ADHS Vaccine for Children Program in the delivery of immunization services. Immunizations are provided according to the Advisory Committee on Immunization Practices (ACIP) recommended schedule.

Providers must document each member’s immunization in the Arizona State Immunization Information System (ASIIS) and maintain the ASIIS immunization record in accordance with Arizona state statues.

**Vision Screening**

The PCP will assess vision screening at each EPSDT visit as appropriate to age according to the EPSDT periodicity schedule and as medically necessary. Prescriptive lenses are provided to correct or ameliorate defects, physical illness and conditions discovered under the EPSDT screening process. The PCP will initiate appropriate referrals to an Ophthalmologist for further evaluation when an EPSDT enrollee fails the vision screening.
Hearing/Speech Screening
The PCP, according to the periodicity schedule, will assess hearing screening at each EPSDT visit. Further necessary evaluations such as impedance testing are referred to an ear, nose and throat (ENT) specialist as needed. Speech screening for language development will also be assessed at each EPSDT visit. Medically necessary and appropriate speech therapy is a covered service.

Physical Therapy
Physical Therapy for enrollees under the age of 21 years to restore, maintain or improve muscle tone, joint mobility or physical function is a covered service when determined medically necessary. The condition for which the therapy is prescribed must have the potential for improvement due to rehabilitation.

Occupational Therapy
Occupational therapy is a covered service when determined medically necessary for EPSDT enrollees to improve and restore functions that have been impaired by illness or injury or have been permanently lost or reduced by illness or injury. The condition for which the therapy is prescribed must have the potential to improve the enrollee’s ability to perform tasks required for independent functioning.

Behavioral Health Screening
Screening for behavioral health and substance abuse is assessed at each EPSDT visit. The provider may refer to AHCCCS Behavioral Health Screening Guidelines. For further details on behavioral health services, refer to the Behavioral Health Services chapter of this Provider Manual.

Dental Screening
Oral screenings must be conducted by the provider as part of the physical exam. The screening is intended to identify gross dental or oral lesions, but is not a thorough clinical examination and does not involve making a clinical diagnosis and treatment plan. Providers should refer enrollees for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of the referral should be documented on the EPSDT tracking form. Enrollees are allowed to self-refer to a dentist.

Health Education
Health counseling and education is provided at each EPSDT visit through the anticipatory guidance section of the EPSDT tracking form. The anticipatory guidance is to assist parents and guardians in what to expect in terms of the enrollee’s development and information about the benefits of healthy lifestyles, accident and disease prevention.

Circumcisions
Circumcisions of newborn male infants are not a covered service unless determined to be medically necessary. The procedure requires prior authorization.

Organ and Tissue Transplantation Services
Medically necessary and approved non-investigational solid organ and tissue transplantation is an EPSDT covered service.
EPSDT Forms

Each EPSDT form is reviewed by the EPSDT/MCH coordinator to assess quality and level of care, monitor PCP’s EPSDT compliance regarding completion of the EPSDT forms, identify children in need of EPSDT services or special programs and assist the PCP in initiation of referrals when indicated. UnitedHealthcare Community Plan will provide all covered medically necessary services.

- Special needs enrollees are identified upon review of the EPSDT forms sent from the PCP offices monthly or upon notification from the prior notification department of a request for service. The EPSDT/MCH coordinator works with the providers and case managers to ensure appropriate referrals to other agencies and programs are completed.

Scheduling of the next enrollee appointment is completed at the time of the current office visit, for children 24 months and younger. Compliance will be reinforced and monitored through a variety of activities including, but not limited to, review of EPSDT tracking forms received from the PCP offices for children newborn to 21 years of age. The PCP office staff is educated regarding EPSDT requirements including scheduling of enrollees’ office appointments, EPSDT tracking form submission and periodicity tables.

EPSDT Dental Services

UnitedHealthcare Community Plan enrollees aged 1 to 21 years are entitled to receive routine dental care services that include emergency, preventive and therapeutic dental services through the federally funded EPSDT program. Authorization or referrals for routine, usual and customary services for this age group are not required. However, it is expected that the provider will complete gross oral exams at every EPSDT visit, encourage routine dental visits, and provide referrals when emergent dental problems are identified.

UnitedHealthcare Community Plan enrollees within this age group who request dental referrals are advised that a referral is not necessary, and that the enrollee or parent may call the dentist directly to schedule an appointment.

Providers may refer members younger than 1 year for a dental assessment if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional.

The following EPSDT dental services are covered:

Emergency Dental

Emergency dental services are covered benefits for all UnitedHealthcare Community Plan enrollees and do not required prior authorization. A retrospective review of emergency services is performed to determine the medical necessity and appropriateness of the services. Emergency dental includes:

1. Treatment for pain, infection, swelling or injury;
2. Extraction of symptomatic, infected and non- restorable primary and permanent teeth, and retained primary teeth; and
3. General anesthesia, conscious sedation or anxiolysis (minimal sedation patients respond normally to verbal commands) when local anesthesia is contraindicated or when management of the patient requires anesthesia.

Routine Dental

Enrollees may receive annual routine dental examinations by a dental provider who reports all findings and resulting treatment to the PCP and UnitedHealthcare Community Plan. The examination includes the following:

1. Instruction in self-care oral hygiene procedures.
2. Complete intra-oral examinations.
3. Diagnostic radiology procedures, including panagraph or full-mouth x-rays: supplemental bitewing x-rays and occlusal or periapical films.
4. Oral prophylaxis performed by the dentist or a dental hygienist.

5. Application of topical fluorides (use of prophylaxis paste containing fluoride is not considered a separate fluoride treatment).

6. Dental sealants on all non-caries permanent first molars.

7. Space maintainers when posterior primary teeth are lost permanently.

**Therapeutic Dental**

Therapeutic dental services are covered when medically necessary. These services include:

1. Periodontal procedures, scaling/root planning, curette, gingivectomy, osseous surgery.

2. Stainless steel crowns for both primary and permanent teeth; composite crowns for only anterior primary teeth; plastic or acrylic crowns for anterior primary teeth.

3. Cast non-precious or semi-precious crowns for enrollees 18 through 21-years-of-age on all functional permanent endodontically treated teeth, except third molars.

4. Pulp therapy for permanent and primary teeth, except third molars unless it is functioning in place of a missing molar.

5. Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the enrollee is 18 through 21-years-of-age and has endodontic treatment.

6. Dentures, orthodontics and orthognathic surgery when medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan agreed upon by the PCP and in consultation with the dentist.

**EPSDT Immunizations**

Comprehensive periodic immunization compliance shall be addressed at each EPSDT visit. The immunization compliance will be conducted according to the recommended childhood immunization schedule approved by the Advisory Committee on Immunization Practice (ACIP). EPSDT visits should occur at birth, 2-4 days, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, and annually starting at 2 years.

All UnitedHealthcare Community Plan physicians and health care providers of EPSDT services shall meet the following immunization conditions:

1. Provide immunization services at no charge to UnitedHealthcare Community Plan enrollees.

2. Obtain EPSDT Immunization Vaccines through the Arizona Department of Health Services (ADHS) Vaccines for Children Program (VFC).

3. Utilize all clinical encounters with enrollees to screen, and when indicated, immunize as per ACIP schedule.

4. Educate parents and/or responsible parties about immunizations at each EPSDT visit. This includes explaining the importance of immunizations, the true contraindications of vaccines, and the risks and benefits of the immunization.

5. Adhere to only true contraindications to vaccine, as specified in the ACIP recommended Standards for Pediatric Immunization Practices.

6. Administer to enrollees all vaccine doses needed according to the ACIP Schedule.

7. Record the following, as required by Arizona Revised Statue (ACIP standard):
   - Vaccine and dosage given.
   - Date the vaccine was given (month/day/year).
   - Name of the manufacturer of the vaccine.
• Lot number of the vaccine.
• Signature of the person administering the vaccine.
• Edition date of the vaccine, information materials distributed and the date those materials were provided.

This information shall be kept in the child’s medical record at the PCP’s office.

8. Ensure that all immunizations are entered into the Arizona State Immunization Information System (ASIIS) as required by state statues.

9. Encourage parents and/or responsible parties to maintain a copy of their child’s personal immunization record. The physician or health care provider’s office will update this record at each EPSDT visit, documenting what vaccine was given, the date (month/day/year) of the vaccine, and who administered the vaccine.

10. If an enrollee receives their immunizations from any other source than the PCP, UnitedHealthcare Community Plan will provide this record to the assigned PCP for inclusion in their chart.

Exemptions From Immunization
UnitedHealthcare Community Plan and state regulations allow for exemption based on medical or personal beliefs. However, such exemptions are not intended to be used to achieve compliance. Claiming exemptions is not a substitute for protection that can only be gained from immunization. Documentation of exemption for personal or medical reasons may be written in the provider’s progress notes on the enrollee’s chart.

• Medical Exemption: An ADHS approved form must be signed by the child’s provider stating that the child has a medical condition such that the required immunizations would seriously endanger his or her well-being. This statement must be disease specific, state whether the condition is permanent or temporary, and include the date.

• Personal Exemption: The parent or guardian must submit a signed statement, using an approved ADHS form, stating that he or she has read and understands the risks and benefits of the disease(s) and immunization(s) and refuses consent of the immunization of the child.

EPSDT Tracking Forms can be found at: http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf.

Arizona Early Intervention Program (Az EIP)

The Arizona Early Intervention Program is a system of professionals working together with parents and families of children, from birth to age three (3), with developmental delays and/or disabilities. AzEIP provides assistance, encouragement and treatment and allows early intervention and developmental services to occur in a family’s natural environment.

UnitedHealthcare works in collaboration with AzEIP and DD support coordinators, PCPs, servicing providers (therapist/facilities), CRS and member families. This is to ensure that the child is provided with medically eligible services, such as physical therapy, speech therapy and/or occupational therapy, in accordance with EPSDT guidelines. Providers working with this population will receive an AzEIP Request for EPSDT Services and documentation completed by an AzEIP service coordinator. The AzEIP Request for EPSDT Services and documentation is faxed to UnitedHealthcare for review and then faxed to the provider for medical necessity review. If provider feels that services are medically necessary, then the provider will fax back the request with signature, date and diagnosis codes related to the therapy request. The EPSDT coordinator at UnitedHealthcare will coordinate prior authorization and notify AzEIP service coordinator of approved services.
Ch. 11  Claims Billing

AHCCCS Provider Identification Number and NPI Number

All providers for UnitedHealthcare Community Plan enrollees requesting reimbursement for services must be properly registered with AHCCCS and have a valid AHCCCS Physician or Health Care Provider Identification Number.

Physicians or health care providers can find AHCCCS registration information at: http://www.azahcccs.gov/commercial/ProviderRegistration/registration.aspx.

Claims submissions that are missing the National Provider Identification Number (NPI) numbers will be denied for payment. All providers are impacted with the exception of a few excluded providers such as housekeeping, home care, personal care, non-emergency transportation, adult day health care. To verify if you are a provider who is excluded, please use the link below to reference the NPI Fact Sheet and NPI Provider Type files published by AHCCCS http://www.azahcccs.gov/commercial/ProviderRegistration/NPI/NPI.aspx.

Providers must communicate their NPI’s to health plans, clearing houses, other providers and AHCCCS well before the compliance date.

If you have obtained your NPI number, please contact your provider relations advocate. If you have any changes to your NPI or AHCCCS registration numbers, please contact your provider relations advocate to update your records.

Acceptable Claim Forms

UnitedHealthcare Community Plan requires all providers to use one of two forms when billing for services whether they are capitated for fee-for-service as per AHCCCS requirements and guidelines.

- Effective April 1, 2014, all paper claims submitted are required to be submitted on the new 02/12 1500 Claim Form. The 02/12 1500 Claim Form is to be used for all professional services, including ancillary services, ambulatory surgery centers, urgent care centers, professional services billed by a hospital and other providers as required by AHCCCS. A CMS-1500 form is to be used for the above mentioned services prior to April 1, 2014.

- A UB-04 form is used to submit claims for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospiceservices and other providers as required by AHCCCS. UnitedHealthcare Community Plan will not process claims received on any other type of claim form. All AHCCCS billing guidelines and requirements must be followed.

ALTCS Enrollee Billing and Encounter Submission

In accordance with Arizona Administrative Codes R9-22-702, R9-27-702, UnitedHealthcare Community Plan enrollees cannot be billed. Enrollees may also not be billed for services that are not paid due to the failure of the provider to comply with UnitedHealthcare Community Plan’s authorization or billing requirements.

AHCCCS rules prohibit physicians and health care providers from billing enrollees for any AHCCCS-covered services. Providers cannot request additional payments from the enrollee or family for any Medicaid-covered service. If a member requests a service that is not covered by AHCCCS, providers should have the member sign a release form indicating they understand that the service is not covered by AHCCCS and the member is financially responsible for all applicable charges.
AHCCCS Approved Codes, Units and Values

Valid and approved AHCCCS codes should be used when submitting claims to UnitedHealthcare Community Plan. This includes but is not limited to:

- Place of service codes.
- Revenue codes.
- Diagnosis codes.
- CPT codes.
- Modifiers.
- ICD-9 procedure and condition codes.

UnitedHealthcare Community Plan will apply AHCCCS billing and payment requirements to all claims submitted. This applies to the application of max-unit guidelines, age/gender guidelines, place of service/procedure combinations, procedure/modifier combinations, duplicate claim billing, duplicate line-item, and revenue/procedure/modifier combination guidelines.

Billing Multiple Units

Reminder when billing multiple units

- If the same procedure is provided multiple times on the same date of service, the procedure code must be entered once on the claim form with the appropriate number of units.
- The units field is used to specify the number of times the procedure was performed on the date of service.
- The total bill charge is the unit charge multiplied by the number of units.

EDI/Electronic Claims Submission

UnitedHealthcare Community Plan requires Electronic Claims Submission for most of our contracted providers.

EDI offers providers several advantages, including less paperwork, reduced postage, less time spent handling claims, decreased turn-around time on claims processing, HIPAA compliant and flexibility to submit your claims 24-hours-per-day.

To submit claims electronically simply contact your clearinghouse or software vendor and request that Primary and Secondary UnitedHealthcare Community Plan Claims be sent electronically. UnitedHealthcare Community Plan Claims Payer ID is 87726.

If you are interested in billing electronically, please visit the UnitedHealthcare Provider Portal at UHCCommunityPlan.com.

COB (Secondary) EDI Claims Submissions are Preferred Electronically

- Please visit the Electronic Data Interchange (EDI) page of our Arizona website and reference the link to Companion Guides at: http://www.uhccommunityplan.com.
  This link will take you to the HIPAA Companion Guides, including the 837 guides for Institutional and Professional claims
- Do not send paper claim back up if they have already been submitted electronically

EDI Support Services

EDI Support Services provides support for all electronic transactions involving claims and electronic remittances. Please call us for assistance with any of these transactions at 800-210-8315 or e-mail at: ac_edi_ops@uhc.com.
Electronic Payments and Statements (Direct Deposit)

You can take advantage of a free, electronic system that streamlines and simplifies the payment process for your UnitedHealthcare Community Plan claims.

Electronic Payments and Statements (EPS) reduces your administrative burden and creates more time for patient care. With EPS, claim payments are conveniently transferred into the checking account you designate, eliminating the need to physically deposit checks and significantly reducing the time your staff spends on manual processing and claim payment reconciliation.

EPS also eliminates countless stacks of mail and paper from your office, by providing online remittance advices for each claim that you can view, print or save electronically. And, you can download a free, consolidated HIPAA 835 that shows all claims for a given day’s deposit and can be posted automatically into your Practice Management System.

Registration is easy: Just visit us on the web at UnitedHealthcareOnline.com. When enrolling online, choose “Claims & Payments” from the top bar navigation, and then select “Electronic Payments & Statements.” From the “Welcome to Electronic Payments and Statements” page, choose “Continue” to register/login to Electronic Payments and Statements, and an enrollment form will appear. When your registration is complete we’ll email you a confirmation, and payments will begin to be processed electronically in approximately seven-to-ten days.

If you have any questions, please call the UnitedHealthcare Connectivity Help Desk at 866-842-3278 and select option 5. We’re available from 7 a.m. to 6 p.m. Central Time, Monday through Friday, and would be happy to explain how EPS can work for you.

Initial Claims Filing Time Limits

UnitedHealthcare Community Plan requires that all initial claims must be submitted within 90 days following the date that the services are rendered or the date of discharge, or eligibility posting, whichever date is later. UnitedHealthcare Community Plan is always the payer of last resort and thus you must bill any other insurance, including Medicare, first before submitting your claim to us.

Claims involving coordination of benefits must be submitted within 60 days from the date of the Explanation of Benefits (EOB) from the primary and/or secondary payer. Providers must attach a copy of the payer’s EOB with your UnitedHealthcare Community Plan claim, even if the claim was originally denied. Please refer to your physician and health care Provider Agreement for further clarification.

