

2023 Care Provider Manual

Mississippi Children's Health Insurance Program (CHIP)

Physician, Health Care Professional, Facility and Ancillary

Welcome

Welcome to the Community Plan manual. This complete and up-to-date reference PDF manual allows you and your staff to find important information such as how to process a claim and submit prior authorization requests. This manual also includes important phone numbers and websites on the How to Contact Us page. Find operational policy changes and other electronic tools on our website at UHCprovider.com.

Click the following links to access different manuals:

- [UnitedHealthcare Administrative Guide](#) for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual: go to UHCprovider.com/guides and click Find Your State.

Easily find information in the manual using the following steps:

1. Press CTRL+F.
2. Type in the keyword.
3. Press Enter.

If available, use the binoculars icon on the top right hand side of the PDF to search for information and topics.

If you have any questions about the information or material in this manual or about our policies, please log into the Provider Portal, or call [Provider Services](#).

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

Important information regarding the Use of this Manual

If there is a conflict between your Agreement and this care provider manual, use this manual unless your Agreement states you should use it, instead. If there is a conflict between your Agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This manual is amended as operational policies change.

Table of Contents

- UnitedHealthcare Community Plan Corporate Overview 4**
 - Our Approach to Health Care
- How to Contact Us 5**
- Quick Reference Guide 6**
- CHIP Benefits 7**
- CHIP Services 13**
 - Behavioral Health & Substance Use Disorder (SUD) Treatment Services
 - Behavioral Health Line Services
 - Online Resources
 - Pharmacy Services
 - Pharmacy – Preferred Drug List (PDL)
 - Dental
 - Prior Authorization
 - Vision
- Medical Management 18**
 - Referral Guidelines
 - Emergency Care Resulting in Admissions
 - Prior Authorization
 - InterQual Care Guidelines®
 - How to Contact Our Utilization Management Team
 - Determination of Medical Necessity
 - Disease Management
 - Coordination of Care
 - Case Management
 - Clinical Practice Guidelines
 - Preventive Health Care Standards
 - Maternity Care
 - Healthy First Steps (Maternity Care)
 - Obstetrical Admissions
 - Newborn Admissions
 - Inpatient Concurrent Review: Clinical Information
- Appeals and Grievances 31**
 - Compliance with State Requirements
 - Independent External Review Process
 - Independent External Review Requirements
 - Summary of Care Provider Complaints, Grievances and Appeals

Table of Contents

- Quality Management 37**
 - Your Participation in Quality Management
 - Quality Improvement Program
 - Your Satisfaction
 - Credentialing and Recredentialing
 - Resolving Disputes
 - HIPAA Compliance Care Provider Responsibilities
 - Member Rights and Responsibilities
 - Member Rights
 - National Provider Identifier
 - Fraud and Abuse
 - Reporting Fraud and Abuse
 - Ethics and Integrity
 - Reporting and Auditing

- Our Claims Process..... 47**
 - Claims Billing Procedures
 - Claims Format
 - Claims Processing Time
 - Claims Submission Rules
 - Tax Identification Numbers/Care Provider IDs
 - Coordination of Benefits
 - Electronic Claims Submission and Billing
 - Span Dates
 - Effective Date/Termination Date
 - Overpayments
 - Subrogation
 - Care Provider/Member Cost Sharing Responsibilities
 - Timely Filing and Late Bill Criteria
 - Reconsideration Requests
 - Care Provider Complaints and Claims Payment Disputes
 - The Correct Coding Initiative
 - Immunization Billing
 - Member Identification Cards

- Care Provider Standards and Policies..... 53**
 - Primary Care Providers
 - Role of Primary Care Provider
 - PCP Responsibilities
 - Timeliness Standards for Appointment Scheduling
 - Timeliness Standards for Notifying Members of Test Results
 - Allowable Office Waiting Times
 - Care Provider Office Standards

Medical Record Charting Standards
Screening and Documentation Tools
Medical Record Review
Advance Directives
Protect Confidentiality of Member Data

Care Provider Communications and Outreach 62

UnitedHealthcare Community Plan Corporate Overview

Mississippi contracts with UnitedHealthcare Community Plan to provide services to its Children's Health Insurance Program (CHIP). As a result, we provide services to Mississippi children younger than 19 whose families meet income requirements.

UnitedHealthcare Community Plan, 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 Community Plan 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.

A number of factors distinguish UnitedHealthcare Community Plan from other companies serving CHIP and other government health care programs:

- We have a private sector focus on cost accounting, data analysis and fiscal discipline, coupled with sensitivity to the imperatives of public sector accountability.
- We invest in the systems and personnel required to successfully manage our business.
- We emphasize service to all our customers — regulators, members and care providers.
- We understand the unique needs of the populations we serve, and our health plans are designed specifically to meet those needs.

UnitedHealthcare Community Plan understands compassion and respect are essential components of a successful health care company. UnitedHealthcare Community Plan employs a diverse workforce, rooted in the communities we serve, with varied backgrounds and extensive practical experience that gives us a better understanding of our members and their needs.

Our Approach to Health Care

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

Through our Healthy First Steps® program, UnitedHealthcare Community Plan helps parents select a pediatrician and get health services for their children. Many of our programs address food insecurity for children and family members.

In addition to the usual health plan reminders to get preventive care services, UnitedHealthcare Community Plan identifies members who have fallen behind in scheduling appointments and care providers who are failing to focus on preventive care and optimal treatment.

You are expected to provide family-centered care. As such, interpretive and language assistance services may be necessary. If you are unable to provide necessary services, UnitedHealthcare Community Plan's Member Services can help at no cost to members. For interpretation assistance, please call 877-743-8731, TTY: 711. Sign language services require a two-week notice.

UnitedHealthcare Community Plan does not require or request you to enter into an exclusive relationship with us or any of our business affiliates.

How to Contact Us



Provider Services	<p>800-557-9933</p> <p>Hours of Operation: Monday – Friday 7 a.m. to 5 p.m. Central Standard Time</p>	<p>Please have your National Provider Identifier number and your Tax ID or the Member ID ready. The call center is available to you for many topics, including:</p> <ul style="list-style-type: none"> • Answer general questions • Verify member eligibility • Check status of claims • Ask questions about your participation • Notify us of demographic and practice changes • Assist with new procedures
Provider Portal	<p>UHCprovider.com > Sign In</p>	<p>To review a patient’s eligibility or benefits, check claims status, submit claims or review Directory of Physicians, Hospitals and other Health Care Professionals</p>
Pharmacy Services	<p>Optum Rx 877-305-8952</p>	
Behavioral Health	<p>800-980-7393 (Phone) 800-867-6758 (Interactive Voice Response System) providerexpress.com</p>	<p>For information and questions about Mental Health and Substance Use Disorder.</p>
Medical Prior Authorization Notification	<p>800-557-9933 888-310-6858 - Fax UHCprovider.com > Sign In</p>	<p>To request prior authorization or to notify us of the procedures and services outlined in the prior authorization/notification requirements section of this manual</p>
Dental	<p>Dentist Inquiries: 800-822-5353, Customer Inquiries: 800-445-9090 UHCprovider.com</p>	<p>For information and questions about dental benefits.</p>
Vision	<p>March Vision 844-606-2724 eyesynergy.com > Providers</p>	<p>For information and questions about vision benefits.</p>

Mississippi CHIP Provider Quick Reference Guide

Our claims process

To help ensure prompt payment:

1 Review and copy both sides of the member's ID card. UnitedHealthcare Community Plan members receive an ID card containing information that helps you process claims accurately. These ID cards display information such as claims address, copayment information (if applicable), and telephone numbers such as those for member and provider services.

2 Notify Health Services of planned procedures and services on our Prior Authorization list.

3 Prepare a complete and accurate electronic or paper claim form (see "complete claims" at right). Complete a CMS 1500 (formerly HCFA) or UB-04 form.

4 Submit claims electronically: have your office software vendor make connection to our clearinghouse. Please call us at 800-210-8315 for assistance. Use our electronic payer (87726) to submit claims to us. For more information, contact your vendor or our Electronic Data Interchange (EDI) unit at 800-210-8315. If you do not have access to internet services, you can mail the completed claim to:
UnitedHealthcare Community Plan
PO Box 5032
Kingston, NY 12402-5032

Complete claims

A complete claim includes the following:

- Patient's name, date of birth, address and ID number
- Name, signature, address and phone number of physician or care provider performing the service, as in your contract document
- National Provider Identifier (NPI) number
- Physician's or care provider's tax ID number
- CPT-4 and HCPCS procedure codes with modifiers where appropriate
- ICD-10 diagnostic codes
- Revenue codes (UB-04 only)
- Date of service(s), place of service(s) and number of services (units) rendered
- Referring physician's name (if applicable)
- Information about other insurance coverage, including job-related, auto or accident information, if available
- Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers
- Attach an anesthesia report for claims submitted with QS modifier
- Attach a description of the procedure/service provided for claims submitted with unlisted medical or surgical CPT codes or experimental or reconstructive services (if applicable)

Injectable Drugs provided in an office/clinic setting:

The health plan will be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to care providers providing both home infusion services and the drugs and biologics. The health plan will require that all professional claims contain NDC (National Drug Code) 11-digit number and unit information to be paid for home infusion and J codes. The NDC number must be entered in 24D field of the CMS-1500 Form or the LIno3 segment of the HIPAA 837 electronic form. Injectable drugs provided in the office/clinic setting, reimbursed by the health plan, will not be included in any pharmacy benefit limits established for pharmacy services.

How to contact us

UHCCommunityPlan.com

Verify member eligibility, check status of claims, submit claim adjustment requests

Provider Services

800-557-9933

This is an automated system. Please have your National Provider Identifier number and your Tax ID or the Member ID ready, or you may hold to speak to a representative. The call center is available to you to:

- Answer general questions
- Verify member eligibility
- Check status of claims
- Ask questions about your participation, or
- Notify us of demographic and practice changes
- Request information regarding credentialing

Prior Authorization

For a complete and current list of prior authorizations, go to UHCProvider.com/priorauth or call 800-557-9933.

Fax your prior authorizations to 888-310-6858.

Case Management

800-557-9933

Case Management Intake – Pain Management; Medication; Utilization Management

Disease Management

800-557-9933

Pharmacy Optum Rx

877-305-8952

Pharmacy Prior Authorization

For a copy of the pharmacy provider authorization form, go to UHCProvider.com/priorauth or call 800-310-6826 Fax your pharmacy prior authorization to 866-940-7328

Behavioral Health

800-980-7393 (Phone); 800-867-6758 (Interactive Voice Response System); providerexpress.com

Member Services Helpline

800-992-9940

Member Service Representatives in our call center will be available to answer Member calls Monday through Friday from 8 a.m. to 6 p.m. In addition, our interactive voice response (IVR) telephone system is available to Members 24 hours a day, 7 days a week, and our nurse triage hotline is available through our IVR for health-related issues.