Clean Claim

A clean claim is a claim that has all the required fields filled out correctly and is legible. Claims that are not completely filled out or are illegible will be returned unprocessed to the provider and are not considered as received by UnitedHealthcare Community Plan. Claims that have inaccurate or inappropriate information in the fields will be processed and denied. The provider can then resubmit a corrected claim for processing.

Where to Mail Your Claims

UnitedHealthcare Community Plan is always the payer of last resort. Physicians and health care providers must bill any other health care insurance carrier that the enrollee has prior to billing UnitedHealthcare Community Plan, including Medicare.

Mailing to the street address will delay the processing of the claim and as a result may be denied for untimely filing. Any claims that are
received at the street address will be returned to the sender for proper mailing of the claims.

Primary and secondary UnitedHealthcare Community Plan claims, including medical records, should be submitted to:

UnitedHealthcare Community Plan
P.O. Box 30995,
Salt Lake City, UT 84130

Claims, Copayments and Deductibles for UnitedHealthcare Community Plan Dually Enrolled Members

Providers billing for services for enrollees that have primary coverage with United Healthcare Nursing Home Plan (PPO SNP), UnitedHealthcare Community Plan will process the single claim for both primary and secondary coverage. All other plans must submit a separate claim to UnitedHealthcare Community Plan for the Long Term Care coverage.

If you are not sure who the enrollee’s primary insurance is, contact UnitedHealthcare Community Plan’s Customer Call Center.

UnitedHealthcare Community Plan will coordinate payment of benefits of UnitedHealthcare Community Plan enrollees that have a primary carrier. In accordance with the requirements of the Balanced Budget Act of 1997, UnitedHealthcare Community Plan will pay co-payments, deductibles and/or coinsurance for AHCCCS covered services up to the lower of either the AHCCCS fee for service schedule or the primary insurance allowed amount.

Cost-Sharing

UnitedHealthcare Community Plan has cost-sharing responsibility for AHCCCS-covered services provided to members by an in-network fee-for-service providers. UnitedHealthcare Community Plan has an obligation to pay for applicable Medicare fee-for-service deductibles, coinsurance and copayments. UnitedHealthcare Community Plan has no cost-sharing responsibility if the Medicare payment exceeds the contracted rate for covered services. UnitedHealthcare Community Plan liability for cost sharing plus the Medicare payment shall not exceed the contracted rate for the service.

Medical Claims Review

Medical claims review (MCR) nurses evaluate practitioners’ and providers’ claims before the claims are paid. The MCR nurses use medical review criteria to confirm that the services being billed are a covered benefit for the member and were medically necessary. Medical claims review evaluates claims for emergency room, transportation, and inpatient and outpatient medical services.

Proper Documentation and Medical Review

Medical review is performed to determine if services were provided according to policy, particularly related issues of medical necessity and emergency services. Medical review also is performed to audit appropriateness, utilization, and quality of the service provided.

Please note the following scenarios where the appropriate documentation is required to process the claim:

A. Out-of-state providers corrected claims, please include itemization of charges.

B. Inpatient claims with extraordinary cost-per-day thresholds may qualify for an outlier reimbursement. For an inpatient claim to be paid the outlier payment, the facility must bill a Condition Code 61 in any of the Condition Code fields (18-28) on the UB-04. If the inpatient claims is an interim bill, only the last bill (e.g. bill type 114) will be considered for outlier reimbursement. All hospitals for inpatient claims that may qualify for outlier payment please include itemization of charges.
C. When billing unlisted procedures, including any documentation, providers must include: the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used that details what service was provided.

D. Medicaid services:

1. Behavioral Health/Substance Abuse
   a) ER notes.
   b) Physician orders, MD, RN and social work notes.
   c) MARS for each day of hospitalization.
   d) Discharge orders and/or Instructions.
   e) Psychiatric evaluation and psychiatric discharge summary.
2. Cardiology services
3. Radiological service interpretation
4. Home health visits
5. Injectable drugs
6. Urgent care
7. Pharmacy supplies
8. Prosthetics
   a) Surgical Procedures with Modifier 22 indicating unusual procedural service.
   b) Itemized bill for claims where member is eligible for part of the date span but not the entire date span.
   c) Elective Abortions require a Certificate of Medical Necessity and Operative.

Prior Period Coverage (PPC) Claims

Prior Period Coverage (PPC) is the period of time, prior to UnitedHealthcare Community Plan’s notification of an enrollee’s enrollment, during which UnitedHealthcare Community Plan is retroactively liable for payment of covered services received by the enrollee. Physicians and health care providers can bill UnitedHealthcare Community Plan for medically necessary services incurred by our enrollees during the PPC period, if the service is a PPC-covered benefit. Prior authorization is not required during the PPC period for medically necessary services that are an AHCCCS PPC-covered benefit. Providers must have a valid AHCCCS ID number. Claims must be submitted to UnitedHealthcare Community Plan on the appropriate CMS1500 or UB-04 claim form. Please contact the enrollee’s UnitedHealthcare Community Plan Case Manager or the Customer Call Center for more information or to verify the enrollee’s PPC eligibility status.

Eligible PPC services include medications, physician visits, hospitalizations, therapies, durable medical equipment, medical supplies, home and community-based services (HCBS) and skilled nursing facility (SNF) care. For members who have HCBS in place prior to enrollment (during the PPC enrollment) a documented retrospective assessment must be conducted to determine whether those services are medically necessary, cost-effective and if they were provided by a registered AHCCCS provider. If so, a care service plan must be developed to indicate that services will be retroactively authorized and reimbursed by the program contractor.

PPC claims should be directed to the following address:

UnitedHealthcare Community Plan
P.O. Box 30995
Salt Lake City, UT 84130
Reconsiderations/Resubmissions of Claims

Rejected claims must be corrected and sent via the designated reconsideration/resubmission process. Do not resubmit these claims via EDI. Claims will be rejected or processed in error. Resubmitting a claim via EDI may not correct the issue and could delay processing time.

Providers have up to 12 months from the date of service or discharge date to resubmit their claim. All claims resubmissions should include at a minimum the following information:

- Reconsideration Form detailing the reason for reconsideration (e.g., corrected claim, timely filing documentation, COB information, authorization information, incorrectly processed claim, etc.). A copy of this form can be obtained at: https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=1873b55e335a910VgnVCM1000007740dc0a_____ or by calling your Provider Relations Advocate.
- Corrected claim form (if applicable) with the original claim number written in box 22 of the CMS 1500 form, or box 80 of the UB04.
- Copy of the remittance advice from the denied claim.
- There should be one Reconsideration form for each resubmitted, corrected, or reconsideration claim.
- Claims should be resubmitted to UnitedHealthcare Community Plan at the following address:
  UnitedHealthcare Community Plan
  P.O. Box 30995,
  Salt Lake City, UT 84130
- Note: The reconsideration process does not take the place of the dispute process nor does it extend the dispute filing deadline.

Optum Cloud Dashboard and Claim Reconsideration

Through our partnership with Optum, UnitedHealthcare is taking another step forward in helping to ease our providers' administrative burden with the addition of new features and functions on Optum Cloud Dashboard.

Optum Cloud is a cloud-based website where registered providers can submit reconsideration requests electronically when attachments, such as medical notes, are required.

Registration is required to access Optum Cloud Dashboard. To access the Cloud Dashboard, or for more information, please visit UnitedHealthcareOnline.com. Click on Tools & Resources, select Health Information Technology and then ‘Optum Cloud Dashboard’

Claims Submission Education

Please contact your Provider Relations Advocate for technical assistance on how to bill UnitedHealthcare Community Plan for services rendered.

Claims Filing Requirements

- Use codes that are within your AHCCCS registration (Category of Service). Billing codes not within your category of service will cause a claim denial.
- Use the CPT, HCPCS and ICD-9 codes that were approved for the date of service.
- When filing claims to UnitedHealthcare Community Plan as a secondary payer, you must include the primary insurer’s EOB with the claim submission, or your claim will deny.
- Use a separate claim for each enrollee.
• The member’s UnitedHealthcare Community Plan Group Number is required on the claim form (Box 11 on the CMS-1500 form or Box 62 on the UB-04 form). The member’s Group Number is listed on their Member ID Card. You may also call your provider relations advocate or the Provider Call Center to obtain this information.

• Make sure to file the claim within the timely filing limits. For contracted providers: 90 days from the date of service or 60 days from the date of the primary carriers EOB.

• Complete all required fields and ensure that the claim is legible. Please see our instructions on the following pages for how to fill out your claim form.

• The state of Arizona requires that providers submit claims with 99 lines or less. Any claims submitted that contain more than 99 lines are rejected by the state when submitted as part of encounter data.
CMS 1500 Instructions

The CMS 1500 (formerly HCFA 1500) claim form is used to bill for professional services, transportation, durable medical equipment, ancillary services, and assisted living facilities.

The following instructions explain how to complete the CMS 1500 claim form and whether a field is required, required if applicable, or not required. Failure to complete the form as required may cause your claim to be denied.

<table>
<thead>
<tr>
<th></th>
<th><strong>Program Block</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Check the second box labeled “Medicaid.”</td>
</tr>
<tr>
<td>1A</td>
<td><strong>Insured's ID Number</strong></td>
</tr>
<tr>
<td></td>
<td>Enter the enrollee’s AHCCCS ID number.</td>
</tr>
<tr>
<td>2</td>
<td><strong>Patient's Name</strong></td>
</tr>
<tr>
<td></td>
<td>Enter the enrollee’s last name, first name, and middle initial as shown on the AHCCCS ID card.</td>
</tr>
<tr>
<td>3</td>
<td><strong>Patient's Date of Birth and Sex</strong></td>
</tr>
<tr>
<td></td>
<td>Enter the month, day and year (MM/DD/YYYY) of the enrollee’s birth. Check the appropriate box to indicate the enrollee’s gender.</td>
</tr>
<tr>
<td>4</td>
<td><strong>Insured's Name</strong></td>
</tr>
<tr>
<td>5</td>
<td><strong>Patient Address</strong></td>
</tr>
<tr>
<td>6</td>
<td><strong>Patient's Relationship to Insured</strong></td>
</tr>
<tr>
<td>7</td>
<td><strong>Insured's Address</strong></td>
</tr>
<tr>
<td>8</td>
<td><strong>Reserved for NUCC Use</strong></td>
</tr>
<tr>
<td>9</td>
<td><strong>Other Insured's Name</strong></td>
</tr>
<tr>
<td></td>
<td>If the enrollee has no coverage other than AHCCCS, leave this section blank. If other coverage exists, perhaps through the enrollee or spouse’s employment or some other source, enter the name of the insured. If the other insured is the enrollee, enter “Same.”</td>
</tr>
<tr>
<td>9A</td>
<td><strong>Other Insured’s Policy or Group Number</strong></td>
</tr>
<tr>
<td></td>
<td>Enter the group number of the other insurance.</td>
</tr>
<tr>
<td>9B</td>
<td><strong>Reserved for NUCC Use</strong></td>
</tr>
<tr>
<td>9C</td>
<td><strong>Reserved for NUCC Use</strong></td>
</tr>
<tr>
<td>9D</td>
<td><strong>Insurance Plan Name or Program Name</strong></td>
</tr>
<tr>
<td></td>
<td>Enter the name of the insurance company or program name that provides the insurance coverage.</td>
</tr>
<tr>
<td>10</td>
<td><strong>Is Patient's Condition Related to</strong></td>
</tr>
<tr>
<td>----</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Check “YES” or “NO” to indicate whether the patient’s condition is related to employment, an auto accident, or other accident. If the patient’s condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11</th>
<th><strong>Insured's Group Policy or FECA Number</strong></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Required if Applicable</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>11A</th>
<th><strong>Insured's Date of Birth and Sex</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Required if Applicable</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>11B</th>
<th><strong>Other Claim ID (Designated by NUCC)</strong></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Not Required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11C</th>
<th><strong>Insurance Plan Name or Program Name</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Required if Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11D</th>
<th><strong>Is There Another Health Benefit Plan</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Check the appropriate box to indicate coverage other than AHCCCS. If “Yes” is checked, you must complete Fields 9A-D.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12</th>
<th><strong>Patient or Authorized Person's Signature</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13</th>
<th><strong>Insured’s or Authorized Person's Signature</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14</th>
<th><strong>Date of Illness or Injury</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Required if Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15</th>
<th><strong>Other Date</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16</th>
<th><strong>Dates Patient Unable to Work in Current Occupation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>17</th>
<th><strong>Name of Referring Provider or Other Source</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Required if Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>17A</th>
<th><strong>ID Number of Referring Provider</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The ordering provider is required for: Laboratory Drugs (J-codes) Radiology Temporary K and Q codes Medical and surgical supplies Orthotics Respiratory DME Prosthetics Enteral and Parenteral Therapy Vision codes (V-codes) Durable Medical Equipment 97001 – 97546 Ordering providers can be an M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Psychologist or Certified Nurse Midwife.</td>
</tr>
<tr>
<td></td>
<td>Description</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17B</td>
<td><strong>NPI # of Referring Provider</strong></td>
</tr>
<tr>
<td>18</td>
<td><strong>Hospitalization Dates Related to Current Services</strong></td>
</tr>
<tr>
<td>19</td>
<td><strong>Reserved for Local Use</strong></td>
</tr>
<tr>
<td>20</td>
<td><strong>Outside Lab</strong></td>
</tr>
<tr>
<td>21</td>
<td><strong>Diagnosis Codes</strong></td>
</tr>
<tr>
<td></td>
<td>Enter at least one ICD-9 diagnosis code describing the recipient’s condition.</td>
</tr>
<tr>
<td></td>
<td>Behavioral health providers must not use DSM-4 diagnosis codes.</td>
</tr>
<tr>
<td></td>
<td>Up to twelve diagnosis codes in priority order (primary condition, secondary</td>
</tr>
<tr>
<td></td>
<td>condition, etc.) may be entered.</td>
</tr>
<tr>
<td>22</td>
<td><strong>Medicaid Resubmission Code</strong></td>
</tr>
<tr>
<td>23</td>
<td><strong>Prior Authorization Number</strong></td>
</tr>
<tr>
<td></td>
<td>If a service requires prior authorization, either from the UnitedHealthcare</td>
</tr>
<tr>
<td></td>
<td>Community Plan case manager or Utilization/Prior Authorization department,</td>
</tr>
<tr>
<td></td>
<td>enter that number.</td>
</tr>
<tr>
<td>24A</td>
<td><strong>Dates of Service</strong></td>
</tr>
<tr>
<td></td>
<td>Enter the beginning and ending service dates.</td>
</tr>
<tr>
<td>24B</td>
<td><strong>Place of Service</strong></td>
</tr>
<tr>
<td></td>
<td>Enter the two-digit code that describes the place of service. Refer to the</td>
</tr>
<tr>
<td>24C</td>
<td><strong>EMG Emergency Indicator</strong></td>
</tr>
<tr>
<td></td>
<td>Mark this box with a checkmark, an “X” or a “Y” if the service was an</td>
</tr>
<tr>
<td></td>
<td>emergency service, regardless of where it was provided.</td>
</tr>
<tr>
<td>24D</td>
<td><strong>Procedures, Services or Supplies</strong></td>
</tr>
<tr>
<td></td>
<td>Enter the CPT or HCPCS procedure code that identifies the service provided.</td>
</tr>
<tr>
<td></td>
<td>If the same procedure is provided multiple times on the same date of service,</td>
</tr>
<tr>
<td></td>
<td>enter the procedure only once. Use the Units field (Field 24G) to indicate</td>
</tr>
<tr>
<td></td>
<td>the number of times the service was provided on that date. Unit definitions</td>
</tr>
<tr>
<td></td>
<td>must be consistent with the HCPCS and CPT coding manuals.</td>
</tr>
<tr>
<td></td>
<td>For some claims billed with CPT/HCPCS codes, procedure modifiers must</td>
</tr>
<tr>
<td></td>
<td>be used to accurately identify the service provider and avoid delay or denial</td>
</tr>
<tr>
<td></td>
<td>of payment.</td>
</tr>
<tr>
<td>24E</td>
<td><strong>Diagnosis</strong></td>
</tr>
<tr>
<td></td>
<td>Relate the service provided to the diagnosis code(s) listed in Field 21 by</td>
</tr>
<tr>
<td></td>
<td>entering the letter of the appropriate diagnosis. Enter only the reference</td>
</tr>
<tr>
<td></td>
<td>letter from Field 21 (A-L), not the diagnosis codes itself. If more than one</td>
</tr>
<tr>
<td></td>
<td>letter is entered, they should be in descending order of importance/</td>
</tr>
<tr>
<td></td>
<td>relevance to the reason for the service.</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>24F</td>
<td>Charges</td>
</tr>
<tr>
<td></td>
<td>Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is $50.00 and three units were provided, enter &quot;$150.00&quot; in this Field and &quot;3&quot; units in Field 24G.</td>
</tr>
<tr>
<td>24G</td>
<td>Units</td>
</tr>
<tr>
<td></td>
<td>Enter the number of units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line.</td>
</tr>
<tr>
<td>24H</td>
<td>EPSDT/Family Planning</td>
</tr>
<tr>
<td>24I</td>
<td>ID Qualifier</td>
</tr>
<tr>
<td>24J</td>
<td>COB/Rendering Provider ID SHADED AREA – Use for COB Information (Required if Applicable)</td>
</tr>
<tr>
<td></td>
<td>Use this SHADED field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a recipient's Deductible has been met, enter zero (0) for the Deductible amount.</td>
</tr>
<tr>
<td></td>
<td>For recipients and service covered by a third party payer, enter only the amount paid.</td>
</tr>
<tr>
<td></td>
<td>Always attach a copy of the Medicare or other insurer's EOB to the claim.</td>
</tr>
<tr>
<td></td>
<td>If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should &quot;zero fill&quot; Field 24J (Shaded area). Leaving this field blank will cause the claim to be denied.</td>
</tr>
<tr>
<td></td>
<td>NON-SHADED AREA – Rendering Provider ID (Required)</td>
</tr>
<tr>
<td></td>
<td>Rendering Provider’s NPI is required for all providers that are mandated to maintain an NPI #.</td>
</tr>
<tr>
<td></td>
<td>For atypical provider types, the AHCCCS ID must be used unless the provider has chosen to obtain an NPI and has provided this NPI to AHCCCS.</td>
</tr>
<tr>
<td>25</td>
<td>Federal Tax ID</td>
</tr>
<tr>
<td></td>
<td>Enter the tax ID number and check the box “EIN.” If you do not have a tax ID, enter your SSN and check the box labeled “SSN.”</td>
</tr>
<tr>
<td>26</td>
<td>Patient Account Number</td>
</tr>
<tr>
<td></td>
<td>Number that the Provider has assigned to uniquely identify this claim in the provider’s records.</td>
</tr>
<tr>
<td>27</td>
<td>Accept Assignment</td>
</tr>
<tr>
<td>28</td>
<td>Total Charge</td>
</tr>
<tr>
<td></td>
<td>Enter the total for all charges for all lines on this claim.</td>
</tr>
<tr>
<td>29</td>
<td>Amount Paid</td>
</tr>
<tr>
<td></td>
<td>Enter the total amount that you have been paid for this claim by all sources other than UnitedHealthcare Community Plan. Do not enter any amounts expected to be paid by UnitedHealthcare Community Plan.</td>
</tr>
<tr>
<td>Column</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>30</td>
<td>Reserved for NUCC use.</td>
</tr>
<tr>
<td>31</td>
<td><strong>Signature and Date</strong></td>
</tr>
<tr>
<td></td>
<td>The provider or his/her authorized representative must sign the claim form. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.</td>
</tr>
<tr>
<td>32</td>
<td><strong>Service Facility Location Information</strong></td>
</tr>
<tr>
<td>32A</td>
<td><strong>Service Facility NPI #</strong></td>
</tr>
<tr>
<td>32B</td>
<td><strong>Service Facility AHCCCS ID #</strong></td>
</tr>
<tr>
<td>33</td>
<td><strong>Billing Provider Name, Address and Phone</strong></td>
</tr>
<tr>
<td></td>
<td>Enter your provider name, address and telephone number. If a group is billing, enter the group’s name, address and telephone number.</td>
</tr>
<tr>
<td>33A</td>
<td><strong>Billing Provider NPI #</strong></td>
</tr>
<tr>
<td>33B</td>
<td><strong>AHCCCS ID #</strong></td>
</tr>
</tbody>
</table>
The UB-04 claim form is to be used to bill all hospital inpatient, outpatient, emergency room and hospital-based clinic services (including pharmacy services provided as an integral part of a hospital service), dialysis clinic, nursing facility, free-standing birthing center, residential treatment center and hospice services.

The following instructions explain how to complete the UB-04 claim form and whether a field is required, required if applicable, or not required. Failure to complete the form as required may cause your claim to be denied.

<table>
<thead>
<tr>
<th></th>
<th><strong>Provider Data</strong></th>
<th><strong>Unassigned</strong></th>
<th><strong>Patient Control Number</strong></th>
<th><strong>Bill Type</strong></th>
<th><strong>Fed Tax No.</strong></th>
<th><strong>Statement Covers Period</strong></th>
<th><strong>Covered Days</strong></th>
<th><strong>Patient Name</strong></th>
<th><strong>Patient Address</strong></th>
<th><strong>Patient Birth Date</strong></th>
<th><strong>Patient Sex</strong></th>
<th><strong>Admission/Start of Care</strong></th>
<th><strong>Admission Hour</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enter the name, address and telephone number of the provider rendering the service.</td>
<td></td>
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</tr>
<tr>
<td>4</td>
<td>Facility type (1st digit), bill classification (2nd digit), and frequency (3rd digit).</td>
<td></td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>5</td>
<td>Enter your federal tax ID number.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6</td>
<td>Enter the beginning and ending dates of the billing period in MM/DD/YY or MM/DD/YYYY format.</td>
<td></td>
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<tr>
<td>7</td>
<td>Enter the total number of days covered by a primary payer. If UnitedHealthcare Community Plan is the enrollee’s only coverage, leave blank.</td>
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</tr>
<tr>
<td>8</td>
<td>Enter enrollee’s last name, first name, and middle initial as they appear on the Member’s ID Card.</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Enter the month; day and year (MM/DD/YYYY) of enrollee’s birth.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>11</td>
<td>Enter “M” (male) or “F” (female).</td>
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<td>12</td>
<td>Enter the admission date in MM/DD/YY or MM/DD/YYYY format.</td>
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<td>13</td>
<td>Required</td>
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<td><strong>Admit Type (Priority Type of Admission/Visit)</strong></td>
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<td>14</td>
<td>Required for all inpatient claims. An Admit Type of “1” is required for all emergency inpatient and outpatient claims.</td>
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<td>1. Emergency: Enrollee requires medical intervention for severe, life-threatening or potentially disabling conditions. Documentation must be attached to claim.</td>
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<td>2. Urgent: Enrollee requires immediate attention. Claim marked as urgent will not qualify for emergency service consideration.</td>
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<td>3. Elective: Enrollee’s condition permits time to schedule services.</td>
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<td>4. Newborn: Enrollee is newborn. Newborn source of admission code must be entered in Field 20.</td>
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<td>5. Trauma Center: Visit to a trauma center/hospital as licensed or designated by the State or local government authority to do so, or as verified by the American College of Surgeons and involving a trauma activation.</td>
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<td>15</td>
<td><strong>Point of Origin for Admission or Visit</strong></td>
<td><strong>Required</strong></td>
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<td>16</td>
<td><strong>Discharge Hour</strong></td>
<td><strong>Required if Applicable</strong></td>
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<td>Enter the code which best indicates the enrollee’s time of discharge. Required for all inpatient claims when the enrollee has been discharged.</td>
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<td>Patient Discharge Status</td>
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<tr>
<td>Required for all inpatient claims. Enter the code that best describes the recipient’s status for this billing period:</td>
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<tr>
<td>01. Discharged to home or self-care (routine discharge).</td>
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<td>02. Discharged/Transferred to a short-term general hospital for inpatient care.</td>
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<td>03. Discharge/Transferred to SNF with Medicare Certification in anticipation of skilled care.</td>
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<td>04. Discharge/Transferred to a facility that provides custodial or supportive care.</td>
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<td>05. Discharge/Transferred to a designated cancer center or children’s hospital.</td>
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<td>06. Discharge/Transferred to home under care of organized home health service organization in anticipation of covered skilled care.</td>
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<td>07. Left against medical advice or discontinued care.</td>
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<td>08. Not for use/unassigned.</td>
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<td>09. Admitted as an inpatient to this hospital.</td>
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<td>20. Expired.</td>
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<td>21. Discharged/Transferred to Court/Law Enforcement.</td>
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<td>30. Still a Patient.</td>
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<td>40. Expired at home.</td>
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<td>41. Expired in a medical facility (hospital, SNF, etc.).</td>
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<td>42. Expired, place unknown (hospice only).</td>
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<td>43. Discharged/Transferred to a federal health care facility.</td>
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<td>50. Discharged to Hospice – home.</td>
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<td>51. Discharged to Hospice – medical facility (certified).</td>
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<td>61. Discharged/Transferred within this institution to a hospital-based Medicare-approved swing bed.</td>
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<td>62. Discharged/Transferred to an inpatient rehabilitation facility (IRF).</td>
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<td>63. Discharged/Transferred to a Medicare-certified long term care hospital.</td>
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<td>64. Discharged/Transferred to a nursing facility certified under Medicaid but not certified under Medicare.</td>
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<td>65. Discharged/Transferred to a psychiatric hospital or psychiatric distinct part/unit of hospital.</td>
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<td>66. Discharges/Transfers to a Critical Access Hospital.</td>
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<td>70. Discharged/Transferred to another type of healthcare institution not defined elsewhere in this code list.</td>
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<td>Description</td>
<td>Required if Applicable</td>
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<td>18-28</td>
<td><strong>Condition Codes</strong>&lt;br&gt;Enter the appropriate condition codes that apply to this bill. In state, non-HIS inpatient hospitals may request outlier consideration for a claim by entering “61” in any Condition Code Field. To bill for self-dialysis training, freestanding dialysis facilities approved to provide self-dialysis training must enter “73” in any Condition Code Field and bill revenue code 841 (Continuous Ambulatory Peritoneal Dialysis, per day) or revenue code 851 (Continuous Cycling Peritoneal Dialysis, per day). To bill for multiple distinct/independent outpatient visits on the same day facilities must enter “GO”.</td>
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<td>29</td>
<td><strong>Accident State</strong></td>
<td>Required if Applicable</td>
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<td>31-34</td>
<td><strong>Occurrence Codes and Dates</strong></td>
<td>Required if Applicable</td>
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<td>35-36</td>
<td><strong>Occurrence Span Codes and Dates</strong></td>
<td>Required if Applicable</td>
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<td>38</td>
<td><strong>Responsible Party Name and Address</strong></td>
<td>Required if Applicable</td>
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<td>39-41</td>
<td><strong>Value Codes and Amounts</strong></td>
<td>Required if Applicable</td>
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<td>42</td>
<td><strong>Revenue Code</strong>&lt;br&gt;Enter the appropriate revenue code(s) that describe the service(s) provided. Accommodation day should not be billed on outpatient bill types. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes.</td>
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|   | **Revenue Code Description/NDC Code (effective 07/01/12)** Enter the description of the revenue code billed in Field 42. To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):
|   |   - The NDC qualifier of N4 in the first 2 positions on the left side of the field.
|   |   - The NDC 11-digit numeric code, without hyphens.
|   |   - The NDC Unit of Measurement Qualifier (as listed above).
|   |   - The NDC quantity, administered amount, with up to three decimal places (i.e., 1234.456). Any unused spaces are left blank.
<p>|   | The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens. | <strong>Required/NDC if Applicable</strong> |
|   | <strong>HCPCS/Rates</strong> Enter the inpatient (hospital or nursing facility) accommodations rate. Dialysis facilities must enter the appropriate CPT/HCPCS code for certain lab, radiology and pharmacy codes. Hospitals must enter the appropriate CPT/HCPCS code when billing for outpatient therapy services. | <strong>Required if Applicable</strong> |
|   | <strong>Service Date</strong> The dates the indicated outpatient service was provided on a series bill. The date of service should only be reported if the From and Through dates in Form Locator 6 are not equal to each other on the form. Enter the date in MM/DD/YY or MM/DD/YYYY format. | <strong>Required if Applicable</strong> |
|   | <strong>Service Units</strong> If accommodation days are billed, the number of units billed must be consistent with the patient status field (Field 17) and statement covers period (Field 6). If the enrollee has been discharged, UnitedHealthcare Community Plan covers the admission date to, but not including, the discharge date. Accommodation days reported must reflect this. If the enrollee expired or has not been discharged, UnitedHealthcare Community Plan covers the admission date through the last date billed. | <strong>Required</strong> |
|   | <strong>Total Charges</strong> Total charges are obtained by multiplying the units of service by the unit charge for each service. Each line other than the sum of all charges may include charges up to $999,999.99. Total charges are represented by revenue code 001 and must be the last entry in Field 47. Total charges on one claim cannot exceed $999,999.99. | <strong>Required</strong> |
|   | <strong>Non-covered Services</strong> Enter any charges that are not payable by UnitedHealthcare Community Plan. The last entry is total non-covered charges, represented by revenue code 001. Do not subtract this amount from total charges. | <strong>Required if Applicable</strong> |</p>
<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Required/Not Required</th>
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<tbody>
<tr>
<td>49</td>
<td>Unassigned</td>
<td>Not Required</td>
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<tr>
<td>50A-C</td>
<td>Payer</td>
<td>Required</td>
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<td></td>
<td>Enter the name and identification number, if available, of each payer who may have full or partial responsibility of the charges incurred by enrollee and from which provider might expect some reimbursement.</td>
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<tr>
<td>51A-C</td>
<td>Health Plan ID</td>
<td>Required</td>
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<td></td>
<td>Enter the facility’s ID number as assigned by the Payer(s) listed in Fields 50A, B, and/or C. Your six-digit AHCCCS service provider ID number should be listed last. Behavioral health providers must not enter their BHS provider ID number.</td>
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<tr>
<td>52A-C</td>
<td>Release of Information</td>
<td>Not Required</td>
</tr>
<tr>
<td>53A-C</td>
<td>Assignment of Benefits</td>
<td>Not Required</td>
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<tr>
<td>54A-C</td>
<td>Prior Payments</td>
<td>Required if Applicable</td>
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<td></td>
<td>Enter the amount received from Medicare Part B (Inpatient only) or any other insurance or payer other than UnitedHealthcare Community Plan, including the patient, listed in Field 50. If the enrollee has other insurance but no payment was received, enter “0.” The “0” indicates that a reasonable attempt was made to determine available coverage and obtain payment. Enter only the actual payments received. Do not enter any amounts expected from UnitedHealthcare Community Plan.</td>
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<tr>
<td>55A-C</td>
<td>Amount Due</td>
<td>Not Required</td>
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<td>56</td>
<td>National Provider Identifier – Billing Provider</td>
<td>Required</td>
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<tr>
<td>57</td>
<td>Other Billing Provider Identifier</td>
<td>Required if Applicable</td>
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<tr>
<td>58A-C</td>
<td>Insured’s Name</td>
<td>Not Required</td>
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<td></td>
<td>Enter the name of the insured (enrollee) covered by the payer(s) in Field 50.</td>
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<tr>
<td>59A-C</td>
<td>Patient’s Relationship to Insured</td>
<td>Not Required</td>
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<tr>
<td></td>
<td>Enter enrollee identification number related to the payer(s) in Field 50. The enrollee’s AHCCCS ID number must be listed last.</td>
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<td>If a service requires prior authorization, either from the UnitedHealthcare Community Plan case manager or Utilization/Prior Authorization department, enter that number in this field.</td>
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| 67   | **Principle Diagnosis**  
Enter the principal ICD-9 diagnosis code. Behavioral health providers must **not** use DSM-4 diagnosis codes. | **Required** |
| 69   | **Admitting Diagnosis**  
Required for inpatient bills. Enter the ICD-9 diagnosis code that represents the **significant** admitting diagnosis. | **Required** |
| 70   | **Patient's Reason for Visit**  
Not Required |
| 72   | **E-Codes**  
Enter trauma diagnosis code, if applicable. | **Required if Applicable** |
| 74   | **Principal Procedure Code and Dates**  
Enter the ICD-9 procedure code and the date the procedure was performed during the inpatient stay or outpatient visit. Enter the date in MM/DD/YY or MM/DD/YYYY format. If more than one procedure is performed, the principal procedure should be the one that is related to the primary diagnosis, performed for definitive treatment of that condition, and which requires the highest skill level. | **Required if Applicable** |
| 76   | **Attending Provider Name and Identifiers**  
Required if Applicable |
| 77   | **Operating Physician Name and Identifier**  
Required if Applicable |
| 78-79| **Required if Applicable**  
Not Required |
| 80   | **Remarks**  
Required if Applicable |
| 81   | **Other Procedure Codes**  
Enter other procedure codes in descending order of importance. | **Required if Applicable** |
Provider Remittance Advice

A Provider Remittance Advice (PRA) will be returned for every claim processed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each PRA carefully and compare to prior remittance advices to ensure proper tracking and posting of adjustments. We recommend that you keep all PRA’s and use the information to post payments and make correction for any claims requiring resubmission. Keeping your PRA will also ensure that you have an accurate record of claims that have been received for processing and assist you in tracking any adjustments.