* For more important telephone numbers, see next page



CHIP Benefits

Some services require prior authorization. Please check authorization status before rendering specialty services.

CHIP Medical Benefits

Benefit	Covered	Limitations
Air Ambulance	Yes	Emergent only
Ambulatory Surgical Center	Yes	
Chiropractic Services	Yes	
Christian Science Sanatoria Services	No	
Cosmetic & Reconstructive Surgery	Yes	
Dental Services Over 21 – emergency pain relief & diagnostic services	Yes	Benefits for restorative, edodontic, periodontic and surgical services limited to \$2,000 per calendar year
Diabetes Training	Yes	
Dialysis Outpatient Center	Yes	
Doctor Visits and Care	Yes	
Durable Medical Equipment	Yes	Authorization needed for items over \$500
Emergency Room	Yes	
EPSDT Services	No	
Expanded EPSDT Services	No	
Eye Care Exams & Glasses	Yes	1 exam per year; 1 pair of medically necessary glasses
Family Planning Services	Yes	
Federally Qualified Health Centers	Yes	
Genetic Testing	No	
Health Department Services	Yes	
Hearing Services	Yes	

CHIP Benefits

Home Health Services	Yes	
Home Infusion	Yes	Injectables may need authorized
Hospice	Yes	Limit of \$15,000 per lifetime
Hospital Services	Yes	
Imaging	Yes	
Laboratory & X-Ray Services	Yes	
Maternity Services	Yes	Includes parenting education services
Medical Supplies	Yes	
Mental Health Services	See separate grid for benefits	
Newborn Circumcision	No	
Non-Contracted Providers	Yes	
Non-Emergency Transportation	No	
Nurse Practitioner Services	Yes	
Orthotics & Prosthetics	Yes	
Outpatient PT/OT/ST	Yes	Speech therapy does require authorization Speech therapy is not covered for maintenance speech, delayed speech development or articulation disorders
Perinatal High- Risk Management Services	Yes	
Physician Assistant Services	Yes	
Physician Services	Yes	
Podiatrist Services	Yes	Routine foot care is not covered
Private Duty Nursing	Yes	8 hours or more per day; \$10,000 limit annually

CHIP Benefits

Prescribed Pediatric Extended Care (PPEC)	No	
Prescription Drugs	Yes	
Rural Health Clinic Services	Yes	
Sleep Studies	Yes	
Transplant Services	Yes	
Well-child Care	Yes	

CHIP Behavioral Health Benefits

Benefit	Covered	Limitations
Individual Psychotherapy	Yes	
Family Psychotherapy	Yes	
Group Psychotherapy	Yes	
Neuropsychological Testing	Yes	
Crisis Intervention	Yes	
Psychosocial Rehabilitation	Yes	
Community Psychiatric Supportive Treatment	Yes	
Day Treatment	Yes	
Peer Support Services	Yes	
Case/Target Management	Yes	
Inpatient Psychiatric Hospitalization	Yes	
Inpatient Detoxification	Yes	
Crisis Residential Services	Yes	
Partial Hospitalization Program	Yes	
MYPAC Services	No	
Intensive Outpatient Program (ICORT)	No	
Assertive Community Treatment	Yes	
Electroconvulsive Therapy (ECT)	Yes	
Psychological Testing	Yes	

Some services require prior authorization. Please check PA requirements at UHCprovider.com/priorauth.

CHIP Benefits

Exclusions & Limitations

Despite any other provisions of these rules and regulations, benefits are limited, excluded, and conditioned as follows:

No benefits will be provided for services or supplies which are provided for the following:

- A. Convalescent, custodial, or domiciliary care or rest cures, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care or supervisory care by a care provider for an enrolled child who is mentally or physically disabled as a result of delayed development or body infirmity, or who is not under specific medical, surgical or psychiatric treatment to reduce his disability to the extent necessary to enable him to live outside an institution providing care; neither will benefits be provided if the enrolled child was admitted to a hospital for their own convenience or the convenience of their care provider, or that the care or treatment provided did not relate to the condition for which the enrolled child was hospitalized, or that the hospital stay was excessive for the nature of the injury or illness, it being the intent to provide benefits only for the services required in relation to the condition for which the enrolled child was hospitalized and then only during such time as such services are medically necessary.
- B. Cosmetic purposes, except for correction of defects incurred by the enrolled child while covered under the program through traumatic injuries or disease requiring surgery.
- C. Sex therapy or marriage or family counseling.
- D. Custodial care, including sitters and companions.
- E. Elective abortion unless documented to be medically necessary to preserve the life or physical health of the mother.
- F. Equipment that has a non-therapeutic use.
- G. Procedures which are experimental/investigative in nature.
- H. Palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment for subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
- I. Services and supplies related to infertility, artificial insemination, intrauterine insemination and in vitro fertilization regardless of any claim to be medically necessary.
- J. Services which we determine are not medically necessary for treatment of injury or illness.
- K. Services provided under any other federal, state, or governmental plan or law.
- L. Nursing or personal care facility services, e.g. extended care facility, nursing home, or personal care home, except as specifically provided otherwise.
- M. Treatment or care for obesity or weight control including all diet treatments, gastric or intestinal bypass or stapling, or related procedures regardless of degree of obesity or any claim to be medically necessary.
- N. For refractive surgery such as radial keratotomy and other procedures to alter the refractive properties of the cornea.
- O. Inpatient rehabilitative services consisting of the combined use of medical, social, educational or vocational services, or any such services designed to enable enrolled children disabled by disease or injury to achieve functional ability, except for acute short-term care in a hospital or rehabilitation hospital as approved by the Utilization Management program.
- P. Outpatient rehabilitative services consisting of pulmonary rehabilitation, or the combined use of medical, social, educational or vocational services, or any such services designed to enable enrolled children disabled by disease or injury to achieve functional ability, except for physical, occupational, or speech therapy services specified in a plan of

CHIP Benefits

treatment prescribed by the enrolled child's care provider and provided by a licensed therapist.

- Q. Care rendered by a care provider who is related to the enrolled child by blood or marriage or who regularly resides in the enrolled child's household.
- R. Services rendered by a care provider not practicing within the scope of his license at the time and place service is rendered.
- S. Treatment related to sex transformations regardless of claim of medical necessity or for sexual function, sexual dysfunction or inadequacies not related to organic disease.
- T. Reversal of sterilization regardless of claim of medical necessity.
- U. Charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, or to obtain medical records or information required to adjudicate a claim.
- V. Travel, whether or not recommended by a care provider, except as provided for under transplant benefits.
- W. Services related to diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.
- X. Treatment of any injury arising out of or in the course of employment or any sickness entitling the enrolled child to benefits under any Workers' Compensation or Employer Liability Law.
- Y. Any injury growing out of a wrongful act or omission of another party for which injury that party or some other party makes settlement or is legally responsible; provided, however, that if the enrolled child is unable to recover from the responsible party, benefits of the program will be provided.

CHIP Services

Behavioral Health & Substance Use Disorder (SUD) Treatment Services

- (1) Inpatient mental health services, other than services described under substance use disorder services, but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services.
 - (a) Benefits for covered medical expenses are paid for medically necessary inpatient psychiatric treatment of an enrolled child.
 - (b) Benefits for covered medical expenses are provided for partial hospitalization.
 - (c) Certification of medical necessity by the Utilization Management program is required for admissions to a hospital.
 - (d) Benefits for mental/nervous conditions do not include services where the primary diagnosis is a substance use disorder.
- (2) Outpatient mental health services, other than services described under substance use disorder services.
 - (a) Benefits for covered medical expenses for treatment of nervous and mental conditions on an outpatient basis.
 - (b) Benefits for mental/nervous conditions do not include services where the primary diagnosis is a substance use disorder.
- (3) Inpatient SUD treatment services and residential SUD treatment services:
 - (a) Benefits for covered medical expenses are provided for the treatment of SUD, whether for alcohol, drug, or a combination of alcohol and drug.
 - (b) Benefits for covered medical expenses are provided for medically necessary inpatient stabilization and residential SUD treatment.
- (c) Certification of medical necessity by our Utilization Management program is required for admissions to a hospital or residential treatment center.
- (d) Benefits for SUD do not include services for treatment of nervous and mental conditions.
- (4) Outpatient SUD treatment services:
 - (a) Benefits are provided for covered medical expenses for medically necessary intensified outpatient programs in a hospital, an approved licensed alcohol or chemical dependency facility, or an approved drug treatment facility.
 - (b) Benefits are provided for covered medical expenses for SUD treatment while not confined as a hospital inpatient.
 - (c) Benefits for SUD do not include services for treatment of nervous and mental conditions.

Behavioral Health Line Services

Helping our Members to Make Confident Health Care Decisions

Coping with health concerns can be time-consuming and complex. With so many choices, it can be hard to know where to look for trusted information and support.

That's why our Behavioral Health Line services were developed – to give our members peace of mind with:

- Immediate answers to your health questions any time, from anywhere – 24 hours a day
- Access to caring registered nurses who have an average of 15 years' clinical experience
- Trusted, physician-approved information to guide health care decisions

CHIP Services

When a member calls, a caring nurse can help our members to:

Choose appropriate medical care.

- Understand a wide range of symptoms.
- Determine if the emergency room, a doctor visit or self-care is right for their needs.

Find a doctor or hospital.

- Find doctors or hospitals that meet their needs and preferences.
- Locate an urgent care center and other health resources.

Understand treatment options.

- Learn more about a diagnosis.
- Explore the risks, benefits and possible outcomes of treatment options.

Achieve a healthful lifestyle.

- Get tips on how nutrition and exercise can help the member maintain a healthful weight.
- Learn about important health screenings and immunizations.

Ask medication questions.

- Explore how to save money on prescriptions.
- Learn how to take medication safely and avoid interactions.

Members can call a NurseLine nurse any time for health information and support – all at no cost – at 877-410-0184.

Online Resources

Members can visit [UHCCommunityPlan.com](https://www.uhc.com/communityplan) for health and well-being news, tools, resources and more. Members can even chat with a nurse any time about health questions or concerns.