The PRA provides a legend that identifies the key items, such as denial reasons, on the remit. Your provider relations advocate will review a PRA with you upon contracting with UnitedHealthcare Community Plan. Please contact the Customer Service Center if you need assistance with reading a PRA.

The following pages include a sample UnitedHealthcare Community Plan PRA and Claims Dispute Insert.
## PROVIDER REMITTANCE ADVICE

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QUESTIONS? CONTRACTED PROVIDERS CALL 1-800-293-3740. NON-CONTRACTED PROVIDERS WRITE TO UHC OF Long Term Care P.O. Box 30915, SALT LAKE CITY, UT 84130

---

### MEMBER

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#### CLAIMS

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**CLAIM TOTAL**: 42101.43
## PROVIDER REMITTANCE ADVICE

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FROM 06/09/13 TO 06/09/13
ICD9 DIAG 5990 56032

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**CLAIM TOTAL**
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**CLAIM TOTAL**
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### MEMBER NUMERER ACCOUNT NO.

**ADJUSTMENT ORIGINAL PAID DATE 07/11/12**
**CLAIM NO.**
FROM 06/16/12 TO 06/16/12
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**CLAIM TOTAL**
308.84

**-256.86**

**=-51.98**
CODE DESCRIPTIONS

PROV NO. 0050  NAME NORTHEAST MEDICAL CENTER

INELIGIBLE EXPLANATION CODES

0034 CHGS ABOVE ALLOWABLE/DON'T BILL MEMBER
0091 PRIMARY CARRIER PAID IN FULL
0292 REQUIRES NOTIFICATION/PLAN NOT NOTIFIED
0313 RESUBMISSION FILED AFTER TIME LIMIT
0482 MANUALLY SPLIT CLAIM DO NOT BILL MEMB

ADJUSTMENT EXPLANATION CODES

0018 COORDINATION OF BENEFITS
PROVIDER CLAIM DISPUTE RESOLUTION

For Long Term Care Medicaid claims, please contact the customer service center at 1-800-377-2055 before filing a claim dispute for assistance.

A provider may file a claim dispute with the contractor if the provider meets the requirements below:

Per ARS 36-2903.01(4): A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the program contractor within:

1) Twelve months after the date of service,
2) Twelve months after the date that eligibility is posted, or
3) Sixty days after the date of the denial of a timely claim submission, whichever is later.

AAC R9-34-404 indicates that the written claim dispute must state the factual and legal basis for the dispute and the relief requested. Failure to meet these requirements shall result in the denial of a claim dispute.

All claims disputes must be in writing and mailed to the contractor below:

UnitedHealthcare Community Plan
Long Term Care Claims
Attn: Provider Claim Dispute Coordinator
1 E. Washington Street, Suite 800
Phoenix, AZ 85004

A claim inquiry or research request does not extend the claim dispute filing deadlines.

In the event that the provider disagrees with the contractor’s decision, the provider may request a Hearing within 30 days of the decision. The contractor will forward the Hearing request to AHCCCS, Office of Grievance and Appeals.
Ch. 12 Claims Disputes and Appeals

Claims Research

UnitedHealthcare Community Plan can assist providers in resolving claims issues. The provider should call the Customer Call Center at 800-293-3740 for any questions regarding claims status on previously submitted claims.

Claim Disputes

Physicians and health care providers are required to submit claims timely or the claim may be subject to denial. Contracted providers must submit their original claim(s) within the contractual deadline of 90 days from the date of service or 60 days from the date of the primary carrier’s EOB. Please remember that submitted means the date the claim is received by the UnitedHealthcare Community Plan.

Should the provider receive a denial or reimbursement that does not meet the provider’s expectations for the submitted claim, the provider should exhaust all processing procedures before filing a claim dispute. If the physician or health care provider has exhausted all processing procedures and still has a disputed claim, the provider has the right to file a claim dispute with UnitedHealthcare Community Plan.

The claims dispute process should be used only after attempts to resolve the claims informally have failed. This chapter outlines the steps the provider should take prior to filing a claims dispute.

Providers are encouraged to contact the Customer Call Center or their provider relations advocate if they need assistance with understanding the payment amount or denial reason. UnitedHealthcare Community Plan asks providers to consider the following when determining if a claims dispute should be filed:

• Did you receive a provider remittance advice (PRA) with the claim in question listed?
• Was the claim resubmitted with the corrected information as identified on the PRA?
• Have you contacted the Customer Call Center or your provider relations advocate to discuss the claim in question?

Time Limits for Filing a Claim Dispute

A physician or health care provider must submit any claim dispute challenging the claim payments, denials or recoupments (adverse actions) in writing within 12 months (365 days) from the end date of service, 12 months after the date of eligibility posting, or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later. Upon receipt, the Claim Dispute coordinator will date stamp the request and that date will be considered the filing date for timeliness purposes. Refer to AAC R9-34-405 and ARS 36-2903.01(B)(4) for additional information.

If your claim has not been paid or denied, your letter will be returned.
Definitions:
• A timely submitted claim is one that has been originally submitted within the contractual deadline of 90 days from the date of service or 60 days from the date of the primary carrier’s EOB.
• An adverse action is a claim denial or payment reduction.
• Submitted means the date the claim is received by UnitedHealthcare Community Plan for processing.

Dispute Process
Please follow these steps to ensure proper review of your dispute:
1. Submit a cover letter indicating why you think your claim was under-paid or denied. Please include the following:
   • The date you wrote the letter.
   • Details of the reason for the dispute and your outcome/resolution expectations.
   • Any documentation supporting the facts.
   • The enrollee’s AHCCCS ID number, name, and date of service in question.
   • The writer’s signature.
2. A typed letter is preferred; however if you choose to handwrite your letter, make sure that it is legible.
3. Please use letterhead paper or include a correspondence address on your letter so we know where to send the resolution letter.
4. Include with the letter, if available:
   • A copy of the PRA from UnitedHealthcare Community Plan
   • A copy of the original claim
   • A copy of the Medicare EOB (if applicable)
   • A copy of the authorization (if applicable)
   • If you are a contracted provider and have specific rates associated to your contract, please include a copy of the rates page of your contract.
5. Mail the letter and attachments to:
   UnitedHealthcare Community Plan
   Attn: Provider Claim Disputes
   1 East Washington, Suite 800
   AZ009-800E
   Phoenix, AZ 85004

Upon receipt of a dispute, UnitedHealthcare Community Plan will mail an acknowledgement to the party identified on the request. This letter should be retained for future reference.

Upon investigation, UnitedHealthcare Community Plan will issue the provider a decision notice or a request for additional information and/or extension.

If UnitedHealthcare Community Plan makes a decision on the same day we open your dispute, an acknowledgement/decision letter will be mailed to the party identified on the request.

Dispute Resolution/Decision Letter

Reversal
If the physician or health care provider receives a decision letter in their favor, the claim will be forwarded to the claim unit for processing. All claims are subject to all routine claims processing edits and audits. If the submitted claim contains errors, omissions, or does not have the required documentation, the claim may be denied even though the decision was in your favor.
Denial

If the physician or health care provider receives a denial resolution/decision letter, the provider will have 30 days from the postmark to request, in writing, to the UnitedHealthcare Community Plan dispute coordinator, a state fair hearing. The provider must reference the dispute number and indicate that a request for state fair hearing is being filed. Further instructions are outlined in the decision letter.

Hearing Process

Upon receipt of a request for state fair hearing, UnitedHealthcare Community Plan will forward all documentation on file pertaining to the issue (e.g. claim, medical records, and decision) to the AHCCCS Administration.

When a hearing is requested, the AHCCCS administration will notify the provider in writing of a hearing date, time and location.

The Office of Administrative Hearings (OAH), an independent state agency, conducts all AHCCCS hearings. An administrative law judge (ALJ) from the OAH will conduct the hearing, review the facts, apply law, and make a recommendation to the AHCCCS Administration.

All requests and motions concerning the case must be submitted to the assigned ALJ. All requests must also be copied to any other party involved, including requests to appear telephonically.

The ALJ submits a “Recommended Decision” to the AHCCCS Administration within 20 days following the closure date of the hearing. AHCCCS will then issue a final decision 30 days from the date they receive the recommendation of the ALJ.

Dispute Submission

Suggestions/Reminders

The following are a few suggestions that will help prevent errors commonly made by providers when filing disputes:

- If a provider files a dispute concerning nonpayment but payment is made before a decision is rendered, the provider should submit a letter withdrawing the dispute.
- Once the claim is paid, if the provider is dissatisfied with the reimbursement, an additional dispute may then be entertained within the required time frames.
- Providers may not submit a dispute for claims that have not been submitted, paid or denied. These dispute letters will be returned to the providers.
- If a provider submits a dispute regarding timely filing of a claim, the provider should submit proof of timely filing (e.g. certified mail receipt/bill of lading) with the dispute documents or your dispute may be denied.
- If a dispute involves medical necessity/level of care, the provider should submit documentation to support medical necessity and/or the level of care requested.
- All disputes must be filed with specificity. The provider must explain why the dispute is being filed and why the provider believes that the claim was not processed or paid correctly AAC R9-34-404.
- Disputes should also include a copy of the original claim submission and all necessary payment information.
- The claim dispute department will not review requests for a retro authorization.

Claim dispute regulations and requirements are detailed on the provider remittance advice.
Ch. 13  Corporate Compliance - Fraud and Abuse

UnitedHealthcare Community Plan is committed to joining the Centers for Medicare & Medicaid Services (CMS) and AHCCCS in the prevention and detection of fraud. We also encourage our providers to do the same.

Definitions

Abuse of a member: Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual or emotional abuse or sexual assault. (A.R.S. § 46-451 and 13-3623).

Abuse by a provider: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program. (42 CFR 455.2).

Fraud by a member or provider: Intentional deception or misrepresentation made by a person or persons with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 CFR 455.2).

Examples of Fraud

Falsifying Claims/Encounters: Alteration of a claim, incorrect coding, double billing, and false data submitted.

Falsifying Services: Billing for services/supplies not provided, misrepresentation of services/supplies, or substitution of services.

Administrative/Financial: Kickbacks, falsifying credentials, fraudulent enrollment practices, fraudulent Third Party Liability (TPL) reporting, fraudulent recoupment practices.

Member Issues (Fraud) Eligibility

Determination Issues: Resource misrepresentation (transfer/hiding), residency, and household composition.

UnitedHealthcare Community Plan Responsibilities

UnitedHealthcare Community Plan Medicare and Medicaid Services (CMS) and AHCCCS are committed to the prevention and detection of fraud. Unchecked fraud has the potential for diverting dollars which could otherwise be spent to safeguard the health and welfare of people with limited income.

Each department of UnitedHealthcare Community Plan has a part in detection and prevention of Medicaid and Medicare fraud and abuse. To detect potential case of fraud and abuse, the various departments of UnitedHealthcare Community Plan do the following.

Provider Services is required to:

• Ensure a careful review of all participating providers during the credentialing/certification process (including re-credentialing),

• Monitor providers for non-compliance with UnitedHealthcare Community Plan and/or AHCCCS rules, policies and procedures.

Prior Authorization is required to verify:

• Member eligibility,

• Medical necessity,

• Appropriateness of service being authorized

• The service being requested is a covered service, and

• Appropriate provider referral
Claims Editors are Required to Review Claims During the Initial Processing for Items Such as:

- Member eligibility
- Covered services
- Excessive or unusual services for sex or age
- Duplication of services
- Prior authorization
- Invalid procedure codes
- Duplicate claims

Claims over a certain amount and any unusual items found during this review process will cause the claim to pend for review.

Post Processing Claims Reviewers Look Retrospectively at a Sample of Paid Claims to Determine the Following:

- Reasonable charges were made for services provided.
- Appropriateness of inpatient and outpatient care.
- Appropriate level of care.
- Excessive diagnostic testing or ancillary referrals.
- Payments are being prepared correctly.
- Payments are not being made to providers for services not performed, not authorized, or otherwise inappropriate.
- Test validity of the original claims process for detecting fraud and misuse.

Utilization/Quality Management controls include:

- Prior authorization and/or pre-admission review.
- Admission review.
- Concurrent review.
- Discharge review.

- Retrospective reviews for under and over service utilization.

Quality Management conducts regularly scheduled and ad hoc on-site reviews for concern report investigation and medical record audits.

If at any time during above processes an “unusual incident” is suspected or discovered, the matter would be referred to the UnitedHealthcare Community Plan, Compliance/Fraud and Abuse Officer or designee. The Contractor agrees to immediately (within 10 business days of discovery) inform the OIG in writing of instances of suspected fraud or abuse [42 CFR 455.1].

Provider Responsibilities

UnitedHealthcare Community Plan encourages providers to join in the prevention and detection of fraud and abuse. Summarized below are things providers can do to help preserve the Medicaid/Medicare systems for future generations.

Providers are asked to:

- Complete a pre-application for participation in the contract process, to be reviewed by UnitedHealthcare Community Plan provider relations. Credentialing criteria include, but are not limited to:
  - A complete, accurate and verified application,
  - Current Arizona professional license,
  - Proof of completion of education and training commensurate with the provider’s field of practice,
  - Review of any history of limitations, suspensions or restrictions of privileges,
  - Review of any felony convictions, substance abuse, and suspensions or terminations from the Medicaid or Medicare programs and/or debarment from the Department of Health and Human Services.
• Comply with all applicable federal, state and local laws, rules and regulations,
• Notify UnitedHealthcare Community Plan of any credentialing/licensure change,
• Maintain professional standards,
• Maintain and furnish records and documents as required by law, rule and regulation,
• Abide by contract provisions to avoid termination of the contract,
• Self-report errors in which fraud has unknowingly been committed,
• Report cases in which members are suspected of fraud,
• Refrain from engaging in kickbacks.

Self-Reporting to External Agencies

If the affected UnitedHealthcare Community Plan enrollee is in a skilled nursing facility, assisted-living facility, or a home and community-based setting (HCBS), the following agencies must be notified of the suspected abuse, fraud, negligence or exploitation, as appropriate:

• Adult Protective Services/Child Protective Services.
• Arizona Department of Health Services (except for incidents involving financial matters).
• Arizona health Care Cost Containment System (AHCCCS).
• Centers for Medicare and Medicaid Services (CMS).
• Local police department.

Notification of these agencies is not considered confirmation of abuse, fraud, negligence or exploitation. UnitedHealthcare Community Plan providers are required to notify these agencies so they may begin their own investigations of the incident as soon as possible. If the provider fails to notify the above agencies, it is UnitedHealthcare Community Plan’s duty to report cases once they have been discovered.
Provider Training & Awareness

Providers are encouraged to take the training on the AHCCCS website, “Fraud Awareness for Providers” http://www.azahcccs.gov/fraud/reporting/reporting.aspx.

Billing Educational Opportunities

New Provider Education

Ongoing Training

Additional educational information may be found on the following websites:

http://www.cms.hhs.gov/home/medicaid.asp

http://www.medicare.gov/FraudAbuse/HowToReport.asp

http://www.ahcccs.state.az.us/Site/RptFraud.asp

http://www.cms.hhs.gov/FraudAbuseforProfs/

References:

• Section 1903(q) of the Social Security Act
• Title 42 of the Code of Federal Regulations (42 CFR) 1007.1 through 1007.21
• 42 CFR 455.1 through 455.23
• Arizona Revised Statutes (A.R.S.) § 46-451
• A.R.S. § 13-3623
• Arizona Administrative Code R9-22, Article 5
• AHCCCS Contractors Operations Manual, Chap 100, 103-1 to 103-5
All employees and management to include contractors and agents will receive written information regarding the False Claims Act. The False Claims Act and Whistle-blower Training includes information on the following:

False Claims Act (FCA): United States Code Title 31 § 3729-3733:

- The False Claims Act, also known as the “Lincoln Law,” dates back to the Civil War.
- The original law included “qui tam” provisions that allowed private persons to sue those who defrauded the government and receive a percentage of any recovery from the defendant.
- Providers are required to train their staff on the following aspects of the Federal False Claims Act provisions:
  a. The administrative remedies for false claims and statements;
  b. Any state laws relating to civil or criminal penalties for false claims and statements;
  c. The whistleblower protections under such laws

Activities Covered by the FCA:

- Knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment;
- Knowingly using (or causing to be used) a false record or statement to get a claim paid by the federal government;
- Conspiring with others to get a false or fraudulent claim paid by the federal government; and;
- Knowingly using (or causing to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the federal government;
- In general, the False Claims Act covers fraud involving any federally funded contract or program, with the exception of tax fraud

Liability for Violating the FCA:
- Three times the dollar amount that the Government is defrauded (i.e., treble damages) and civil penalties of $5,500 to $11,000 for each false claim.

Types of Fraud Prosecuted Under the FCA:
It is impossible to list all of the frauds that have been prosecuted under the False Claims Act, but the following list gives some idea of the scope of the false claims on the government that have been uncovered to date:

- Billing for goods and services that were never delivered or rendered.
- Billing for marketing, lobbying or other non-contract related corporate activities.
- Submitting false service records or samples in order to show better-than-actual performance.
- Presenting broken or untested equipment as operational and tested.
- Performing inappropriate or unnecessary medical procedures in order to increase Medicare reimbursement.
- Billing for work or tests not performed.
- Billing for premium equipment but actually providing inferior equipment.
- Automatically running a lab test whenever the results of some other test fall within a certain range, even though the second test was not specifically requested.
- Defective testing - Certifying that something has passed a test, when in fact it has not.
- “Lick and stick” prescription rebate fraud and “marketing the spread” prescription fraud, both of which involve lying to the government about the true wholesale price of prescription drugs.
• Unbundling - Using multiple billing codes instead of one billing code for a drug panel test in order to increase remuneration.

• Bundling - Billing more for a panel of tests when a single test was asked for.

• Double billing - Charging more than once for the same goods or service.

• Upcoding - Inflating bills by using diagnosis billing codes that suggest a more expensive illness or treatment.

• Billing for brand - Billing for brand-named drugs when generic drugs are actually provided.

• Phantom employees and doctored time slips: Charging for employees that were not actually on the job, or billing for made-up hours in order to maximize reimbursements.

• Upcoding employee work: Billing at doctor rates for work that was actually conducted by a nurse or resident intern.

• Yield burning - skimming off the profits from the sale of municipal bonds.

• Falsifying natural resource production records - Pumping, mining or harvesting more natural resources from public lands that is actually reported to the government.

• Being over-paid by the government for sale of a good or service, and then not reporting that overpayment.

• Misrepresenting the value of imported goods or their country of origin for tariff purposes.

• False certification that a contract falls within certain guidelines (e.g. the contractor is a minority or veteran).

• Billing in order to increase revenue instead of billing to reflect actual work performed.

• Failing to report known product defects in order to be able to continue to sell or bill the government for the product.

• Billing for research that was never conducted; falsifying research data that was paid for by the U.S. government.

• Winning a contract through kickbacks or bribes.

• Prescribing a medicine or recommending a type of treatment or diagnosis regimen in order to win kickbacks from hospitals, labs or pharmaceutical companies.

• Billing for unlicensed or unapproved drugs.

• Forging physician signatures when such signatures are required for reimbursement from Medicare or Medicaid.

How and when an individual can receive an award for blowing the whistle under the FCA?

• You must file a qui tam lawsuit. Merely informing the government about the False Claims Act violation is not enough.

• The whistleblower that files a False Claims Act suit receives an award only if, and after, the government recovers money from the defendant as a result of the lawsuit.

How much money can an individual receive for filing a qui tam lawsuit?

• Generally, the court may award between 25 and 30 percent of the total recovery from the defendant, whether through a favorable judgment or settlement.

• The amount of the award depends, in part, upon: if the government participates in the suit and the extent to which the person substantially contributed to the prosecution of the action.

Is A Whistle Blower Protected Under the FCA?

• Under Section 3730(h) of the False Claims Act, any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the Act is entitled to any relief necessary to make the employee whole.
Contracted Providers are required by contract to train their staff on the following aspects of the Federal False Claims Act provisions:

- The administrative remedies for false claims and statements;
- Any state laws relating to civil or criminal penalties for false claims and statements;
- And the whistleblower protections under such laws.

UnitedHealthcare Community Plan will provide the required information at least annually through dissemination of written information through our Provider Newsletters and/or information distributed and documented at provider site visits.

Contracted providers’ compliance with AHCCCS DRA training requirements is accomplished through a combination of contract amendment to add detailed training requirements and/or provider attestations statements. Monitoring of provider compliance will be conducted by the Office of Inspector General.

UnitedHealthcare Community Plan will research potential overpayments identified by the AHCCCS Office of Inspector General. After conducting a cost-benefit analysis to determine if recoup action is warranted, UnitedHealthcare Community Plan will attempt to recover any overpayments identified. The AHCCCS Office of Inspector General shall be advised of the final disposition of the research and actions, if any, taken by UnitedHealthcare Community Plan.

Additional information sources available are:
State statutes relating to false claims: Arizona Revised Statutes (ARS)
- ARS 13-1802: Theft
- ARS 13-2002: Forgery
- ARS 13-2310: Fraudulent schemes and artifices
- ARS 13-2311: Fraudulent schemes and practices; willful concealment
- ARS 36-2918: Duty to report fraud

Websites for obtaining additional information:
Arizona Revised Statutes
www.azleg.state.az.us/
ArizonaRevisedStatutes.asp

Deficit Reduction Act – Public Law 109-171
www.gpoaccess.gov/plaws/index.html
(insert public law 109-171 in the quick search box)
All adult ALTCS enrollees in hospitals, nursing facilities, hospices and other health care settings have certain rights, including those defined in federal law as an “Advance Directive.” All contracted hospitals, nursing facilities, home health agencies, hospices and other organizations responsible for providing personal care must comply with federal and state law regarding Advance Directives for adult enrollees.

Each provider must provide written information to adult enrollees regarding medical care and the health care provider’s written policies concerning Advance Directives. Providers must document in the enrollee’s medical record whether an Advance Directive has been executed. Providers may not discriminate against an enrollee because of his or her decision to execute or not execute an Advance Directive and cannot make it a condition for provision of care. These providers must also provide education to staff on issues concerning Advance Directives including notification of direct care provider of services, such as home health care and personal care, of any Advance Directives executed by enrollees to whom they are assigned to provide services.

All contracted PCPs must document in the UnitedHealthcare Community Plan enrollee’s medical record whether or not the adult enrollee has been provided the Advance Directive information and whether an Advance Directive has been executed. Hospitals, nursing facilities, home health agencies, hospice and organizations responsible for providing personal care will provide a copy of the enrollee’s executed Advance Directive, or documentation of refusal to the enrollee’s PCP for inclusion in the enrollee’s medical record.

UnitedHealthcare Community Plan is required to provide written information to adult enrollees that describe the enrollee’s rights relating to Advance Directives. The narrative set out below is given to ALTCS enrollees by AHCCCS to inform them of their Advance Directive rights and is quoted directly to inform health care providers of ALTCS enrollees’ rights in this regard:

“You have the right to have your personal and medical records kept private. You also have the right to know what treatment you will receive. As of Dec. 1, 1991, per federal law, you have the right to fill out a paper known as an “Advance Directive.” The paper says, in advance, what kind of treatment you want, or do not want. This paper is very useful when you are unable to tell medical staff of your wishes.”

The questions and answers below will help explain this law. It requires hospitals, nursing centers and other health care providers to inform you of Advance Directives. It will explain your legal choices in making decisions about medical care. The law is intended to increase your control over medical treatment decisions.

**Q: Who has the right to make health care decisions?**

**A:** You do, if you are able to make and let health care providers know of your health care decisions. You decide what health care, if any, you will not accept.

**Q: What if I become unable to make or let health care providers know of my health care decisions?**

**A:** You can still have some control over these decisions if you have signed an Advance Directive. Your health care provider must include in your medical record whether you have signed an Advance Directive. If you have not named someone in your Advance Directive, your doctor must seek a person authorized by law to make these decisions.
Q: What is an Advance Directive?

A: It is a written statement about how you want your health decisions made. Under Arizona law, there are three common types of Advance Care Directives. These are:

1. **A Health Care Power of Attorney** – a written statement in which you have an adult to make health care decisions for you only when you cannot make or let others know of such decisions.

   The Health Care Power of Attorney must:
   - State the name of the person you have permitted to make health care decisions for you.
   - State that this person can only make health care decisions for you when you cannot, if that is what you want.
   - Be dated and signed by you.

   Your Health Care Power of Attorney may also:
   - Include any details or guidance about health care you want or do not want. This could include withholding or withdrawing procedures if you are in a “terminal condition.”
   - Name a second person to make these decisions if the first person is not able to do so.
   - Include signatures of witnesses and a notary public that saw you sign the Power of Attorney.

2. **A Living Will** – a written statement about health care you want or do not want that is to be followed if you cannot make these decisions. For example, a Living Will can say whether you would want to be fed through a tube if you were unconscious and unlikely to recover. A Living Will may direct doctors to withhold/withdraw or continue life-sustaining procedures if you are in a “terminal condition.” For instance, a Living Will can tell whether you want to be fed through tubes if you cannot eat or drink. You can also tell doctors whether to use other life-sustaining procedures. Your doctors will use your Living Will only if you are not able to make or state your health care decisions. Even if you have a Living Will, you can be kept comfortable with drugs and other procedures if this is what you want.

   To make a valid Living Will:
   - Sign and date your Living Will in front of two witnesses who must also sign it.
   - Neither witness may be directly involved in your care.
   - In addition, one of the witnesses must not be related to you by blood or marriage; have a right to receive any of your estate; have a claim against the estate; or directly pay for your medical care.

3. **A Pre-Hospital Medical Care Directive** – a directive refusing certain lifesaving emergency care given outside a hospital or in a hospital emergency room. To make one, you must complete a special orange form. A Pre-Hospital Medical Directive must be completed as required by law. The form will list the following treatments you may refuse:

   - Chest Compression (chest pressure to restart your heart)
   - Defibrillation electronically correcting the heart beat)
• Assisted ventilation (breathing by machine)
• Intubations (supplying air through a tube down the throat)
• Advanced life support medications

You should talk to your doctor about Pre-Hospital Directives if you are thinking about signing one. In addition, a Pre-Hospital Directive must:
• Be signed or marked by you and dated
• Be signed by a licensed physician or health care provider and a witness

If you have signed an orange Pre-Hospital Medical Directive, you may also wear a special orange bracelet. It must state your name, your doctor’s name, and the words “Do not resuscitate.” The bracelet will call to the attention of emergency medical personnel that you have completed the form and that you do not want the emergency medical care you have checked on the form. These directives used separately or together, can help you say “yes” to treatment you want and “no” to treatment you do not want.

Q: Must my Advance Directives be followed?
A: Yes. Both health care providers and the person you name in your directive must follow valid Advance Directives.

Q: Must a lawyer prepare my Advance Directive?
A: No. There are local and national groups that may provide you with facts on Advance Directives, including forms. Be sure any Advance Directive you use is valid under Arizona law.

Q: Who should have a copy of my Advance Directive?
A: Give a copy of your Advance Directive to your doctor and to any health care center upon your admission. If you have a Health Care Power of Attorney, give a copy to the person you have named on it. You should also keep extra copies for yourself.

Q: Can I be required to make an Advance Directive?
A: No. Whether you make an Advance Directive is entirely up to you. A health care provider cannot refuse care based on whether or not you have an Advance Directive.

Q: Can I change or cancel my Advance Directives?
A: Yes. If you change or cancel your Advance Directive, let anyone know who has a copy of it.

Q: What if I already have an Advance Directive?
A: You may want to review it or have it reviewed. If it has been prepared in another state, make sure it is valid under Arizona law. If you prepared it before September 1992, you should know the law has changed, and new choices are available to you.

Q: Does Arizona law limit what can be done under an Advance Directive?
A: The Arizona law does not allow actions or inactions, which may lead to the injury, or death of physically or mentally impaired adults. It is unclear whether this law will be applied to the health care decision-making process. It is important to have a properly prepared Advance Directive that state your wishes as to the treatment(s) you do/do not want.
Q: Who can legally make health care decisions for me if I cannot make those decisions and I have no Advance Directive?

A: A court may appoint a guardian to make health care decisions for you. Otherwise, your health care provider must go down the following list to find someone else to make health care decisions for you:

- Your husband or wife, unless you are legally separated
- Your adult child. If you have more than one adult child, a majority of them
- Your mother or father
- Your domestic partner, unless someone else has financial responsibility for you
- Your brother or sister
- A close friend of yours (someone who shows special concern for you and knows your health care views)

If your health care provider cannot find a person able to make health care decisions for you, then your doctor can decide. Your doctor can do this with the advice of an ethics committee, or with the approval of another doctor.

You can keep anyone from making decisions for you by saying so in writing. The person you name in your Advance Directive will not have the right to refuse the use of tubes to give you food or fluids unless:

- You have appointed that person to make health care decisions for you in a Health Care Power of Attorney
- A court has appointed that person as your guardian to make health care decisions for you
- You have stated in an Advance Directive that you do not want this “specific treatment”
Ch. 16 Credentialing/Re-Credentialing

All physician and health care providers providing health services to UnitedHealthcare Community Plan enrollees must be credentialed in accordance with UnitedHealthcare Community Plan’s policies and procedures. Beginning in 2009, all credentialing will take place through United HealthCare’s National Credentialing Committee.

Under CMS regulation, the credentialing process and approval must be completed before providing care to a UnitedHealthcare Community Plan enrollee. In addition, UnitedHealthcare Community Plan follows this policy for all contracted ALTCS providers.

Re-credentialing will occur every three years thereafter for all contracted physicians, other health care providers, facilities, and hospitals.

The following items are required to complete primary source verification:

**Physician and Health Care Providers**

- Five-year work history
- State License
- DEA & CDS (controlled dangerous substances) certificates
- Malpractice Insurance Coverage and History
- Education and Training
- Board Certification
- Hospital Privileges
- NPDB/HPDB query
- Medicare/Medicaid Sanctions
- Disclosure Statement and Signed Attestation
- Verification of “Opt Out” or Private Contract from Medicare participation

**Skilled Nursing Facility Credentialing**

- Medicare, Medicaid, CARF, CHAPS, or JCAHO accreditation
- Copy of License
- Copy of Professional Liability Certificate

The credentialing process is considered complete when the credentialing committee approves the credentialing application. The physician or health care provider will be notified by Provider Relations and issued a UnitedHealthcare Community Plan provider number once the credentialing process has been completed.

**Medical Record Review**

PCPs and mid-level practitioners (e.g. NPs and PAs) that have more than 50 UnitedHealthcare Community Plan enrollees under their care will have 5 percent of their medical records reviewed to meet the re-credentialing criteria. The medical record review will be audited for the following 14 items:

1. Identifying information on the enrollee
2. Identification of all physician and health care providers participating in the enrollee’s care and information on services furnished by these physician and health care providers
3. Is there a completed problem list?
4. Are all entries signed/initialed?
5. Are all entries dated?
6. Is the record legible?
7. Are allergies/adverse reactions prominently displayed?
8. Is there evidence of an advanced directive in the enrollee’s chart?
9. Is there evidence of prescribed medications, including dosages and dates of initial or refill prescriptions?

10. Is there evidence of past medical history, physical examination treatments, treatments necessary, and possible risk factors for the enrollee relevant to the particular treatment?

11. Are problems from previous visits addressed?

12. Evidence of follow up for abnormal test results

13. Evidence of presenting complaints, diagnoses and treatment plan

Office Visits for PCP’s and High Volume Specialists

All PCP’s and high-volume specialists that see non-institutionalized UnitedHealthcare Community Plan enrollees may be required to have an office visit to complete initial credentialing or re-credentialing, if not captured during initial credentialing. An office visit will consist of an UnitedHealthcare Community Plan representative walking you through your office or clinic and assessing handicap accessibility and safety of the clinic. You will be notified in advance if you will have an office visit. This office visit is a regulatory requirement.

Adverse Credentialing Determination Appeals

Physicians or other health care providers must meet UnitedHealthcare Community Plan’s rules for continued participation in UnitedHealthcare Community Plan. Physicians or other health care providers receive written notice of such rules in the contract between the physician and UnitedHealthcare Community Plan (provider contract), in UnitedHealthcare Community Plan’s credentialing policies and procedures, and other communication vehicles from time to time. If UnitedHealthcare Community Plan makes an adverse determination regarding a physician’s continued participation, the physician will be notified of such decision in writing and given an opportunity to initiate a formal appeal.
Network Development

The Network Management Department is responsible for developing the UnitedHealthcare Community Plan network in Apache, Coconino, Maricopa, Mohave, Navajo, Pima, Santa Cruz, Yuma, La Paz, and Yavapai Counties. Network Management conducts contract negotiations and re-negotiations and considers many factors in potential contracting decisions are:

• Geographic needs based on AHCCCS standards
• Geographically convenient flow of patients among providers
• Access to at least equal to or better than community norms for UnitedHealthcare Community Plan members
• Accessible services in terms of timeliness, amount, duration and scope as those available to non-ALTCS person within the same service area
• Amount of membership versus number of providers or provider types in a given area
• Enrollee accessibility
• Quality and reputation of the provider
• The needs and service requirements of AHCCCS’ culturally and linguistically diverse member population
• Maximum availability of community based primary care and specialty care access that can reduce emergency room services and hospital admissions

If you are interested in becoming a contracted provider, please submit a letter of interest to:

UnitedHealthcare Community Plan
Attn: Provider Relations
1 East Washington, Suite 800
AZ009-800E
Phoenix, AZ 85004

UnitedHealthcare Community Plan will review your request. If UnitedHealthcare Community Plan determines the need to contract, you will need to submit additional information (such as a W9, sample claim form, licensure, proof of insurance) in order to proceed with the contract. If UnitedHealthcare Community Plan declines your request to contract, you will receive a letter informing you of why your request was declined.