Pharmacy Services

The following drugs and medical supplies are covered:

- (a) Legend drugs (federal law requires these drugs be dispensed by prescription only)
- (b) Compounded medication of which at least one ingredient is a legend drug
- (c) Disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-Tape)
- (d) Disposable insulin needles/syringes
- (e) Growth hormones
- (f) Insulin
- (g) Lancets
- (h) Legend contraceptives
- (i) Retin-A (tretinoin topical)
- (j) Fluoride supplements (e.g., Gel-Kam, Luride, Prevident, sodium fluoride tablets)
- (k) Vitamin and mineral supplements, when prescribed as replacement therapy
- (l) Legend prenatal vitamins

The following are excluded:

- (a) Anabolic steroids (e.g., Winstrol, Durabolin)
- (b) Anorectics (drugs used for the purpose of weight loss), with the exception of select anti-obesity agents that are covered with a medical necessity prior authorization, which may be found on the PDL
- (c) Anti-wrinkle agents (e.g., Renova)
- (d) Charges for the administration or injection of any drug; exception that the administration of immunization as specified in this benefit plan is covered
- (e) Dietary supplements
- (f) Infertility medications (e.g., Clomid, Metrodin, Pergonal, Profasi)
- (g) Minerals (e.g., Phoslo, Potaba)
- (h) Medications for the treatment of alopecia, e.g.

CHIP Services

Minoxidil (Rogaine)

- (i) Non-legend drugs other than those listed as covered
- (j) Pigmenting/depigmenting agents
- (k) Drugs used for cosmetic purposes
- (l) Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed as covered, such as insulin needles and syringes
- (m) Any medication not proven effective in general medical practice
- (n) Investigative drugs and drugs used other than for the FDA approved diagnosis
- (o) Drugs that do not require a written prescription
- (p) Prescription drugs if an equivalent product is available over the counter
- (q) Refills in excess of the number specified by the care provider or any refills dispensed more than one year after the date of care provider's original prescription

Pharmacy Prior Authorization

Medications can be dispensed as an emergency 72-hour supply when drug therapy must start without delay and prior authorization is not available. The rules apply to non-preferred drugs on the PDL and to any drug that is affected by a clinical prior authorization edit.

To request pharmacy prior authorization, please call the OptumRx Pharmacy HelpDesk at 800-310-6826 or fax your authorization request to 866-940-7328. Prior authorization requests are reviewed and notification is sent back within 24 hours.

Pharmacy – Preferred Drug List (PDL)

The Division of Medicaid (DOM) determines and maintains its Universal Preferred Drug List (PDL), which applies to all Mississippi CHIP members. The PDL applies only to medications dispensed by contracted pharmacies to outpatient members; it does not apply to inpatient

medications.

You are required to prescribe preferred drugs listed on the Universal PDL for Medicaid members. For drugs not listed on the Universal PDL, Mississippi law requires the DOM to not reimburse for a brand-name drug if an equally effective generic equivalent is available and is the least costly. The same applies to UnitedHealthcare Mississippi CHIP members.

If a non-preferred medication is required for a member's treatment, you must call the Pharmacy Prior Authorization Service at 800-310-6826, or fax a Pharmacy Prior Notification Request form to 866-940-7328. The request is promptly reviewed, and you are notified of the decision.

PDL information, including updates when changes occur, will be provided to you in advance, and a summary of changes posted to the plan's website. The PDL, Pharmacy Prior Notification Request form are on the plan's website at UHCprovider.com/MSCCommunityPlan > Pharmacy Resources and Physician Administered Drugs. To obtain a print copy of the PDL, contact the Provider Service Center.

Dental

- (1) Benefits are provided for preventive and diagnostic dental care as recommended by the American Academy of Pediatric Dentistry (AAPD). The following Covered Dental Services are limited to \$2,000 each calendar year:
 - (a) Bitewing X-Rays-as needed, but no more frequently than once every six months;
 - (b) Complete Mouth X-Ray and Panoramic X-Ray – as needed, but no more frequently than once every 24 months;
 - (c) Prophylaxis- one every six months; must be separated by six full months;
 - (d) Fluoride Treatment – limited to one each six month period;
 - (e) Space maintainers – limited to permanent teeth through age 15;
 - (f) Sealants – covered up to age 14, every 36

CHIP Services

months.

- (g) Restorative, endodontic, periodontic and surgical dental services, shown as follows:
 - (1) Amalgam, Silicate, Sedative, and Composite Resin Fillings including the replacement of an existing restoration;
 - (2) Stainless steel crowns to posterior and anterior teeth;
 - (3) Porcelain crowns to anterior teeth only;
 - (4) Simple extraction;
 - (5) Extraction of an impacted tooth;
 - (6) Pulpotomy, pulpectomy and root canal;
 - (7) Gingivectomy, gingivoplasty and gingival curettage.

Other Dental Services (The calendar year maximum does not apply to these services.)

- (1) Benefits are provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled child is covered under the plan. Injury to teeth as a result of chewing or biting is not considered an accidental injury.
- (2) Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the enrolled child requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office.
- (3) No benefits will be provided for dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions.
- (4) Benefits are provided for diagnosis and surgical

treatment of temporomandibular joint (TMJ) disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a care provider or dentist, subject to a lifetime maximum benefit of \$5,000 per member. This lifetime maximum will apply regardless of whether the temporomandibular/craniomandibular joint disorder was caused by an accidental injury or was congenital in nature.

- (5) For members younger than 3 years old, PCPs can apply fluoride varnish as part of routine primary care/preventive services.

For more information go to our dental provider website at UHCprovider.com.

Prior Authorization

Prior authorization or other limitations may apply for some dental services such as crowns, periodontal or specific oral surgery procedures. Prior authorization is also required for accidental injury benefits, and procedures for diagnosis and treatment of TMJ syndrome. Please contact Provider Services for specific instruction.

Vision

Routine vision, which includes a comprehensive eye exam and glasses once per calendar year, is provided through our third-party vendor, March Vision. Additionally, the March Vision network of ODs and MDs provides primary eye care services. The primary eye care plan provides supplemental coverage for non-surgical medical eyecare through a March Vision doctor. Examples of services covered include diagnosis and tests for loss of vision, treatment for conditions such as conjunctivitis (pink eye), and management of glaucoma and diabetic retinopathy. March Vision doctors may provide services, if covered, up to the optometry scope of licensure in the state of Mississippi in accordance with the covered benefits. Patients do not need a referral before the initial visit with their selected March Vision doctor. Patients may call for an appointment or be seen immediately if the care

CHIP Services

provider determines urgent care is necessary. Please refer patients to March Vision's toll-free Customer Service number at 844-606-2724.

Medical eye care beyond the scope of primary eye care, to include surgical care, is provided through participating ophthalmologists as listed in the UnitedHealthcare Community Plan Provider Directory. If medical eyecare is needed, please refer patients to a participating ophthalmologist.

Medical Management

Referral Guidelines

Care providers caring for our members are generally responsible for initiating and coordinating referrals of members for medically necessary services beyond the scope of their practice. You are expected to monitor the progress of referred members' care and help ensure that they are returned to your care as soon as medically appropriate. We require prior authorization of all out-of-network referrals. The request is generally processed like any other authorization request. The nurse reviews the request for medical necessity and/or service. If the case does not meet criteria, the nurse routes the case to the medical director for review and determination. Out-of-network referrals are generally approved for, but not limited, to the following circumstances:

- Continuity of care issues
- Necessary services are not available within network.

Only in-network care providers can initiate prior authorizations. Authorization for out-of-network services should be initiated by the in-network PCP or specialist who intends to seek other services. Through the provider portal, the in-network provider should appropriately indicate the provider who is performing the service.

Out of network referrals are monitored on an individual basis and trends related to individual care providers or geographical locations are reported to Network Provider Services to assess root causes for action planning.

Emergency Care Resulting in Admissions

Prior authorization is not required for emergency services. Emergency care should be rendered at once, with notification of any admission to the Prior Authorization Department at 800-557-9933 or fax to 888-310-6858 by 5 p.m. next business day. Nurses in the Health Services Department review emergency admissions within one working day of notification. UnitedHealthcare Community Plan uses evidence-based, nationally accredited, clinical criteria for determinations of appropriateness of care.

Additionally, in accordance with the provisions of 42 C.F.R. § 422.133-c, post-stabilization services are covered and provided without the need of prior authorization if the services are medically necessary and resulting from the emergency medical condition.

Admission to inpatient starts at the time the order is written by a physician that a member's condition has been determined to meet an acute inpatient level of stay.

Care in the Emergency Room

UnitedHealthcare Community Plan members who visit an emergency room should be screened to determine whether a medical emergency exists. Prior authorization is not required for the medical screening. UnitedHealthcare Community Plan provides coverage for these services without regard to the emergency care provider's contractual relationship with UnitedHealthcare Community Plan. Emergency services, i.e. physician and outpatient services furnished by a qualified care provider necessary to treat an emergency condition, are covered both within and outside UnitedHealthcare Community Plan's service area.

An emergency is defined as a medical or behavioral condition, which manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect in the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child), or in the case of a behavioral condition, perceived as placing the health of the person or others in serious jeopardy
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

Medical Management

Facility Admission Notification Requirements

Facilities are responsible for Admission Notification for the following inpatient admissions (even if an advanced notification was provided prior to the actual admission date):

- Planned/elective admissions for acute care
- Unplanned admissions for acute care
- Skilled Nursing Facility (SNF) admissions
- Admissions following outpatient surgery
- Admissions following observation

Services that Require Prior Authorization

Advanced Radiology Services
Auditory Implants & Hearing Devices
Bone Growth Stimulator
Cardiac testing
Certain Genetic Tests
Cosmetic and Bariatric Surgery
Dental Major Services <ul style="list-style-type: none"> • Crowns (excluding D2930 prefabricated stainless steel crowns-primary tooth and D2933 prefabricated stainless steel crown with resin window-anterior teeth only) • Periodontal procedures <ul style="list-style-type: none"> – Oral surgery procedures (excluding extractions) • Accidental injury benefits • TMJ coverage benefit
Durable Medical Equipment and Supplies > \$500 Per Item
Enteral & Parenteral Services
Focused Radiation Therapy
Prosthetics and Orthotics > \$500 Per Item
Home Health Care Services <ul style="list-style-type: none"> • Medication or infusion • Therapy services provided in home • All other
Hospice Services – Inpatient and Outpatient
Hospital Services * <ul style="list-style-type: none"> • Inpatient admissions (emergency admissions do not require prior authorization)
Hospital Services – Sub-acute Inpatient <ul style="list-style-type: none"> • Rehabilitation and skilled nursing facility

Prior authorization information changes frequently. Always consult the most recent list at UHCprovider.com/MSCCommunityPlan.