Once a provider is contracted, the provider is assigned to a provider relations advocate in the Provider Relations department.

Utilizing Your Provider Relations Advocate

New providers will receive an initial orientation as well as periodic focused training by provider type. Your provider relations advocate is available to assist you with your contract, training and orientation needs. For questions concerning the status of a claim, please contact the UnitedHealthcare Community Plan Customer Call Center. If the Customer Call Center is unable to resolve your question, you will be referred to your appropriate provider relations advocate for additional assistance.

Provider relations meets provider communication needs through site visits, provider meetings, provider newsletters, targeted mailings, provider surveys, provider manuals, provider agreements and conference calls. These communications can include prior authorization processes, claims submissions and dispute processes, contractual issues, fraud and abuse, eligibility verification, behavioral services, advanced directives, credentialing, cultural competency awareness, EPSDT, family planning, training on non-provision of service, appointment accessibility and availability and other Medicare and Medicaid issues of importance to providers. Provider relations also conducts monitoring of credentialing status, appointment standards, claims disputes and encounters, provider network and availability, and licensure verification.
Your provider relations advocate will assist in ensuring that all your necessary provider paperwork is current. UnitedHealthcare Community Plan requires you to supply copies of all updated and current licensures, insurance liability coverage, AHCCCS registration, W-9 form, sample claim form, etc., in a timely fashion as required in your contract. Failure to provide this information may result in non-payment of services rendered or termination of your contract with UnitedHealthcare Community Plan. UnitedHealthcare Community Plan requires you to contact your provider relations advocate immediately upon making a change in AHCCCS registration, business ownership, licensure, or insurance liability coverage to avoid reimbursement discrepancies.

You have only one provider relations advocate for all UnitedHealthcare Community Plan products that you are contracted with. Your Provider relations advocate will schedule periodic visits with you or as needed or requested. During these visits, they will review changes to policies and procedures that affect your office, review your provider information for accuracy and current status, provide initial orientation and follow-up training, perform compliance with office standards for quality purposes, exchange ideas and discuss any issues or problems that have occurred. UnitedHealthcare Community Plan encourages providers to give the provider relations advocate feedback about how UnitedHealthcare Community Plan is doing and how satisfied you are with UnitedHealthcare Community Plan.

If you are not sure who your provider relations advocate is, please contact UnitedHealthcare Community Plan at 800-377-2055 and listen for the Provider Relations prompt.

Contact your provider relations advocate for questions regarding:

- Changes in physician and health care provider information, including clinic name, address, telephone number or Federal Tax Identification Number
- If you open or close an office
- If your clinic has reached capacity and you are no longer accepting new patients. Please provide the effective date and date anticipated for accepting new patients.
- Contract administration issues
- Credentialing and re-credentialing issues
- Reimbursement issues, fee schedules, coding questions that the Customer Call Center is unable to assist you with
- Specific information about UnitedHealthcare Community Plan’s policies and procedures
- Training for billing and claim submission
- To request copies of current benefit plan documents
- General education needs

Visit the UnitedHealthcare Community Plan website for general information about the UnitedHealthcare Community Plan program and to view current information regarding UnitedHealthcare Community Plan’s:

- Comprehensive and Abridged Formulary
- Provider Directories
- Provider Forms
- Provider Manual
- Recent changes to Provider Manuals
- Recent Provider Newsletter
- Clinical Practice Guidelines
- General Updates

Visit the UnitedHealthcare Community Plan website for general information about the UnitedHealthcare Community Plan program and to view current information regarding UnitedHealthcare Community Plan’s:
Network Management

UnitedHealthcare Community Plan reviews its networks regularly to determine potential gap areas, areas where membership growth requires additional providers and areas where the network is over saturated. The provider relations advocate helps to monitor the services within their assigned territories and work with the Network Development department to obtain additional contracts.

The network is determined by a variety of factors, primarily based on membership and utilization patterns. You can help us keep our network accurate by notifying us of changes to your office or service area locations, additions or terminations of providers within your office, or addition or elimination of services that you provide.

We request that you notify Provider Relations promptly with any changes, including changes that will affect credentialing, certification, liability coverage, AHCCCS registration changes etc. Timely notification will also reduce the risk of reimbursement complications due to the changes.

Provider Agreements

UnitedHealthcare Community Plan uses a standard provider agreement when subcontracting with physicians, hospitals, ancillary services, nursing and assisted living facilities. This contractual agreement may be changed from time to time in order to conform to current state and federal policies and trends. All provider agreements are “evergreen” and do not have a renewal date. The provider agreements remain in place until either party request in writing otherwise, as outlined in the provider agreement.

All skilled nursing facilities, assisted-living facilities and home and community-based providers are reviewed annually prior to the beginning of a new AHCCCS contract year.

All physician and health care provider agreements comply with the applicable state and federal regulations as applicable to the UnitedHealthcare Community Plan product, such as regulations and policies established by the Centers for Medicare and Medicaid Services, AHCCCS and set forth in the Arizona Administrative Code, Article 4, Contracts, Administration and Standards. Each UnitedHealthcare Community Plan physician and health care provider agreement contains the minimum subcontract provisions established by AHCCCS and are updated annually as AHCCCS updates.

All questions concerning your provider agreement should be directed to your provider relations advocate.

Contract Concerns or Complaints

If you have a concern or complaint about your agreement with us, please contact the local UnitedHealthcare Community Plan office in writing containing the details of your concern or complaint. Your provider relations advocate will look into your complaint and try to resolve it through informal discussions. If you disagree with the outcome of this discussion, an arbitration proceeding may be filed as described below and in our agreement.
Arbitration

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

ALTCS Change of Program Contractor Policy

The information provided in this chapter is the AHCCCS policy “Enrollment Choice in a Choice County and Change of Contractor Policy”, revised Aug. 8, 2001, regarding enrollee enrollment. For more information on AHCCCS policies, visit www.azahcccs.gov.

UnitedHealthcare Community Plan recognizes that AHCCCS has the exclusive authority to enroll and dis-enroll members. UnitedHealthcare Community Plan does not dis-enroll any members for any reason unless directed to do so by AHCCCS.

ENROLLMENT CHOICE IN A CHOICE COUNTY AND CHANGE OF CONTRACTOR POLICY: ARIZONA LONG TERM CARE SYSTEM (ALTCS), ELDERLY/PHYSICALLY DISABLED (EPD) CONTRACTORS

I. Purpose
This policy applies to ALTCS/EPD contractors. This policy establishes guidelines, criteria and timeframes for how, when and by whom enrollment choice in a choice county and contractor change requests will be processed for ALTCS enrollees. This policy applies to Arizona Long Term Care (ALTCS) Contractors only (hereafter referred to as contractors). This policy delineates the rights, obligations and responsibilities of:

- The enrollee
- The enrollee’s current contractor
- The receiving contractor, and
- The AHCCCS administration,

In facilitating continuity of care, quality of care and efficient and effective program operations and in responding to administrative issues regarding enrollee notification and errors in assignment.

II. Definitions

ALTCS Local Office: The ALTCS local office currently responsible for the enrollee’s financial eligibility case record.

Anniversary Date: The month for which the enrollee is entitled to make an annual enrollment choice. The anniversary date is typically 12 months from the date enrolled with the contractor and annually thereafter.

Choice County or Geographic Service Area (GSA): A county or GSA with more than one ALTCS Contractor.

County of Fiscal Responsibility: The county that is financially responsible for the state’s share of ALTCS funding.

Current Contractor: The contractor with whom the enrollee is enrolled at the time the change request is generated.

Day: Day means a calendar day unless otherwise specified.

Receiving Contractor: The contractor to whom the enrollee is being changed.

Requested Contractor: The contractor to whom the enrollee wants to change.
III. Policy
Some, but not all, ALTCS applicants and enrollees who reside in a choice county or who are planning to move to a choice county must be offered an opportunity to choose a contractor.

A. Enrollment Choice in a Choice County

1. Individual Entitled to Enrollment Choice
   a. An individual is entitled to enrollment choice when:
   b. An applicant resides in a choice county and a choice county is the county of fiscal responsibility.
   c. An enrollee moves from another county to his or her own home in a choice county, unless the enrollee’s current contractor is available in the choice county.
   d. An enrollee moves from another county to a nursing facility or alternative residential setting in a choice county and the current contractor has chosen to negotiate an enrollment change.
   e. An enrollee is currently enrolled with a contractor serving a choice county, but a valid condition exists (see Section B) for requesting an enrollment change to another contractor serving a choice county.
   f. A former enrollee resides in a choice county and reestablishes eligibility that results in reenrollment more than 90 days after disenrollment.
   g. An enrollee attains the annual anniversary date.

2. Individual Who Does Not Have Enrollment Choice
   a. This policy does not apply to the following individuals:
   b. An enrollee who is developmentally disabled
   c. An enrollee who is a Native American with on-reservation status
   d. A choice county resident whose county of fiscal responsibility is not a choice county (unless the current contractor chooses to negotiate a change to that choice county)
   e. An enrollee who was disenrolled from a Contractor in a choice county, but subsequently reestablishes ALTCS eligibility that results in reenrollment within 90 days from disenrollment.
   f. Residents of counties other than a choice county, unless a choice county is the county of fiscal responsibility.
   g. An enrollee who moves to a choice county and his or her current contractor is available in that choice county.

3. Initial Enrollment Process
The initial enrollment process is used to obtain enrollment choice from an ALTCS/EPD applicant whose county of fiscal responsibility is a choice county.
Stage Description
1 ALTCS staff provides the applicant with
   • An explanation of enrollment choice
   • Marketing materials from the Contractors serving the choice county
   • Assistance in choosing a contractor
2 ALTCS staff obtains an enrollment choice before the application is approved
3 Ongoing enrollment is prospective, effective the date the application is approved.
   Prior period coverage is effective retroactive to the first day of the first eligible month, unless the enrollee is being transferred from an acute contractor to an ALTCS contractor.

4. Re-enrollment After Disenrollment
When an enrollee, whose county of fiscal responsibility is a choice county, is disenrolled due to loss of ALTCS eligibility, but is subsequently determined eligible within 90 days from the date of disenrollment, the enrollee will be reenrolled with the former contractor, if that contractor is still available. If that contractor is not available, the enrollee will be given the opportunity to choose a contractor.

When reenrollment occurs more than 90 days after the disenrollment, or another valid reason for change exists, the enrollee will be given the opportunity to choose a contractor.

When an enrollee is reenrolled within 90 days, the anniversary date is determined by the previous enrollment date. The enrollee may choose to enroll with a different contractor on his/her anniversary date, which is established by the initial enrollment with that contractor.

5. Enrollment Choice Process For Fiscal County Changes
An enrollment choice must be obtained before an enrollee's enrollment can be changed to a contractor serving a choice county. The enrollment choice process applies to an ALTCS enrollee who moves to a choice county to:
   • His or her own home
   • A nursing facility or alternative residential setting and the current Contractor requests an enrollment choice in order to negotiate an enrollment change with a contractor in a choice county.

The enrollment choice process consists of the following steps:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
</table>
| 1     | The ALTCS local office provides the enrollee with:
   • An explanation of enrollment choice
   • Marketing materials from each of the Contractors serving a choice county
   The enrollee is asked to provide a choice prior to actually moving or within 10 days of our request. |
| 2     | The ALTCS local office provides the enrollee with assistance in making the decision throughout the process. |
| 3     | When the enrollee does not make a choice within 10 days, the ALTCS local office sends an Enrollment Choice Reminder Notice asking the enrollee to provide a choice within the next 10 days. |
B. Identifying and Processing Requests for Contractor Changes Within a Choice County

Generally, once enrollment occurs an enrollee cannot change enrollment until their anniversary date. This is called Annual Enrollment. However, an enrollment change from one choice county contractor to another choice county contractor can be made for certain reasons.

1. Medical Continuity of Care Requests

In unusual situations, special contractor changes may be approved on a case-by-case basis to ensure the enrollee’s access to care. These situations generally involve existing conditions at the time of enrollment as opposed to new conditions that develop after enrollment. The following special process is required:

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The enrollee’s PCP must provide documentation to the medical directors of both contractors that support the need for a contractor change. Both contractors must be reasonable in the request for documentation.</td>
</tr>
</tbody>
</table>
| 2    | The medical directors of both contractors must approve the change.  
• In order to provide continuity of care on a temporary basis for the enrollee's period of illness, the current Contractor may agree to reimburse the enrollee’s provider for service rather than approve a Contractor change.  
• If one of the Contractors denies the request, the change request is forwarded to the AHCCCS Medical Director for a final decision. |
| 3    | When both contractors approve the change, the receiving contractor sends the completed Program Contractor Change Request Form (DE-621) to the Program Contractor Change Request Coordinator at AHCCCS Central Office Field Operations.  
When the requested contractor denies the request, the DE-621 is returned to the current contractor who may forward the DE-621 to the AHCCCS medical director. |

4. If the AHCCCS medical director approves the change, the DE-621 is returned to the current contractor to negotiate the effective date of the change. The current contractor sends the DE-621 to the Program Contractor Change Request Coordinator at AHCCCS Central Office Field Operations.

5. The Program Contractor Change Request Coordinator processes the change.

6. If the Change request is denied by the AHCCCS medical director, the Division of Health Care Management/ALTCS Unit will provide written notice of the denial including notice of appeal rights to the enrollee and to both the current and receiving/requested contractors.

2. Valid Conditions (Excluding Medical Continuity of Care)

When any of the following conditions exist, an ALTCS local office may authorize a change of contractors within a choice county.

a. Erroneous network information or agency error: The applicant or representative made an enrollment choice based on erroneous information regarding facility, residential setting, PCP or other provider contracting with the chosen contractor based on information supplied by the network database, marketing materials, or agency error. Erroneous information includes omissions or failure to divulge network limitations and restrictions in the contractor’s marketing material or database submissions.

b. Lack of initial enrollment choice: An ALTCS applicant residing in a choice county is, for any reason, not offered a choice of contractors during the application process.
c. Lack of annual enrollment choice: The enrollee was entitled to participate in an Annual Enrollment Choice but was not sent an Annual Enrollment Choice notice or the notice was not received, or was sent an Annual Enrollment Choice notice but was unable to participate in the Annual Enrollment Choice due to circumstances beyond the enrollee’s control (e.g., enrollee or representative was hospitalized, anniversary date fell within a 90 day disenroll/reenroll period).

d. Family continuity of care: The enrollee, either through auto-assignment or the choice process, is not enrolled with the same contractor as the other family enrollees. To promote continuity of care, family enrollees, such as married couples, may choose to be enrolled with the same contractor.

e. Continuity of institutional or residential setting: The enrollee’s contractor terminates their contract with the institutional or residential setting in which the enrollee resides, and the enrollee or the enrollee’s representative requests to change to a contractor who contracts with their institutional or residential setting. The enrollee must be enrolled and living in the facility at the time of the contract termination.

f. If the provider (nursing facility or alternative residential setting) terminates the contract, the Local Office will request instructions from the Division of Health Care Management/ALTCS Unit before making any changes.

g. Failure to correctly apply the 90-day reenrollment policy: The enrollee lost ALTCS eligibility and was disenrolled, was subsequently reapproved for ALTCS within 90 days of the disenrollment date, but was enrolled with a different contractor.

3. Processing Enrollment Change Requests
The following procedures apply when an enrollee requests a change of contractors within a choice county.

<table>
<thead>
<tr>
<th>When...</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>The enrollee makes the request for a change to the contractor and claims a valid condition exists</td>
<td>The contractor will report the request to the Local ALTCS Office using the ALTCS Enrollee Change Report Form (DE-701).</td>
</tr>
<tr>
<td>The ALTCS local office receives a change request from a contractor or an enrollee.</td>
<td>The ALTCS local office will investigate the request to determine if a valid condition exists</td>
</tr>
<tr>
<td>The ALTCS local office determines that a valid change condition exists.</td>
<td>The ALTCS local office will change the enrollee’s enrollment to the contractor the enrollee chooses. The enrollment change is effective the day the change is processed by the ALTCS local office</td>
</tr>
<tr>
<td>The ALTCS local office determines that the nursing facility or alternative residential setting terminated the contract.</td>
<td>The ALTCS local office will send written request to the DHCM ALTCS Unit Manager and my change the enrollment only if approved in the response.</td>
</tr>
</tbody>
</table>
| The ALTCS local office determines that a valid situation does not exist. | The ALTCS local office will:  
  • Send the enrollee a Denial of Program Contractor Change Request (DE-548) denying the request and giving the enrollee the right to appeal the decision.  
  • Refer the enrollee to his or her current contractor for resolution of existing issues. |
C. Fiscal County and Enrollment Change Policies

1. Placements by a Contractor
   When a contractor places an enrollee in a nursing facility or alternative residential setting in a different county (either to receive specialized treatment or because of lack of beds in the contractor’s county), the county of fiscal responsibility and enrollment do not change.