Medical Management

Injectable Chemotherapy Drugs – given in an outpatient setting for a cancer diagnosis
Non-contracted Provider Services (hospital and professional)
Pharmacy – Non-preferred drugs and any drugs affected by a need for prior authorization
Skilled Nursing Facility Services
Speech Therapy services
Transplantation Evaluations
Behavioral Health and Substance Use – Ambulatory <ul style="list-style-type: none"> • Routine outpatient services (excluding services with an MD) • Intensive outpatient • Outpatient detoxification and rehabilitation • Psychological and neuropsychological testing • Applied behavioral analysis • Electro-convulsive therapy
Hospital Services – Behavioral Health and Substance Use* <ul style="list-style-type: none"> • Inpatient • Detoxification • Rehabilitation • Partial hospitalization • Residential treatment facility
*Emergency admissions do not require prior authorization
Medical Injectables, including Acthar HP, Botulinum Toxins, Immune globulins, and Makena

This list is meant to serve as a guide. For a complete list go to UHCprovider.com/priorauth.

Medical Management

InterQual Care Guidelines®

The InterQual Care Guidelines are annually updated, evidence-based clinical guidelines that span the continuum of care, including chronic care and behavioral health management. InterQual Care Guidelines is widely regarded for its scientific approach, using comprehensive medical research to develop recommendations on optimal length of stay goals, best practice care templates, and key milestones for the best possible treatment and recovery. These criteria are part of our Utilization Management review process.

If you have questions about these guidelines or would like a copy of the criteria used for specific determination of medical necessity, please call our Utilization Management nurse assigned to the case through our Customer Service Center at 888-980-8728 (TTY: 711). You are offered an opportunity to discuss the requested services with the physician who will make the decision by calling our medical director at 888-980-8728, select option 1, and then option 1 again (for Medicaid) or 800-410-1925, select option 1 (for Medicare).



If you would like a copy of the InterQual Care Guidelines, go to [UHCprovider.com](https://www.uhcprovider.com) > Menu > Health Plans by State > Mississippi > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > Clinical Guidelines > [InterQual Clinical Guidelines for the State of Mississippi](#), or call Provider Services at 888-980-8728 (TTY: 711).

How to Contact Our Utilization Management Team

Our utilization management team is available Monday – Friday, 8 a.m. – 5 p.m. Central Time, to answer any utilization management or prior authorization questions. The team can be reached by calling 888-980-8728. Assistance is also available after hours.

Utilization management decisions are based on appropriateness of care and existence of coverage.

UnitedHealthcare Community Plan does not reward or penalize staff in any way for issuing denials of coverage; there are no financial incentives for Utilization Management decision makers that encourage underutilization of care.

Determination of Medical Necessity

UnitedHealthcare Community Plan evaluates medical necessity according to the following standard.

Medically necessary services or supplies are those necessary to:

- Prevent, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition.
- Maintain health.
- Prevent the onset of an illness, condition or disability.
- Prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity.
- Prevent the deterioration of a condition.
- Promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capabilities that are appropriate for individuals of the same age.
- Prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member.

The services provided, as well as the type of care provider and setting, must reflect the level of services safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the member and not solely for the convenience of the member or care provider. In addition, the services must be in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective.

Medical Management

Experimental services or services generally regarded by the medical profession as unacceptable treatment are considered not medically necessary. These specific cases are determined on a case-by-case basis.

The determination of medical necessity must be based on peer-reviewed publications, expert pediatric, psychiatric and medical opinion, and medical/pediatric community acceptance. In the case of pediatric members, the standard of medical necessity will include the additional criteria that the services, including those found to be needed by a child as a result of a comprehensive screening visit or an inter-periodic encounter, whether or not they are ordinarily covered services for other members, are (a) appropriate for the age and health status of the individual, and (b) will aid the overall physical and mental growth and development of the individual and the service will assist in achieving or maintaining functional capacity.

Disease Management

Our Disease Management (DM) programs are part of our innovative Care Management Program. Our DM program is guided by the principles of the UnitedHealthcare Community Plan Whole Person Care Model. We developed the Whole Person Care Model to address the needs of medically under-served and low-income populations. The model places emphasis on the individual as a whole, to include the environment, social determinants, background and culture.

Identifications and Stratification

A Health Risk Assessment (HRA) and our predictive modeling and stratification system are the primary tools for identifying Members for disease management programs.

Health Risk Assessment

The HRA is an initial assessment tool used for new and existing members, to identify a member's health risks. Based upon the member's response to a series of question, the tool will assign a score that corresponds to

a level. These levels are as follows:

- Level 1: Low-risk members who are typically healthy, stable or only have one medical condition that is well managed.
- Level 2: Moderate-risk members who may have a severe single condition, or multiple conditions issues across multiple domains of care of DM.
- Level 3: High-risk members who are medically fragile, have multiple co-morbidities and need complex care management.

Identification of "rising" is a flag for intervention if a member is progressing into a higher risk category.

Stratification

Our multi-dimensional, episode-based predictive modeling tool, compiles information from multiple sources including claims, laboratory and pharmacy data and uses it to predict future risk for intensive care services.

On a monthly basis, the system uses algorithms to identify members for disease management and stratify them into risk levels by severity of disease and associated co-morbidities. The algorithm takes into consideration inpatient and emergency room (ER) use. An "Overall Future Risk Score" is assigned to each member and represents the degree to which the DM program has the opportunity to impact members' health status and clinical outcomes. This assists care managers in identifying members who are most likely to benefit from interventions.

Outreach and Other Identification Processes

While HRAs and retrospective data are the first line of identification of new members in our DM programs, we have developed an extensive outreach program that supports real-time identification and referral for our DM services. Through community partnerships and relationships, our staff encourages and educates care providers, ER staff, and hospital discharge planners to refer program members for a greater intensity and frequency of DM interventions when the situation requires it.

Medical Management

We supplement the HRA and the stratification tool identification process through several other methods. One of these approaches is an extensive outreach program that supports real-time identification and referral for our DM services. Our staff encourages and educates care providers, ER staff, and hospital discharge planners to refer program members for a greater intensity and frequency of DM interventions when the situation requires it. We also rely on partnering programs and agencies to identify those members most in need. Our DM staff is responsible for collaborating with other community partners such as program care managers, clinic staff, other health care team community partners, and fiduciary entities to identify members. Finally, in addition to claims and pharmacy data, we integrate authorization and pre-certification information into the DM software system. This data provides real-time identification of members experiencing health care barriers and self-care deficits.

DM Interventions

After a member has been identified, the care manager contacts the member's parent or caregiver by telephone and sends program and health education materials targeted to the member's specific care opportunities. The accompanying letter informs the member's parent or caregiver on how the member became eligible to participate in the program, how to use the DM services, and how to opt out if they do not wish to participate.

Because our DM program provides benefits and quality-of-life improvements that ultimately impact the overall costs in care, our enrollment staff makes every attempt to enroll members in the DM program. We employ a number of strategies to locate and contact the Member's parents or caregivers, including after-hours calls, searching for updated member information by contacting the primary care provider (PCP)/specialist office and reviewing prior authorization information, and sending written correspondence. We document and track contacts to help ensure that all options have been exhausted prior to reporting failure to contact.

Once a member agrees to enroll in the DM program, the care manager performs a comprehensive health risk and needs assessment that identifies additional

risk factors, current and past medical history, personal behaviors, family history, social history, and environmental risk factors. This information is used to augment and validate the risk stratification of members. We also institute disease specific assessments to augment the HRA when the caretaker is contacted.

We have developed evidence-based interventions for our DM program. The following general interventions have been structured to improve members' health status.

- Health risk assessment
- Health review phone calls
- Provide assigned care manager's phone number to the member/family
- Ongoing monitoring of claims and other tools to re-assess risk and needs
- Access to program website
- Episodic educational interventions, as needed
- Post hospitalization and emergency room assessment
- Educational materials are sent to member
- Letter is sent to the care provider identifying the member's involvement, intervention and point of contact for the DM program.
- Additional and/or specific interventions are also conducted to individualize the plan of care.

Plan of Care

All of our DM programs are part of the Personal Care Model™, our overall care management program, in which we pioneered a member-centric approach to the development of the plan of care for program participants. Our unique Personal Care Model™ features direct member, parent and caregiver contact by clinical staff who work to build a support network for high risk chronically and acutely ill members involving family, care providers, and community-based organizations. The goal is to employ practical solutions to improve members' health and keep them in their communities with the resources they need to maintain the highest possible functional status.

Medical Management

The goals of the plan of care implementation are two-fold: 1) Care manager interventions support self-management/self-efficacy and patient education; and 2) Care manager interventions are defined to help ensure appropriate medical care referrals and assure appointments are kept, immunizations are received, and the member is connected with available and appropriate community support groups, for example, nutrition programs or caregiver support services. When the plan of care is implemented, our goals are:

- To assure the member is leveraging personal, family, and community strengths when able
- To help ensure that we are using evidence-based guidelines and best practices for education and self-management information while integrating interventions to address co-morbidities
- To modify our approach or services based on the feedback from the member, family, and other health care team members
- To document services and outcomes in a way that can be captured and modified to continually improve
- To communicate effectively with the PCP/specialist and other care providers involved in the member's care
- To monitor member satisfaction with services, adjusting as needed.

The care manager develops and implements an individualized plan of care for members requiring services, reviews the member's progress and adjusts the plan of care, as necessary, to help ensure that the member continues to receive an appropriate level of care. The care manager will involve the care provider treating our member in the plan of care development process and assist them in directing the course of treatment in accordance with the evidence-based clinical guidelines that support our DM program. The plan of care addresses the following areas of care:

- Psychosocial adjustment
- Nutrition
- Complications

- Pulmonary/Cardiac rehab
- Medication
- Prevention
- Self-monitoring, symptoms and vital signs
- Emergency management/co-morbid condition action plan
- Appropriate health care utilization

Pharmacy

Our pharmacy disease management is integrated with our other DM programs into our Care Management program. Like the other DM program, it is based on our Personal Care Model (PCM), which emphasizes the whole individual, including environment, background and culture.

We also integrate our pharmacy disease management for asthma into our regular asthma disease management program.

With the exceptions of the asthma component, pharmacy disease management services, we provide pharmacy disease management through OptumRx, our pharmacy benefit manager, and a United Health Group (UHG) company. OptumRx administers Disease Therapy Management (DTM) programs that are clinical, patient-focused programs offered as part of Specialty Pharmacy Care Management services. The objective of our DTM programs is to improve patient quality of care through education and communication.

OptumRx Specialty Pharmacy offers DTM programs for the following disease states/conditions:

- Rheumatoid Arthritis
- Growth disorders
- Hemophilia
- Risk of respiratory syncytial virus due to prematurity

Medical Management

Additional programs to be provided to MS CHIP members include:

- Hepatitis C
- Multiple sclerosis
- Anemia related to chemotherapy

The Plan of Care (POC) will address the following areas of care:

- Psychosocial adjustment
- Nutrition
- Complications
- Pulmonary/Cardiac rehab
- Prevention
- Self-monitoring, symptoms and vital signs
- Emergency management/co-morbid condition action plan
- Appropriate health care utilization.

Our DM (Medication Management) program is supported by UnitedHealthcare Community Plan's integrated clinical system, which includes basic and comprehensive supplemental assessments, facilitates the development of integrated care plans, and includes ongoing monitoring and evaluation tools.

Preferred Drugs

The Division of Medicaid (DOM) determines and maintains its Universal Preferred Drug List (PDL), which applies to all Mississippi CHIP members. The PDL was developed to help you select medically appropriate, high-quality, and cost-effective drugs for members. The PDL applies to prescription medications dispensed by contracted pharmacies and over-the-counter (OTC) to outpatient members. It does not apply to inpatient medications.

The Universal PDL is organized by therapeutic class. You are encouraged to prescribe drugs included in the preferred drug list whenever appropriate. If a non-preferred medication is required for a member's treatment or if a preferred medication is required which requires

prior authorization, you must call the Pharmacy Prior Authorization Service at 800-310-6826 or fax a Pharmacy Prior Notification Request form to 866-940-7328 to make the request. The request will be promptly reviewed, and you will be notified of the decision within 24 hours.

PDL information, including updates when changes occur, will be provided to you in advance and a summary of changes posted to the plan's website. You may find the PDL and the Pharmacy Prior Notification Request form on the plan's website at UHCprovider.com/priorauth. To obtain a print copy of the PDL, contact the Provider Service Center.

Coordination of Care

Each member is encouraged to select a medical home for community-based health and preventive services. We assign a PCP to members who do not choose a medical home. We choose a care provider from our network based on geographic proximity to the member's home, as well as the care provider's quality scores. By treating our members, you will receive reports regarding the health status of members participating in specific DM programs. As this link is established, we involve you in the plan of care development process and assist you in directing the course of treatment in accordance with evidence-based clinical guidelines.

The care manager collaborates with you on an ongoing basis to help ensure integration of physical and behavioral health issues. In addition, the care manager will help ensure the plan of care supports the member's/caregiver's preferences for psychosocial, educational, therapeutic and other non-medical services.

The care manager also helps ensure the plan of care supports your clinical treatment goals and builds the plan of care to reflect personal, family and community strengths. The care manager and member will review the member's compliance with the treatment during each assessment cycle. Treatment, including medication compliance, is established as a health care goal with interventions and progress towards that goal documented in each assessment session. At any point that the care

Medical Management

manager recognizes the member is non-compliant with part or all of the treatment plan, the care manager will:

- Work to identify and understand the member's barriers to success
- Problem solve for alternative solutions with the member
- Report non-compliance to the treating care provider/specialist, offer potential solutions and integrate your feedback
- Facilitate agreement for change between all parties and monitor progress of the change.

As the member's medical home, you are continuously updated on the member's participation in the DM program(s), the member's compliance with the plan of care and any unscheduled hospital admissions and emergency room visits. You receive notifications of when members are enrolled and disenrolled from the DM programs, the assigned care manager for the DM program, and how to contact the care manager. In addition, you receive notification of members who have generated care opportunities related to specific DM programs. These evidence-based medical guidelines are generated from our multi-dimensional, episode-based predictive modeling tool.

We also distribute clinical practice guidelines upon your request and provide training for you and your staff on how best to integrate practice guidelines into everyday care provider practice. When you demonstrate a pattern of non-compliance with clinical practice guidelines, the medical director may contact you by phone or in person to review the guideline and identify any barriers that can be resolved.

Case Management

We use retrospective and prospective methods to help ensure potential high-risk members are identified as early as possible. To identify members who meet criteria for disease and care management, we continuously forecast risk through predictive modeling of our claims data. To supplement our retrospective, claims-based approach, we perform an automated, mini health risk

assessment. In addition, we also review authorization requests, hospital and ER use, pharmacy data and referrals from you, members and their family/caregivers as well as our clinical staff. Individuals identified for possible care management go through a more in-depth, scored comprehensive assessment and are routed to the appropriate DM or CM program based on the outcome of that scoring.

Prospective Identification – We use numerous data sources to identify members with a diagnosis for which we have a disease management program as well as those whose utilization reflects high-risk and/or complex conditions (level 3). These data sources include:

- Short health risk assessments conducted during new member welcome calls
- Member reported health needs in calls made to our Member Service department
- Pharmacy and lab data indicating the incidence of a specific condition (for example, insulin or inhalers)
- Emergency room utilization reports, hospital inpatient census reports, authorization requests and transitional care coordination requests
- Physician referrals
- Referrals from health departments, rural health clinics and FQHCs
- UnitedHealthcare Community Plan clinical staff referrals.

Risk Stratification – All identified members complete a health risk assessment that scores them into risk categories. Based on the actionable population and aid categories of each health plan and state program, we determine the specific threshold for each case and disease management level. As previously mentioned, members are stratified into one of three levels and/or a "rising" identification, and are assigned to the appropriately qualified staff.

Clinical Practice Guidelines

UnitedHealthcare Community Plan uses nationally recognized, evidence-based clinical criteria to guide

Medical Management

our medical necessity decisions. These guidelines are integrated into our clinical system.

For specific state benefits or services not covered under national guidelines, we develop criteria through the review of current medical literature and peer reviewed publications, Medical Technology Assessment Reviews and consultation with specialists.

Medical Management

Medical guidelines are available and shared with you upon request and are available on the provider website, [UHCprovider.com](https://www.uhcprovider.com). Policies and guideline updates are communicated through care provider notices prior to implementation.

For pharmacy DM, use of guidelines helps ensure appropriate use at the initiation of therapy. OptumRx implements and manages a preferred product listing, which lends itself to standardization, consistency and cost savings. In addition, they offer a case review process, which includes clinical pharmacist review of the clinical progress of the patient, any pertinent labs, and patient compliance to evaluate continuation of a medication.

We adopt clinical practice guidelines from recognized sources as the clinical basis for the DM programs. These clinical guidelines are systematically developed from evidence-based criteria to help you make decisions about appropriate care for specific clinical circumstances. They are reviewed and revised annually. These guidelines can be found at [UHCprovider.com](https://www.uhcprovider.com).

Preventive Health Care Standards

UnitedHealthcare Community Plan's goal is to partner with you to help ensure that members receive preventive care. We endorse and monitor the practice of preventive health standards recommended by recognized medical and professional organizations. Preventive health care standards and guidelines are available at [UHCprovider.com](https://www.uhcprovider.com). Standards such as well-child, adolescent and adult visits, childhood and adolescent immunizations, lead screening and cervical and breast cancer screening are included on the website. Education is provided to both members and you related to preventive health services, and members are offered assistance with gaining access to these services if needed. Members may self-refer to all public health agency facilities for medical conditions treated by those agencies.

Maternity Care

Pregnant UnitedHealthcare Community Plan members should receive care from participating providers only. We will consider exceptions to this policy if 1) the woman was in her second trimester of pregnancy when she became an UnitedHealthcare Community Plan member, and 2) if she has an established relationship with a non-participating obstetrician. Call 800-557-9933 to obtain global authorization. For all other questions, call Healthy First Steps (HFS) at 800-599-5985.

Notify us promptly of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the HFS coordinator.

To notify us of deliveries, call 800-557-9933 or fax the OB Referral Notification Form to 877-353-6913. Fax HFS an American College of Gynecology (ACOG) or any initial prenatal visit form at 877-365-5960.

Provide us with the following information within one business day of the visit when the pregnancy is confirmed:

- Member's name and member ID number
- Obstetrician's name, phone number, and provider ID number
- Facility name
- Expected date of confinement (EDC)
- Planned vaginal or Cesarean delivery
- Any diagnoses that could affect pregnancy or delivery
- Obstetrical risk factors
- Gravida
- Parity
- Number of living children
- Previous care for this pregnancy

Medical Management

An obstetrician does not need approval from you for prenatal care, testing or obstetrical procedures. Obstetricians may give the pregnant member a written prescription to present at any of the participating radiology and imaging facilities listed in the provider directory.

- Date of birth
- Birth weight
- Gender
- Any congenital defect
- Name of attending neonatologist

Healthy First Steps (Maternity Care)

We provide high-risk pregnancy management and discharge planning for NICU-admitted babies through our Healthy First Steps (HFS) program. HFS nurses conduct in-home post-discharge management of high-risk mothers and babies. Perinatal home care services are available for our members when medically necessary. In addition, UnitedHealthcare Community Plan has community-based outreach and social service support programs specific to the needs of pregnant women. The UnitedHealthcare Community Plan maternal case manager can assist obstetricians and you with referrals to these services.

HFS provides newborns, including NICU graduates, with ongoing medical needs. The HFS care managers assist with newborn educational needs as well as assistance accessing all MS CHIP services.

Obstetrical Admissions

UnitedHealthcare Community Plan considers all full-term maternity admissions to be scheduled admissions. You must notify our prior authorization department of the admission. Obstetricians and care providers caring for the members are expected to notify us as soon as a pregnancy is confirmed.

Newborn Admissions

The hospital must notify us prior to or upon the mother's discharge if the baby stays in the hospital after the mother is discharged. HFS will conduct concurrent review of the newborn's extended stay. The hospital should make available the following information:

Inpatient Concurrent Review: Clinical Information

Your cooperation is required with all UnitedHealthcare requests for information, documents or discussions related to concurrent review and discharge planning including: primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information by access to Electronic Medical Records (EMR).

Your cooperation is required with all UnitedHealthcare Community Plan requests from the interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone.

You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director.

UnitedHealthcare uses InterQual (formally MCG Care Guidelines), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. UnitedHealthcare Community Plan maintains a timely and organized process using established policies and procedures to help ensure prompt resolution of informal and formal complaints/grievances filed by members and you. Member and care provider rights are not the same. Please refer to the member handbook for member-specific information about complaints, appeals, grievances, and external

Medical Management

reviews, which you can find at [UHCCommunityplan.com](https://www.uhc.com/MS/CommunityPlan) > MS CHIP > Member Handbook. Our system includes member and care provider appeals processes and a care provider payment dispute process. We have a specialized grievance and appeal department. We allocate qualified and trained personnel to establish, implement and maintain this process.

Our grievance and appeals system is HIPAA-compliant and conforms to applicable federal and state laws, regulations and policies.

Appeals and Grievances

UnitedHealthcare Community Plan maintains a timely and organized process using policies and procedures to help ensure prompt resolution of informal and formal complaints/grievances filed by you and our members. Our system includes an appeal process and grievance process for both you and the member. The member has access to a State Fair Hearing process; you have access to an Administrative Hearing. We have qualified and trained personnel who establish, implement and maintain this process.