2. Moves Initiated by the Enrollee or the Enrollee’s Family
   When an enrollee moves from one county to another county, the county of fiscal responsibility and enrollment are determined according to the following:

<table>
<thead>
<tr>
<th>If the Enrollee Moves to...</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>His or her own home</td>
<td>County of Fiscal Responsibility</td>
</tr>
<tr>
<td></td>
<td>• The county of fiscal responsibility changes to the (new county) county in which the home is located.</td>
</tr>
<tr>
<td></td>
<td>Enrollment</td>
</tr>
<tr>
<td></td>
<td>• Enrollment remains unchanged if the same contractor serves both counties.</td>
</tr>
<tr>
<td></td>
<td>• Enrollment changes if the enrollee moves to a county served by a different contractor.</td>
</tr>
<tr>
<td></td>
<td>• The Enrollment Choice process must be completed prior to enrollment and Fiscal County changes if the home is located in a choice county and the current contractor is not available in that choice county.</td>
</tr>
<tr>
<td>A nursing facility or an alternative residential setting</td>
<td>• The county of fiscal responsibility and enrollment will remain unchanged unless the current contractor successfully negotiates a change with a contractor serving the new county.</td>
</tr>
<tr>
<td></td>
<td>• The Enrollment Choice process must be completed prior to the negotiation process when the enrollee moves to a choice county.</td>
</tr>
</tbody>
</table>
3. Uncoordinated Moves by the Enrollee
   The contractor is responsible for explaining the service limitations and exclusions to enrollees who move out of the contractor’s service area.

   The current contractor is liable only for those services authorized by an ALTCS enrollee’s case manager.

D. Enrollee Moves to Own Home in Another County
   When an enrollee resides in his or her own home the following policies apply:
   
   • The county of fiscal responsibility is the county where the enrollee or child’s parent’s home is located.
   
   • Enrollment is with a contractor serving the geographic service area (or fiscal county) where the home is located.
   
   • When the enrollee moves to his or her own home in a choice county, and is not already enrolled with a contractor serving that choice county, the enrollee must be given an opportunity to choose a contractor. The enrollee will be enrolled with the contractor selected through the enrollment choice process.

   • The enrollment change and the change in county of fiscal responsibility cannot occur until the enrollment choice process is completed.

1. Enrollee’s Responsibilities
   The enrollee is responsible for reporting the move or anticipated move to the current contractor and the ALTCS local office.

2. Contractor Responsibilities
   The current contractor is responsible for:
   
   a. Notifying the ALTCS local office that the enrollee moved by sending an enrollee Change Report (DE-701),
   
   b. Explaining service limitations and exclusions to an enrollee who moves out of the contractor’s service area, and
   
   c. Transitioning the enrollee to the new contractor, this includes forwarding medical records and other materials to the receiving contractor.

3. ALTCS Local Office Responsibilities
   The ALTCS local office is responsible for:
   
   a. Completing the enrollment choice process for enrollees changing to a choice county,
   
   b. Changing the enrollee’s living arrangement (if appropriate) and address when the move occurs,
   
   c. Making necessary changes in the county of fiscal responsibility and enrollment, and
   
   d. Making changes to eligibility and share of cost arising from the change in the enrollee’s living arrangement.

4. Enrollment Change Procedures
   The ALTCS local office will complete the following steps:

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Determine if the county of fiscal responsibility and enrollment need to be changed. (The county of fiscal responsibility and enrollment may already be correct).</td>
</tr>
<tr>
<td></td>
<td>• If a change is required, proceed to Step 2.</td>
</tr>
<tr>
<td></td>
<td>• If no change is needed, update the address and living arrangement, and share of cost, if necessary.</td>
</tr>
<tr>
<td>2</td>
<td>Complete the Enrollment Choice Process if enrollment needs to be changed to a contractor serving a choice county. When the enrollee is unable or unwilling to make a choice, the current ALTCS local office will either select a contractor for the enrollee or permit auto assignment to a contractor by PMMIS in accordance with the criteria in the Eligibility Policy Manual.</td>
</tr>
<tr>
<td>3</td>
<td>Process fiscal county and enrollment changes.</td>
</tr>
<tr>
<td>4</td>
<td>Determine if the eligibility case record should be transferred according to the criteria in the Eligibility Policy Manual.</td>
</tr>
</tbody>
</table>
E. Enrollee Moves to a Nursing Facility or Alternative Residential Setting in Another County

When the current contractor provides services to the county where the enrollee is moving, the enrollment and county of fiscal responsibility do not change.

When the current contractor chooses to contract with the nursing facility or alternative residential setting, the enrollment and county of fiscal responsibility do not change.

When the current contractor requests an enrollment change, the approval of both the current and the requested/receiving Contractor is required.

When the enrollee moves to a choice county, the enrollment choice process must be completed before the current Contractor can initiate negotiations with a requested Contractor.

When the receiving/requested Contractor does not agree to the change, the current Contractor may request a decision from the AHCCCS Medical Director.

1. Enrollee’s Responsibilities

The enrollee is responsible for reporting the move or anticipated move to the current Contractor and the ALTCS local office.

2. Current Contractor Responsibilities

a. When the current contractor is notified that an enrollee has moved to another county or plans to move to another county, and the enrollee resides or plans to reside in a nursing facility or alternative residential setting, and the current Contractor does not serve the other county, the current Contractor has the following options:

   • Retain the enrollee and contract with an out of county provider,
   • Negotiate an enrollment change, or
   • Pay facility expenses for a limited number of days while plans are being made to move the enrollee to a contracted facility. If the enrollee refuses to move to a contracted facility, follow the non-user procedures in the AHCCCS Eligibility Policy Manual.

b. When enrollment change is the preferred option, the current Contractor is responsible for:

   • Calling the ALTCS local office and requesting an enrollment choice when the move is to a choice county
   • Completing a Program Contractor Change Request (DE-621) and sending it to the contractor serving the GSA or the requested choice county Contractor, and
   • Transitioning the enrollee when a change is approved.

3. ALTCS Local Office Responsibilities

a. General Responsibilities The ALTCS local office is responsible for:

   • Assuring that the current contractor is aware of the move or the enrollee’s plan to move, by contacting the current contractor and advising the enrollee to contact the current contractor
   • Informing the enrollee that the current contractor:
     1. Must be involved in the placement change
     2. Is only liable for services authorized by the case manager
   • Changing the enrollee’s address when the move is verified, and
   • Determining whether to retain or transfer the eligibility case file based on the case file transfer policy in the Eligibility Policy Manual.
b. Enrollment Choice for Transfers to a Choice County

When enrollment choice is requested by the current contractor, the ALTCS local office is also responsible for:

• Informing the enrollee about enrollment choice
• Providing marketing materials to the enrollee
• Providing assistance to the enrollee as necessary, and
• Obtaining an enrollment choice from the enrollee and notifying the current contractor.

4. Requested Contractor’s Responsibilities

When a Program contractor Change Request (DE-621) is received the requested Contractor is responsible for:

a. Approving or denying the change request by completing the DE-621, and
b. Transitioning the enrollee when the change request is approved or the AHCCCS Medical Director directs the change.

5. AHCCCS Medical Director’s Responsibilities

The AHCCCS medical director determines whether an enrollment change is appropriate when the receiving/requested Contractor denies the enrollment change and the current contractor requests review by the AHCCCS medical director.

If approved, a written decision is issued to the current contractor. If denied, a written notice of the denial including notice of appeal rights is issued to the current contractor, the receiving/requested contractor and the enrollee.

6. AHCCCS Central Office Field Operations Responsibilities

The AHCCCS Central Office Field Operations is responsible for:

a. Processing enrollment and county of fiscal responsibility changes, and
b. Sending the ALTCS local office a copy of the DE-621.

F. Enrollment Change Process

The following steps are involved in the enrollment change process:

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The enrollee moves or indicates a desire or plan to move to a nursing facility or alternative residential setting in another county.</td>
</tr>
<tr>
<td>2</td>
<td>When advised of the move the ALTCS office: • Notifies the current contractor, • Advise the enrollee to contact the current contractor, and • Warns the enrollee about limitations on services received from out-of-network providers.</td>
</tr>
<tr>
<td>3</td>
<td>When the move has been verified, the ALTCS local office changes only the enrollee’s address/living arrangement, not the county of fiscal responsibility</td>
</tr>
<tr>
<td>4</td>
<td>When the move is to a choice county: • The current contractor asks the ALTCS local office to complete the Enrollment Choice Process. • The SLTCS local office obtains an enrollment choice and informs the current contractor.</td>
</tr>
<tr>
<td>5</td>
<td>The current Contractor completes a Program Contractor Change Request (DE-621) and sends it to the Contractor serving the new county of residence. In a choice county, this will be the requested contractor. If the contractor serving the new county of residence denies the request, the current contractor may forward to the AHCCCS medical director for a final decision.</td>
</tr>
<tr>
<td>Step</td>
<td>Action</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
</tr>
<tr>
<td>6</td>
<td>When the contractors or the AHCCCS medical director approves a change, the Program Contractor Change Request Coordinator at AHCCCS Central Office processes the enrollment and county of fiscal responsibility changes and notifies the ALTCS local office. The current contractor will forward medical records and other materials to the receiving contractor.</td>
</tr>
<tr>
<td>7</td>
<td>If the change request is denied by the AHCCCS Medical Director, the Division of Health care Management/ALTCS Unit will provide written notice of the denial including notice of appeal rights to the enrollee and to both the current and receiving/requested contractors. When the change is denied, the current contractor continues to provide services to the enrollee.</td>
</tr>
<tr>
<td>8</td>
<td>The ALTCS local office determines if the eligibility case record should be transferred according to the criteria in Eligibility Policy Manual.</td>
</tr>
</tbody>
</table>

G. The Contractor’s Responsibilities

1. Provide Contractor Change Policy
   Contractors are responsible for providing information on the contractor change policy in:
   a. The Enrollee Handbook for new and existing enrollees, and
   b. The Provider Manual for providers

2. Address Enrollees’ Concerns
   The current contractor is responsible for promptly addressing enrollees’ concerns regarding availability and accessibility of services and quality of medical care. These issues include but are not limited to:
   a. Quality of care
   b. Case management responsiveness
   c. Transportation service availability
   d. Institutional care issues
   e. Physician or provider office hours
   f. Office waiting time, and
   g. Network limitations and restrictions.

3. Refer Unresolved Issues
   When quality of care and delivery of medical service issues raised by the enrollee cannot be solved through the normal case management process, the current contractor must refer the issue for review by:
   a. The current contractor’s Quality Management Department and/or
   b. The AHCCCS medical director

4. Transitioning Between Contractors
   The current contractor is responsible for:
   a. Reporting the enrollee’s address and living arrangement changes to AHCCCS
   b. Encouraging enrollees to report anticipated moves to another county or geographic service area to them (current contractor) and to the ALTCS local office prior to moving. Advance notice will facilitate continuity of service delivery.
   c. Advising enrollees to contact the ALTCS local office to request an enrollment change between contractors serving a choice county if a valid reason other than medical continuity of care is claimed.
   d. Accepting an enrollee’s request for an enrollment change to another county. The request may be verbal or in writing and may be addressed to the enrollee’s Case Manager.
   e. Forwarding medical records and other materials to the receiving contractor

Both the current contractor and the receiving contractor are responsible for assuring a safe transition for the enrollee when an enrollment change occurs. The contractors will transition within the requirements and protocols in the AHCCCS Medical Policy Manual, Chapter 500.
5. Process Enrollees’ Enrollment Change Requests
The contractor will process enrollment change requests from enrollees as follows:

<table>
<thead>
<tr>
<th>When the Enrollee Requests a Contractor Change...</th>
<th>Then the Current Contractor...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within a choice county and the enrollee claims a valid condition exists.</td>
<td>Refers the issue to the ALTCS local office for review using the ALTCS Enrollee Change Report (DE-701).</td>
</tr>
</tbody>
</table>
| That requires the approval of both the current and the receiving Contractors. | Notifies the ALTCS local office if the enrollee lives in a choice county or is moving to a choice county to initiate the Enrollment Choice Process. Negotiates the change with the requested Contractor. Completes a DE-621 and forwards it to the requested Contractor. Notifies the enrollee if the change is approved. May forward the DE-621 to the AHCCCS Medical Director if the requested Contractor denies the change. Notifies the enrollee in writing if the enrollment change is denied at the Contractor level. The denial notice must include:  
  - The AHCCCS Program Contractor Grievance Policy, and  
  - Timeframes for filing a grievance. |

6. Notify Hospitals of Certain Enrollment Changes
When an enrollment change occurs while the enrollee is hospitalized, the current contractor must notify the hospital of the enrollee’s disenrollment prior to the enrollment with the receiving contractor.

If the current contractor fails to provide such notice to the hospital, the current contractor will continue to be responsible for payment of hospital services provided to the enrollee until the date notice is provided to the hospital as required in the AHCCCS Medical Policy Manual, Chapter 500.

7. Process Grievances
When an enrollment change requested by the enrollee is denied by the contractor (not the AHCCCS medical director), the current contractor is responsible for processing any resulting grievances.

H. AHCCCS Administration’s Responsibilities

1. Enrollment Change Requests Received From Enrollees
Except for valid changes within a choice county or a change due to the enrollee moving to his or her own home, the AHCCCS administration or the ALTCS local office will refer an enrollee’s request for an enrollment change to the current contractor.

2. Process Enrollment Change Requests
The AHCCCSA will process enrollment change requests within five days after the request is received, or all conditions for processing an enrollment change have been met, whichever is later.
3. Issue Decisions
The AHCCCSA will notify contractors of enrollment change approvals via the daily recipient roster. AHCCCSA will mail a new AHCCCS ID card to the enrollee. AHCCCSA will send notification to both the current and receiving contractors and the enrollee when an enrollment change is denied by the AHCCCS medical director. When approved by the AHCCCS medical director, notification will be sent to the current contractor.

4. Process Grievances
When an enrollment change is denied by the AHCCCS Medical Director, AHCCCSA is responsible for processing all resulting enrollee grievance.

   The Division of Health Care Management, ALTCS Unit sends the enrollee a denial notice, which explains the Grievance System under 9 A.A.C. 34.

5. Monitor Policy Compliance
The AHCCCS Division of Health Care Management (DHCM) will monitor contractor compliance with this policy. Any violations of this policy, especially attempts to deny care or steer high cost or difficult enrollees to another contractor, will be considered contract violations and will be subject to sanctions up to and including contract termination.

IV. References
• Arizona Administrative Code R9-28, Article 7
• ALTCS Contract, Section D
• AHCCCS Medical Policy Manual Chapter 500
• ACOM Chapter 400
Ch. 18 Formulary Medicare Part D

UnitedHealthcare Community Plan Formulary

An up-to-date formulary for UnitedHealthcare Community Plan can be found at [UHCCommunityPlan.com](http://UHCCommunityPlan.com). Changes to the formulary will be identified on the UnitedHealthcare Community Plan website.

Medicare Part D Benefit

Medicare Prescription Drug coverage is available through Medicare Advantage Prescription Drug Plans (MA-PD) and standalone Prescription Drug Plans (PDP). The drug benefit, known as Medicare Part D, is a substantial enhancement for Medicare-only UnitedHealthcare Community Plan enrollees, as these enrollees have never had coverage for prescription drugs.

Dual-eligible UnitedHealthcare Community Plan enrollees (enrollees with both Medicare and Medicaid) will receive their primary drug coverage through Medicare Part D. UnitedHealthcare Community Plan will provide wrap-around prescription drug coverage for UnitedHealthcare Community Plan enrollees that are on medication in drug classes not covered through Medicare Part D.

Medicare Part D is a built-in benefit integrated with UnitedHealthcare Community Plan’s existing Medicare plans, and those enrollees will automatically receive Medicare Part D coverage. There are no forms to fill out or selections to make. UnitedHealthcare Community Plan handles the paperwork for all enrollees participating in an UnitedHealthcare Community Plan Medicare plan.

Optum RX is the pharmacy benefits administrator for UnitedHealthcare Community Plan’s Medicare Part D plans. Our national, extensive Medicare Part D network includes retail stores, mail order services, long-term care pharmacies and specialty pharmacies.