Compliance with State Requirements

Our grievance and appeals system is HIPAA-compliant and conforms to applicable federal and state laws, regulations and policies.

Member and Care Provider Notification

Upon enrollment, we inform members and you of our complaint/grievance and appeals procedures, including:

- The right to file grievances, appeals and claim disputes.
- The requirements and time frames for filing grievances, appeals and claim disputes.
- The availability of assistance for informal/formal grievance filing and process.
- Members may use a personal representative during the grievance process.
- You may request a copy of the clinical criteria from:
 - **P.O. Box 5032, Kingston, NY 12402-5032**
- Toll-free numbers to file a grievance or appeal by phone.
- Notice of grievance rights each time a covered service is denied, reduced or terminated.
- Notice of the right to appeal.
- Notice of the right to appeal an adverse benefit decision through an external review process.
- How to obtain an external review.
- Notice that, when timely filed, member-requested benefits continue during appeal/external review.

- Notice that, if the final decision is adverse to the member, the member may be liable for the cost of continued benefits.
- During the appeal/review process, the member and their representative will have the opportunity to examine the member's case files, including medical records and other records considered during the process.

We inform members of their right to file complaints, grievances, and appeals in the UnitedHealthcare Community Plan Member Handbook, new member welcome packet, and online through the UnitedHealthcare Community Plan website. We inform members of this process in prevalent non-English languages, through oral interpretation in any language and TTY/TTD services. We provide members with forms, if requested, and filing assistance.

Members may file either verbally or in writing. We inform you of the member's complaint, grievance and appeal process through the UnitedHealthcare Community Plan care provider manual and provider website. The written notice explains the member's right to file an appeal with us and to request an external review. It also explains information about requesting expedited resolutions and continuation of benefits pending resolution of an appeal.

Notice of Adverse Benefit Determination

UnitedHealthcare Community Plan notifies the requesting care provider and provides written notice to members of adverse benefit determinations. An adverse benefit determination includes:

- The denial or limited authorization of a requested service;
- Including determinations on the service type or level;
- Medical necessity requirements;
- Appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of a service payment;

Appeals and Grievances

- The failure to provide services in a timely manner, as defined by the Division;
- The failure of the health plan to act within the timeframes provided in 42 C.F.R. §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals;
- For residents in a rural area with only one MCO, the denial of a member's request to exercise their right, under 42 C.F.R. §438.52(b)(2)(ii);
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities; and
- Determinations by skilled nursing facilities and nursing facilities to transfer or discharge members and adverse determinations made by a state with regard to the pre-admission screening and annual member review requirements of Section 1919(e)(7) of the Act, if applicable.

If UnitedHealthcare Community Plan does not make a decision within the applicable time frames, a notice will be issued on the date the time frame expires.

Filing an Appeal

The member, or a member's representative or you acting on the member's behalf with the member's written consent, may appeal an adverse benefit determination within 60 calendar days from notice receipt. UnitedHealthcare Community Plan accepts appeals in writing or orally. Any individual or entity acting on behalf of a member must provide signed written consent from the member. This consent indicates the member has given permission for an authorized representative to act on their behalf. This signed consent is required for any action taken by an authorized representative. An acknowledgment letter is sent within 10 calendar days of standard appeal receipt.

The member or their authorized representative will have the opportunity before and during the process to examine the case file including all medical records and other material considered, and present evidence of fact or law. A copy of the file, upon request, is sent to the member or their authorized representative free of charge.

UnitedHealthcare Community Plan resolves an appeal and provides written notice of the resolution within 30 calendar days of standard appeal receipt. We may extend this time frame by up to 14 calendar days upon request, or if we demonstrate the need for more information and that a delay in rendering the decision is in the member's best interest. If the member or you did not request the delay, we provide a written notice of the extension and the delay reasons. Members have the right to file a grievance if they disagree with health plan's request to extend the timeframe in accordance with 42C.F.R. § 438.408(c).

UnitedHealthcare Community Plan will provide resolution of an expedited appeal decision within 72 hours from receipt of the appeal.

If the request for an expedited appeal is denied, the appeal is transferred to the 30 calendar day time frame for standard appeal resolution. We will make reasonable efforts to give prompt oral notice of the decision to deny the expedited appeal request, and will follow-up with a written notice within two calendar days with the decision reasons and the right to file a grievance.

Filing a Complaint

A member, or an authorized representative on behalf of a member, may file a complaint. A complaint is an expression of dissatisfaction, received orally or in writing, that is of a less serious or formal nature and resolved within one calendar day of receipt. Any complaint not resolved within one calendar day shall be treated as a grievance. A complaint includes, but is not limited to inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information. A complaint must be filed within 30 calendar days of the date of the event causing the dissatisfaction.

Filing a Grievance

A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a care provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension

Appeals and Grievances

of time proposed by UnitedHealthcare Community Plan to make an authorization decision.

A member, or their authorized representative, may call or write at any time to file a grievance. We acknowledge receipt of a grievance at the time of the call or in writing, within five calendar days when asked, or when the grievance is sent to us in writing. We will send notice of our decision within 30 calendar days of receipt, or expeditiously as the member's health condition requires.

We may extend the resolution by up to an additional 14 calendar days upon request, or if we demonstrate the need for more information and that a delay in rendering the decision is in the member's best interest. If the member or you did not request the delay, we provide written notice of the extension and the delay reasons. Members have the right to file a grievance if they disagree with health plan's request to extend the timeframe in accordance with 42C.F.R. § 438.408(c).

Filing for a Third Party External Review

Any appeal decision not resolved wholly in favor of the member may be appealed through a third party external review firm. A member may initiate this review after exhausting UnitedHealthcare Community Plan's appeal processes.

A review must be requested in writing by the member or their representative within 120 calendar days of our appeal decision date. If the reviewer reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, we will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires. If the reviewer reverses a decision to deny, limit or delay services and the member received the disputed services while the appeal was pending, we will pay for these services.

Continuation of Benefits

A member may be entitled to request continuation of benefits while the appeal or review is pending. A request for continuation of benefits must occur on or before the later of the following timely filing requirements:

- Within 10 calendar days of the health plan sending the notice of adverse benefit determination.
- The intended effective date of the health plan's proposed adverse benefit determination.

Continuation of benefits will continue if all of the following occur:

- The member timely files the appeal request in accordance with § 438.402(c)(1)(ii) and (c)(2)(ii).
- The appeal involves the termination, suspension, or reduction of previously authorized services.
- The services were ordered by an authorized care provider.
- The period covered by the original authorization has not expired.
- The member timely files for continuation of benefits.

If, at the member's request, the health plan continues or reinstates the member's benefits while the appeal is pending, the benefits will continue until one of following occurs:

- The member withdraws the appeal or request for external review hearing or independent external review.
- The member fails to request an external review and continuation of benefits within 10 calendar days after the health plan sends the notice of an adverse resolution to the member's appeal under § 438.408(d)(2).
- The independent external reviewer issues a decision adverse to the member.

When the reviewer's decision upholds our decision, we may initiate cost recovery for the service(s) provided, pending the outcome of the appeal and/or review.

Independent External Review Process

If a member, you, or an authorized representative of a member is not in agreement with our final determination, a request for an external third party review can be

Appeals and Grievances

initiated. We will refer the medical determinations to the designated independent external review organization. Such documentation will include:

- a) All files associated with the previous adverse determinations;
- b) The member's pertinent medical records;
- c) The attending physician's recommendations;
- d) Consulting reports from appropriate health care professionals;
- e) Other documents submitted by the member, their representative, or a care provider;
- f) Any applicable generally accepted practice guidelines, including those developed by the federal government, national or professional medical societies, boards or associations; and
- g) Any applicable clinical review criteria developed and/or used by UnitedHealthcare Community Plan.

The independent external review will thoroughly review all documentation provided by UnitedHealthcare Community Plan and make a final determination regarding the appeal. Such review and written notice to UnitedHealthcare Community Plan will be completed within 15 calendar days of receipt. The notice to UnitedHealthcare Community Plan will identify the qualifying credentials of the person(s) participating in the review and thoroughly explain the basis for the final determination.

We understand that the decision of the independent external review will be binding.

Exception

Upon member request, and for both a legitimate reason and a reasonable period, the 72 hours timeframe referenced in this section may be extended by up to 14 calendar days. Members have the right to file a grievance if they disagree with health plan's request to extend the timeframe in accordance with 42C.F.R. § 438.408(c).

Independent External Review Requirements

At a minimum, the independent external review:

- a) Establishes and maintains written policies and procedures that govern all aspects of standard and expedited review processes, which include procedures to help ensure reviews are conducted within the specified timeframes;
- b) Provides a toll-free telephone service capable of receiving information on a 24-hours-per-day, seven-days-a-week basis, that is capable of accepting, recording or providing appropriate instructions to incoming callers during other than normal business hours; and
- c) Uses qualified and impartial clinical peer reviewers who are skilled in the subject of the external review. Clinical peer reviewers will be:
 - 1) Currently licensed;
 - 2) Hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and
 - 3) Knowledgeable about the recommended healthcare services or treatment through actual clinical experience.

Neither the independent external review nor the clinical peer reviewer assigned to conduct an external review has a material, professional, familial or financial interest with UnitedHealthcare Community Plan, you, nor the facility recommending the health care services or treatment subject of the external review. Neither may the assigned clinical peer reviewer have a professional or familial interest with the member for whom the review is being conducted.