The Medicare Part D formulary is evidence-based, customer-centered, and reflects the specialized needs of geriatric and disabled enrollees. The formulary is guided by a Pharmacy and Therapeutics Committee of medical experts from several specialties. It accommodates clinical choice and medical best practices, with medication options within each drug class. Formulary administration focuses on patients, with a temporary fill process that ensures emergency access and a therapy management program to reduce potential drug interactions.
## Important Information

| UnitedHealthcare Dental IVR Provider Services and Interactive Voice Response | 1-877-408-0166  
Provider Services: 8 a.m. – 11 p.m. EST  
Monday – Friday  
IVR = 24 hours; 365 days |
|---|---|
| Claims | UnitedHealthcare Community Plan Medicaid  
PO Box 2185  
Milwaukee, WI 53201 |
| Prior Authorizations | UnitedHealthcare Community Plan Medicaid  
PO Box 2020  
Milwaukee, WI 53201 |
| UHC Dental Provider Relations:  
(Correspondence regarding your participation, contractual issues, dentist changes or office changes) | UnitedHealthcare Dental Provider Relations  
6220 Old Dobbin Lane  
Columbia, MD 21045 |
| Claims Dispute for Providers | UnitedHealthcare Community Plan Medicaid  
PO Box 1382  
Milwaukee, WI 53201 |

*Please Note: The member ID cards are medical plan specific. There will not be a UnitedHealthcare Community Plan Dental ID card issued. Please use the claims and prior authorization addresses above for all dental services.

### Important Electronic Claims Submission Information

<table>
<thead>
<tr>
<th>Claim Filing Indicator Field</th>
<th>EDI Payer Number</th>
</tr>
</thead>
</table>
| Enter MC in the Claim Filing Indicator Field  
Note: Failure to enter “MC” in the Claim FilingIndicator field may result in delays in claim payment. | GP133 |

### Important Electronic Claims Submission Information

UnitedHealthcare Community Plan Medicaid is available in Maricopa, Mohave, Coconino, Navajo, Apache, LaPaz, Pima, Santa Cruz, Yavapai, and Yuma Counties.
UnitedHealthcare Community Plan – Medicaid Only for Children

The Arizona Long Term Care System (ALTCS) was created through the Arizona Health Care Cost Containment System (AHCCCS) to provide quality long-term care for all people in Arizona who cannot pay for services. The plan covers children from birth until their 21st Birthday. These services are provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT). A list of these services can be found in the AHCCCS medical policy manual chapter 400. **Members must use a UnitedHealthcare Dental AHCCCS Medicaid provider for all services. Certain Select Medicaid services require prior authorization.**

<table>
<thead>
<tr>
<th>Service Categories</th>
<th>Benefit Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Exams</td>
<td>One exam every 6 months</td>
</tr>
<tr>
<td>Prophylaxis</td>
<td>One cleaning every 6 months</td>
</tr>
<tr>
<td>Dental X-Rays</td>
<td>One series every 12 months</td>
</tr>
<tr>
<td>Restorative Services</td>
<td>As medically necessary*</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>As medically necessary*</td>
</tr>
<tr>
<td>All Other Dental Services</td>
<td>As medically necessary*</td>
</tr>
</tbody>
</table>

*Medically necessary care is described as: The reasonable and appropriate diagnosis, treatment, and follow-up care (including supplies, appliances, and devices) as determined and prescribed by qualified, appropriate health care providers in treating any condition, illness, disease, and injury or birth developmental malformations.

UnitedHealthcare Community Plan – Medicaid Only for Adults

Effective Oct. 1, 2010 the adult emergency dental services benefit for eligible adults ages 21 and older has been eliminated; except under certain circumstances. There remains a limited adult benefit under certain circumstances like organ transplant. **Any covered Adult Service will require prior authorization.** Adults are age 21 and over. The list below confirms which services can be covered with Prior Authorization. **Members must use a UnitedHealthcare Dental AHCCCS Medicaid provider for all services. Please call the provider services number at 877-408-0166 for details regarding the Adult Medicaid benefit.**

**Adult Services Requiring Prior Authorization Are:**

<table>
<thead>
<tr>
<th>Diagnostic</th>
<th>Oral and Maxillofacial Surgery</th>
<th>Adjunctive General Services</th>
</tr>
</thead>
<tbody>
<tr>
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Prior Authorization Guidelines

Prior authorization means the practitioner must submit those procedures for approval with clinical documentation supporting necessity before performing those procedures. To request clinical criteria utilized for each prior authorization service, please call UnitedHealthcare Dental Provider Relations Department at 877-408-0166.

Requesting a Prior Authorization Complete a standard American Dental Association (ADA) claim form and check the box marked “Pre-Treatment ESTIMATE.” Mail the form, along with any required supplemental information (films, narrative, periodontal charting, etc). Your office will then receive an Explanation of Benefits (EOB) outlining the denial or approval of requested treatment and plan payment amounts when applicable.

Prior Authorization for Medicaid
UnitedHealthcare Community Plan Medicaid
PO Box 2020
Milwaukee, WI 53201

Prior authorizations are subject to the following conditions:

1. Total benefit maximums may not be exceeded. Actual dates of service may alter benefits payable.
2. The member must be eligible for benefits when the services are incurred. An expense is incurred when a service is performed.
3. Allowances may vary based on results of post-treatment clinical review.

When submitting for payment, please include the approved EOB, including the actual date(s) of service.

Timeframes and Written Notification

Standard Decisions
When a provider has submitted a prior authorization, UnitedHealthcare Dental must render a decision within 14 business days of receipt. In addition, a denial letter (if applicable) must be sent within one business day of the decision.

Urgent Decisions
When a provider has submitted an urgent request for a prior authorization, UnitedHealthcare Dental must render a decision within three business days of receipt. In addition, a denial letter (if applicable) must be sent within one business day of the decision.

Provider Claim Dispute Resolution

For assistance and instructions, please contact the UnitedHealthcare Dental customer service center at 877-408-0166 prior to filing a claim dispute.

A provider may file a claim dispute with UnitedHealthcare Dental if the provider meets the requirements below:

Per ARS 36-2903.01, paragraph B.4, A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the UnitedHealthcare Dental within:

1. Twelve months after the date of service
2. Twelve months after the date that eligibility is posted
3. Sixty days after the date of the denial of a timely claim submission, whichever is later

AAC R-9-34-404 indicates that the written claim dispute must state the factual and legal basis for the dispute and the relief requested. Failure to meet these requirements shall result in the denial of a claim dispute.
All claim disputes must be in writing and mailed to:

UnitedHealthcare Community Plan Medicaid
PO Box 1382
Milwaukee, WI 53201

A claim inquiry or research request does not extend the claim dispute filing deadlines.

In the event that the provider disagrees with the contractor’s decision, the provider may request a Hearing within 30 days of the decision. UnitedHealthcare Dental will forward the Hearing request to AHCCCS, Office of Grievance and Appeals.
Ch. 20 Clinical Practice Guidelines

All UnitedHealthcare Community Plan Clinical Practice Guidelines can be obtained online at www.uhccommunityplan.com. They can be found by selecting "provider", then selecting “Clinical Practice Guidelines” and then accepting the terms and conditions. If you need to request a hard copy of the Clinical Practice Guidelines, they can be obtained by contacting your Provider Relations Advocate.
## Glossary/Acronyms

### Abuse (of Enrollee)
Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S 46-451.

### Abuse (by Provider)
Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost, as defined by 42 CFR 455.2.

### ADHS
Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.

### AHCCCS
Arizona Health Care Cost Containment System (pronounced “access”) is a State agency that manages the state Medicaid Program. AHCCCS utilizes a competitive bid process to select prepaid Program Contractors such as UnitedHealthcare Community Plan to provide services to eligible enrollees. AHCCCS is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible person defined by A.R.S 36-2932.

### AHCCCSA
Arizona Health Care Cost Containment System Administration. The state agency, which acts as the contracting and regulatory body for the State.

### ALTCS
Arizona Long Term Care System (pronounced “all-teks”) is a program administered under AHCCCSA. ALTCS provides long term, acute, behavioral health care and case management services to eligible enrollees. Enrollees are primarily the elderly and/or physically disabled who meet financial eligibility criteria and are at risk for institutionalization.

### AMPM
AHCCCS Medical Policy Manual

### Annual Enrollment Choice
The time period based upon the anniversary of an enrollee’s enrollment in which the enrollee may select a different health plan/Program Contractor.

### Appeals
A request for a standard or expedited reconsideration of the denial of a requested service or payment of a service.

### Authorization
A process whereby services are reviewed prospectively to determine if they are medically necessary and appropriate. This review also includes verification of enrollee enrollment, verification that the request is a covered benefit, and determination of the provider’s eligibility to perform the service.

### Billed Charges
Charges billed by a provider for rendering services to an UnitedHealthcare Community Plan enrollee.

### Capitation
A prepaid, periodic payment to providers, based upon the number of assigned enrollees that is made to a provider for providing covered services for a specific period.
Case Manager
The individual responsible for coordinating the overall service plan for an enrollee in conjunction with the enrollee, the enrollee's representative and the enrollee’s Primary Care Provider (PCP).

Claim Dispute
A dispute involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

Clean Claim
A claim that may be processed without obtaining additional information from the provider of service or from a third a third party; but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

Centers for Medicare and Medicaid Services (CMS)
Formally known as the Health Care Financing Administration (HCFA). CMS is a division within the U.S. Department of Health and Human Services, which administers the Medicaid, Medicare and State Children’s Health Insurance programs throughout the country.

CMS 1500
Formerly the HCFA 1500, the CMS 1500 is the reimbursement form used to report all outpatient medical service encounters and claims.

Covered Services
Covered services are medically necessary health and medical services (which may vary by product) that are delivered to UnitedHealthcare Community Plan enrollees at the direction of the enrollee’s Primary Care Provider.

Discharge Planning
Identification of the need and provision for an enrollee’s health care needs after discharge from the hospital or skilled nursing setting.

Disenrollment
The discontinuance of an enrollee’s right to receive covered services.

Durable Medical Equipment (DME)
Items that can withstand repeated use, are designed to serve a medical purpose, and are not generally useful to a person in the absence of a medical condition, such as hospital beds, wheelchairs, walkers and crutches.

Dual Eligible
An enrollee who is eligible for Medicare Part A and/or Part B, and Medicaid.

Eligibility Determination
A process of determining whether an applicant meets the requirements for federal or state eligibility.

Emergency Dental Services
Emergency adult dental services are eliminated. However, in accordance with federal law and the State Plan, AHCCCS will cover medical and surgical services furnished by a dentist only to the extent that such services may be performed under State law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician. For members 21 years of age and older, the services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. The covered services include examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Certain pre-transplant services (e.g. dental cleanings, fillings, restorations, extractions) and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head are also covered.
Emergency Medical Condition
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient’s health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; c) serious dysfunction of any bodily organ or part.

Emergency Medical Service
Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition.

Encounter
A record of health care related services rendered by a provider or providers registered with AHCCCS to an enrollee who is enrolled with UnitedHealthcare Community Plan on the date of service. Providers are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan in turn, electronically reports these encounters to AHCCCSA. The State audits encounter submission accuracy and timeliness on a regular basis.

Enrollee
Enrollee is interchangeable with the term member. Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber or dependent.

Enrollment
The process by which a person who has been determined eligible to receive Medicaid or Medicare benefits becomes an enrollee of a health plan.

EOB
Explanation of Benefits

EPD
Elderly and/or Physically Disabled

EPSDT
Early and Periodic Screening, Diagnosis and Treatment is a federally mandated program for persons under 21 years of age. EPSDT includes general screening, diagnostic and treatment services including vision, dental and hearing services. The purpose of the EPSDT program is to provide comprehensive health care through primary prevention, early intervention, diagnosis, and medically necessary treatment of physical and mental health problems, identified by an EPSDT screening.

Fee For Service (FFS)
A method of payment to providers on an amount-per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule.

FHC
Family Health Center

Formulary
A formulary is a preferred list of drugs selected to meet patient needs.

Fraud
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. It includes any act that constitutes fraud under applicable federal or state law.

Grievance System
A system that includes a process for enrollee grievances, enrollee appeals, provider claim disputes, and access to the state fair hearing system.
HCBS
Home and Community Based Services – Care provided in a non-institutionalized setting, as defined in A.R.S. 36-2931 and 36-2939.

HIPAA
Health Insurance Portability and Accountability Act of 1997. HIPAA has many provisions impacting the health care industry, including transaction code sets, privacy and security provisions. HIPAA impacts what is referred to as covered entities, specifically providers who transmit health care information electronically, health plans and health care clearinghouses.

Health Maintenance Organization (HMO)
HMO is a network of physicians and other health care providers that provide or coordinates an individual’s health care services. Physicians that participate within the HMO network are reimbursed on a flat-rate monthly basis based on specific capitation models. Individuals pay a specific co-payment based on the benefit plan.

Medicaid
A federal/state program authorized by Title XIX of the Social Security Act providing federal matching grants, at state’s option, for a medical assistance program for recipients of federally aided public assistance and SSI benefits and medically indigent.

Medically Necessary
“Medically necessary” refers to those covered services provided by a physician or other licensed practitioner within the scope of their practice under state law to preserve and maintain the health status of an enrollee; prevent death, treat/cure disease, and ameliorate disabilities or other adverse health conditions; and/or Prolong life. Only services that are deemed to be medically necessary and covered will be authorized.

Medicare
A federal program authorized by Title XVIII of the Social Security Act that provides health insurance for persons aged sixty-five (65) and older and for other specified groups. Part A is for hospitalization and is compulsory; Part B is for outpatient services and is voluntary. Part D is a prescription benefit and is voluntary.

Medicare Part A
Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.

Medicare Part B
Medicare medical insurance that helps pay for doctors’ services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A).

Medicare Part D
Medicare Prescription Drug coverage available through Medicare Advantage Prescription Drug Plans (MA-PD) and standalone Prescription Drug Plans (PDP). The benefit provides coverage for prescription drugs.

Non-Participating Provider (Non-Par)
Non-Par refers to a non-participating provider. This describes a physician or other health care provider who has not signed an agreement with United HealthCare or UnitedHealthcare Community Plan to be a participating provider of health care. Also known as an out-of-network provider.

Notification
Used interchangeably with “authorization” or “prior authorization”
NPI
National Physician Identifier. Required by CMS for all providers who bill, prescribe or refer for health care services and is to be used on all electronic transactions. It is a single unique provider identifier assigned to a provider for life that replaces all other health care provider identifiers. It does NOT replace your DEA number.

Out of Network
Coverage for treatment obtained from a non-participating provider.

PCP
Primary Care Provider. This term is used interchangeably with “primary care physician”. The PCP is a provider who is responsible for the overall management of an enrollee’s health care. PCPs may include, but are not limited to: a physician who is a family practitioner, general practitioner, internist, pediatrician, obstetrician or gynecologist; a certified nurse midwife or nurse practitioner; or, under the supervision of a physician, a physician’s assistant.

PPO
Preferred Provider Organization (PPO) Physicians and other health care providers under such agreements are referred to as preferred providers. Usually, the PPO benefit contract provides significantly better benefits and lower costs for services received from preferred physicians and other health care providers, thus encouraging enrollees to use these physicians and providers. Enrollees generally are allowed benefits for non-participating physician and provider services, usually on an indemnity basis. There is no requirement to elect a primary physician to serve as gatekeeper for network services.

Program Contractor
Health Plan approved by AHCCCS to administer ALTCS and/or AHCCCS programs.

Quality Management
Activities that focus on measuring, monitoring and improving the quality of care and outcomes for enrollees.

Rate Code
An alpha/numeric classification that identifies the enrollee’s eligibility category status within ALTCS.

Room and Board
The amount paid for food and/or shelter. Medicaid funds can be expended for room and board only when a person lives in an institutional setting (nursing facility, ICF/MR). Medicaid funds cannot be expended for room and board when an enrollee resides in an alternative residential setting (e.g. Assisted Living Facilities, Behavioral Health Level 2) or an apartment like setting that may provide meals. The enrollee is responsible for payment of room and board in these settings.

Share of Cost
ALTCS enrollees are required to contribute toward the cost of their care based on their income and type of placement. Generally, only institutionalized ALTCS enrollees have a share of cost. Some enrollees, either because of their limited income or the methodology used to determine the share of cost, have a zero share of cost. The ALTCS Eligibility Office determines the amount of an enrollee’s share of cost. Except with a trust, a HCBS member may have a share of cost.

Third Party Liability
The resources available from an individual, entity program that is or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by an applicant, eligible person or enrollee.
**UB-04**
A universal billing form for claims. Skilled nursing facilities, hospital inpatient, outpatient and emergency room claims are filed on this form. The UB-04 is not to be confused with a “universal claim form” for filing pharmacy claims.

**UnitedHealthcare Community Plan**
UnitedHealthcare Community Plan is an affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.