Appeals and Grievances

Summary of Care Provider Complaints, Grievances and Appeals

PARTY	ACTION	TIME FRAME	EXTENSIONS AVAILABLE
<p>Complaint: An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one calendar day of receipt. Any complaint not resolved within one calendar day will be treated as a grievance. A complaint includes, but is not limited to: inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information.</p>			
Member, care provider or authorized representative on behalf of a member	Submit a complaint	Within 30 calendar days of the event causing dissatisfaction	
UnitedHealthcare Community Plan	Respond to a provider complaint	Within one calendar day	
<p>Grievance: An expression of dissatisfaction, regardless of whether identified as a “Grievance,” received by any employee of UnitedHealthcare Community Plan, orally or in writing, about any matter or aspect of our operation, other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a network care provider or employee, or failure to respect a member’s rights regardless of whether remedial action is requested. Grievance includes a member’s right to dispute an extension of time proposed by us to make an authorization decision.</p>			
Member, care provider or authorized representative on behalf of a member	File a grievance	<p>A member, or authorized representative, can file a grievance any time after the dissatisfying event has occurred</p> <p>A care provider must file a grievance within 30 calendar days of the dissatisfying event</p>	
UnitedHealthcare Community Plan	Confirm receipt of the grievance and expected date of resolution	Within five calendar days of receipt of the grievance	
UnitedHealthcare Community Plan	Resolve a grievance	Within 30 calendar days of the date we receive the grievance or as expeditiously as the member’s health condition requires	We may extend time frames by up to 14 calendar days; members have the right to file a grievance if they disagree with health plan’s request to extend the timeframe in accordance with 42 C.F.R. § 438.408(c).
<p>Appeal: A request for review by UnitedHealthcare Community Plan of an adverse benefit determination related to a member or care provider. In the case of a member, UnitedHealthcare Community Plan’s adverse benefit determination may include determinations on the health care services a member believes they should receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the member’s health). In the case of a care provider, the adverse benefit determination may include, but is not limited to, delay or non-payment for covered services.</p>			

Appeals and Grievances

PARTY	ACTION	TIME FRAME	EXTENSIONS AVAILABLE
Member, care provider or authorized representative on behalf of a member	File an appeal	<p>A member must file an appeal within 60 calendar days of UnitedHealthcare Community Plan's adverse benefit determination notice</p> <p>A care provider must file an appeal within 30 calendar days of UnitedHealthcare Community Plan's adverse benefit determination</p>	
UnitedHealthcare Community Plan	Confirm receipt of the appeal and provide an expected date of resolution	Within 10 calendar days of receipt of the appeal	
UnitedHealthcare Community Plan	Resolve an appeal	<p>Within 30 calendar days of the date UnitedHealthcare Community Plan receives the appeal, or as expeditiously as the member's health condition requires</p> <p>Within three calendar days after UnitedHealthcare Community Plan receives the request for an expedited resolution of an appeal</p>	We may extend time frames by up to 14 calendar days; members have the right to file a grievance if they disagree with health plan's request to extend the timeframe in accordance with 42 C.F.R. § 438.408(c).
<p>Independent External (or Third Party) Review: A review conducted by an external party following UnitedHealthcare Community Plan's appeal determination. An appeal that is not resolved wholly in favor of the care provider by UnitedHealthcare Community Plan may be appealed by a member, the care provider or the care provider's authorized representative to the Independent Reviewer.</p>			
Member, care provider or authorized representative on behalf of a member	File a request for a review	<p>A member must file within 120 days from the date of UnitedHealthcare Community Plan's notice of resolution</p> <p>A care provider must file within 90 calendar days of the final decision issued by UnitedHealthcare Community Plan</p>	
Division of Medicaid	Take final administrative action	Within 90 calendar days of the date the care provider filed for direct access to an Independent External Reviewer	

Quality Management

Your Participation in Quality Management

UnitedHealthcare Community Plan has a Quality Management Committee (QMC), chaired by the CEO or designee of the CEO, which meets at least quarterly and has oversight responsibility for issues affecting health services delivery. The QMC is composed of our management staff and reports its recommendations and actions to the UnitedHealthcare board of directors. The QMC has three standing sub-committees:

- **Provider Affairs Subcommittee (PAC)** reviews and recommends action on topics concerning credentialing and recredentialing of care providers and facilities, peer review activities, and your performance. Participating care providers give UnitedHealthcare Community Plan advice and expert counsel in medical policy, quality management, and quality improvement. A medical director chairs the PAC.
 - **Health Care Utilization Management Subcommittee** reviews statistics on utilization, provides feedback on UM and Case Management policies and procedures. It makes recommendations on clinical standards and protocols for medical care.
 - **Service Quality Improvement Subcommittee** reviews timely tracking, trending and resolution of member administrative complaints and grievances. This subcommittee oversees member and care provider intervention for quality improvement activities as needed.
- Quality Improvement measures and studies
 - Clinical practice guidelines
 - Health promotion activities
 - Service measures and monitoring
 - Ongoing monitoring of key indicators (e.g., over- and under-utilization, continuity of care)
 - Health plan performance information analysis and auditing (e.g., HEDIS®)
 - Care CoordinationSM
 - Educating members and care providers
 - Risk management
 - Compliance with all external regulatory agencies

Your participation is an integral component of our Quality Improvement Program.

As a participating care provider, you have a structured forum for input through representation on our Quality Improvement Committees and through individual feedback from your network account manager. We require your cooperation and compliance to:

- Participate in quality assessment and improvement activities.
- Provide feedback on our Care CoordinationSM guidelines and other aspects of providing quality care based upon community standards and evidence-based medicine.
- Advise us of any concerns or issues related to patient safety.
- Protect the confidentiality of patient information.
- Share information and follow-up on other care providers and UnitedHealthcare Community Plan to provide seamless, cohesive care to patients.
- Use the Physician Data Sharing information we provide you to help improve delivery of services to your patients.
- Allow the plan to use your performance data.

Quality Improvement Program

The Quality Improvement Program at UnitedHealthcare Community Plan is a comprehensive program under the leadership of the National Quality Oversight Committee (NQOC). A copy of our Quality Improvement Program is available upon request. The Quality Improvement Program consists of the following components:

Quality Management

Your Satisfaction

On an annual basis, UnitedHealthcare Community Plan conducts ongoing assessments of your satisfaction as part of our continuous quality improvement efforts. Key activities related to the assessment and promotion of satisfaction include:

- Annual care provider satisfaction surveys and targeted improvement plans
- Regular visits to care providers
- Care provider town hall meetings

Objectivity is our utmost concern in the survey process. To this end, we work with an outside vendor to conduct our annual care provider satisfaction survey(s). CSS draws the survey samples of eligible care providers working within our networks.

Survey results from all UnitedHealthcare health plans are aggregated annually and reported to our National Quality Management Oversight Committee. The results are compared by health plan year over year and also in comparison to other UnitedHealthcare plans across the country. The survey results include key strengths, secondary strengths, key improvement targets and secondary improvement targets.

Credentialing and Recredentialing

We are required to credential each health care professional, prior to providing services to our members. We conduct recredentialing every three years.

Your Responsibilities

Immediately notify UnitedHealthcare Community Plan in writing if your ability to practice medicine is restricted or impaired in any way, if any adverse action is taken, or an investigation is initiated by any authorized city, state or federal agency, or of any new or pending malpractice actions, or of any reduction, restriction or denial of clinical privileges at any affiliated hospital.

Credentialing and Recredentialing Process

UnitedHealthcare Community Plan maintains a comprehensive credentialing plan relevant to both initial credentialing and recredentialing. Our credentialing process uses standards set forth by our accrediting organization and includes primary verification of training/experience and office site visits. Other state and federal requirements must be met in addition to the activities outlined in the UnitedHealthcare credentialing plan. These include but are not limited to: disclosure of ownership and fingerprinting (of high risk providers).

You will be re-credentialed at least every three years or such other time period as established by the NCQA. UnitedHealthcare Community Plan and Affiliates National Credentialing Committee reviews credentialing information and recommends appointment to the panel. You must supply all requested documentation in a form that is satisfactory to the Credentialing Committee. Applications lacking supporting documentation will not be considered by the committee. You can use CAQH to maintain your documents to support credentialing activities. We process the initial application and present for committee review (within 90 days) upon receipt of a completed application and contract. During processing of the initial application, if additional time is necessary to make a determination due to failure of a third party to provide necessary documentation, the NCC and its agents will make every effort to obtain such information as soon as possible.

The NCC and its agents will notify you of the missing information by written correspondence or phone call.

Confidentiality

All credentialing documents or other written information developed or collected during the approval processes are maintained in strict confidence. Except with authorization or as required by law, information contained in these records will not be disclosed to any person not directly involved in the credentialing process.

Quality Management

Your Agreement

Contract concern or complaint

If you have a concern or complaint about your agreement with us, send a letter containing the details to:

UnitedHealthcare Community Plan Central Escalation Unit
P.O. Box 5032
Kingston, NY, 12402-5032.

Or call us at 866-574-6088.

A representative will look into your complaint and try to resolve it through informal discussions. If you disagree with the outcome of this discussion, please follow the dispute resolution provisions in your provider agreement.

If your concern or complaint relates to a matter which is generally administered by certain UnitedHealthcare Community Plan procedures, such as the credentialing or Care Coordination process, we will follow the procedures set forth in those plans to resolve the concern or complaint. After following those procedures, if you remain dissatisfied, please follow the dispute resolution provisions of your applicable provider agreement.

If we have a concern or complaint about our agreement with you, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions with you, please follow the dispute resolution provisions of your applicable provider agreement.

If a member has authorized you to appeal a clinical or coverage determination on their behalf, that appeal will follow the process governing member appeals outlined in the member's Mississippi CHIP handbook, and this care provider manual.

HIPAA Compliance Care Provider Responsibilities

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is aimed at improving the efficiency and effectiveness of the health care system in the United States. While the portability and continuity of insurance coverage for workers and greater ability to fight health care fraud and abuse were the core goals of the Act, the Administrative Simplification provisions of HIPAA have had the greatest impact on the operations of the health care industry. UnitedHealthcare Community Plan is a "covered entity" under the regulations, as are you if you conduct business electronically.

1. Transactions and Code Sets

These provisions were originally added because of the need for national standardization of formats and codes for electronic health care claims to facilitate electronic data interchange (EDI). From the many hundreds of formats in use prior to the regulation, nine standard formats were adopted in the final Transactions and Code sets Rule. If you conduct business electronically, you are required to do so using the standard formats adopted under HIPAA or use a clearinghouse to translate proprietary formats into the standard formats for submission to UnitedHealthcare Community Plan.

2. Unique Identifiers

HIPAA also requires the development of unique identifiers for employers, you, health plans and individuals for use in standard transactions involving PHI (see NPI information).

3. Privacy of Individually Identifiable Health Information

The privacy regulations help ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is electronic, paper or oral.

Quality Management

The major purposes of the regulation are to protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information; also, to improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, and individual organizations and individuals.

4. Security

The security regulations require covered entities to meet basic security objectives.

1. Help ensure the confidentiality, integrity and availability of all electronic protected health information (PHI) the covered entity creates, receives, maintains and transmits;
2. Protect against any reasonably anticipated threats or hazards to the security or integrity of such information;
3. Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the privacy regulations; and
4. Help ensure compliance with the security regulations by the covered entity's workforce.

UnitedHealthcare Community Plan expects you to be in compliance with the HIPAA regulations that apply to your practice or facility within the established deadlines. Additional information on HIPAA regulations can be obtained at [cms.hhs.gov](https://www.cms.hhs.gov).

Member Rights and Responsibilities

Privacy Regulations

HIPAA privacy regulations provide comprehensive federal protection for the privacy of health care information. These regulations control the internal uses and the external disclosures of health information. The privacy regulations also create certain individual patient rights. Exercising these rights does not adversely affect the way UnitedHealthcare Community Plan treats members. The

same member protection should be extended by you.

- **Access to Protected Health Information**

Our members have the right to access information in a designated record set held at your office or at the health plan. Members may make this request to us for claims and data used to make medical treatment decisions. They may also ask you for copies of their medical records.

- **Amendment of PHI**

Our members have the right to request information held by you or the health plan be amended if they believe the information to be inaccurate or incomplete. Any request for amendment of PHI must be acted on within 60 days. This limit may be extended for a period of 30 days with written notice to the member.

- **Accounting of Disclosures**

Our members have the right to request an Accounting of Disclosures of their PHI made by you or the health plan. This accounting must include disclosures by business associates.

- **Right to Request Restrictions**

Members have the right to request restrictions to your or health plan's uses and disclosures of the individual's PHI. Such a request may be denied, but if it is granted, the covered entity is bound by any restriction to which is agreed and these restrictions must be documented.

- **Right to Request Confidential Communications**

Members have the right to request that communications from you or the health plan be received at an alternative location or by alternative means. You must accommodate reasonable requests and may not require an explanation from the member as to the basis for the request, but may require the request be in writing. A health plan must accommodate reasonable requests if the member clearly states the disclosure of all or part of that information could endanger the member.

We tell our members they have certain rights and responsibilities, all of which are intended to help uphold

Quality Management

the quality of care and services they receive from you. The three primary member responsibilities as required by the NCQA are:

1. A responsibility to supply information (to the extent possible) that the organization and its care providers need
2. A responsibility to follow plans and instructions for care that they have agreed to with you
3. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

Member rights can be found at [UHCCommunityPlan.com](https://www.uhc.com). They are also listed as follows for your reference.

Member Rights

All members have the following rights and responsibilities.

Members have the right to:

- Be treated with respect and dignity.
- Get covered benefits or services regardless of gender, race, ethnicity, age, religion, national origin, sexual orientation, physical or mental disability, type of illness or condition, ability to pay or ability to speak English.
- Pick a doctor who works with our provider network.
- Not have their medical records shown to others without their approval, unless allowed by law.
- Privacy when they are at an office visit, getting treatment, or talking to the health plan.
- Get information about UnitedHealthcare Community Plan, the services we cover, the doctors who provide care, and the member's rights and responsibilities.
- Have their doctor tell they plan to treat them. The doctor should tell them if other treatments can be used and the risks for each one no matter how much they cost or if UnitedHealthcare Community Plan will pay for it.
- Know the cost to them if they choose to get a service that UnitedHealthcare Community Plan does not cover.
- Be involved in deciding on the type of care they want or do not want.
- Get a second opinion from an appropriately qualified participating health care professional at no cost to them. If a UnitedHealthcare Community Plan provider is not available, we will help them get a second opinion from a non-participating provider at no cost to them.
- Find out what is in the member's medical records, as allowed by law, and request a copy of their records.
- Ask that corrections be made to their medical records if they are incorrect.
- Ask for a list of people who have been given a copy of their medical records.
- To be free from any form of restraint and/or seclusion used as a means of coercion, discipline, or staff convenience or retaliation.
- Get interpretation services if they do not speak English or have a hearing impairment, to help them get the medical services they need. If the care provider is unable to provide necessary services, UnitedHealthcare Community Plan's Member Services can help at no cost to members. For interpretation assistance, at least 72 hours before a scheduled appointment, please call 877-743-8731, TTY: 711. Sign language services require a two-week notice.
- Ask for materials to be presented in a manner or language that they understand, at no cost to them.
- Voice their complaints and grievances about UnitedHealthcare Community Plan and the care they receive from their doctor.
- Use the methods listed in the Member Handbook to share questions and concerns about their health care or about UnitedHealthcare Community Plan.
- Tell us ways to improve our policies and procedures, including the Member Rights and Responsibilities.
- Develop advance directives or a living will, which tells how to have medical decisions made for them if they are not able to make them for themselves.

Quality Management

- Know how UnitedHealthcare Community Plan pays care providers, controls costs and uses services.
- Get emergency health care services without the approval of their PCP or UnitedHealthcare Community Plan when they have a true medical emergency.
- Say no to treatment, services, or PCPs, and be told what may happen if they refuse the treatment. They can continue to get Medicaid and medical care even if they refuse treatment.
- Refuse care from a doctor they were referred to and ask for a referral to a different doctor.
- Be told in writing by UnitedHealthcare Community Plan when any of the health care services requested by their PCP are reduced, suspended, terminated, or denied. They must follow the instructions in their notification letter.

Member Responsibility

You and your child have a responsibility to:

- **Give information that we and your child's doctor need to care for your child.**
- **Listen to the doctor's advice, follow instructions and ask questions.**
- **Understand your child's health problems and work with the doctor to set treatment goals.**
- **Work with your child's doctor to guard and improve your child's health.**
- **Find out how your child's health care system works.**
- **Go back to your child's doctor or ask for a second opinion if your child does not get better.**
- **Treat health care staff with the respect you expect yourself.**
- **Tell us if you have a problem with any health care staff.**
- **Adhere to the appointment process.**
- **Keep your child's appointments. If you must cancel, call as soon as you can.**

- **Use the emergency room only for real emergencies.**
- **Call your doctor when your child needs medical care, even if it is after office hours.**
- **Pay for unapproved health care received from non-participating providers, and have the right to know how to obtain approval for these services.**
- **Inform the plan of changes in family size, address or health care coverage.**

Right to Nondiscrimination

In accordance with federal law and U.S. Department of Agriculture (USDA) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, religious creed, age, disability, political beliefs, or retaliation.

If the member requires this information in an alternative format (Braille, large print, audiotape, etc.), contact the USDA's TARGET Center at 202-720-2600 (voice or TDD).

If the member requires information about this program, activity or facility in a language other than English, contact the USDA agency responsible for the program or activity, or any USDA office.

To file a complaint alleging discrimination, members should write to USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250-9410, or call 866-632-9992 (voice). TDD users can contact the USDA through local relay or the Federal Relay at 800-877-8339 (TDD) or 866-377-8642 (relay voice users). The USDA is an equal opportunity provider and employer.

Quality Management

National Provider Identifier

NPI is a standard unique identifier (a 10-character number with no embedded intelligence) that HIPAA requires you to use during any transaction involving PHI.

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES) and should be shared by you with all affected trading partners. This includes care providers to whom you refer patients, billing companies, and health plans.

The NPPES assists you with your application, processes the application and returns the NPI to you. There are two entity types for the purposes of enumeration. A Type 1 entity is an individual health care provider and a Type 2 entity is an organizational provider, such as a hospital system, clinic, or DME providers with multiple locations. Type 2 care providers may enumerate based on location, taxonomy or department.

Only care providers who are direct providers of health care services are eligible to apply for an NPI. This creates a subset of providers who provide non-medical services who will not have an NPI.

NPI Compliance

HIPAA mandates the adoption and use of NPI in all standard transactions (claims, eligibility, remittance advice, claims status request / response, and authorization request / response) for all health care providers who conduct business electronically.

Additionally, most state agencies are requiring the use of the NPI on paper claims – UnitedHealthcare will require NPI on paper claims also in anticipation of encounter submissions to the state agency.

NPI will be the only health care provider identifier that can be used for identification purposes in standard transactions for those covered health care providers.

How to get an NPI:

You can apply for NPIs in one of three ways:

- Use the web-based application process. Simply log onto the National Plan & Provider Enumeration System - Home Page and apply online at nppes.cms.hhs.gov/NPPES.
- Agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on your behalf (i.e., through a bulk enumeration process) if an EFIO requests your permission to do so.
- Obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. The form will be available only upon request through the NPI Enumerator. If you wish to obtain a copy of this form, you must contact the NPI Enumerator in any of these ways:

Phone: 800-465-3203 or
TTY: 800-692-2326

Mail: NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

How to share your NPI with us

Once you have your NPI, call our Network Account Management team at 866-574-6088. You may also email SWProviderservices@uhc.com.

You can also fax NPI information to 866-455-4068 or 414-721-9006. To assist us in expediting this process, please include your name, address, and TIN.

Fraud and Abuse

Fraud and abuse by you, members, health plans, employees, etc. hurts everyone. Your assistance in notifying us about any potential fraud and abuse that comes to your attention and cooperating with any review of such a situation is vital and appreciated. We consider

Quality Management

this an integral part of our mutual ongoing efforts to provide the most effective health outcomes possible for all our members.

Definitions of Fraud and Abuse

Fraud: An intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit to them or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse: Care provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the CHIP program or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the CHIP program.

Examples of fraud and abuse include:

Misrepresenting Services Provided

- Billing for services or supplies not rendered
- Misrepresentation of services/supplies
- Billing for higher level of service than performed

Falsifying Claims/Encounters

- Alteration of a claim
- Incorrect coding
- Double billing
- False data submitted

Administrative or Financial

- Kickbacks
- Falsifying credentials
- Fraudulent enrollment practices
- Fraudulent third-party liability reporting

Member Fraud or Abuse Issues

- Fraudulent/altered prescriptions
- Card loaning/selling

- Eligibility fraud
- Failure to report third-party liability/other insurance

Reporting Fraud and Abuse

If you suspect another care provider or member has committed fraud or abuse, you have a responsibility and a right to report it. Call the Anti-Fraud and Recovery Solutions (AFRS) unit at Optum at 866-242-7727 to make anonymous reports and offer tips about suspected fraud, waste or abuse. Hours of operation are Monday – Friday, 8 a.m. – 4:30 p.m. Central Time. This number is accessible to both care providers and members.

For care provider-related matters (e.g. doctor, dentist, hospital), please furnish the following:

- Name, address and phone number of care provider
- Care provider number
- Type of care provider (physician, physical therapist, pharmacist, etc.)
- Names and phone numbers of others who can aid in the investigation
- Dates of events
- Specific details about the suspected fraud or abuse

For member-related matters (beneficiary/recipient), please furnish the following:

- The person's name, date of birth, Social Security number, ID number
- The person's address
- Specific details about the suspected fraud or abuse

Ethics and Integrity

Introduction

We are dedicated to conducting business honestly and ethically with members, you, suppliers and governmental officials and agencies. The need to make sound, ethical decisions as we interact with you, regulators and others

Quality Management

has never been greater. It's not only the right thing to do. It is necessary for our continued success and that of our business associates.

Compliance Program

As a business segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity Program. The UnitedHealthcare Corporate Compliance Program is a comprehensive program designed to educate all employees regarding the ethical standards that guide our operations, provide methods for reporting inappropriate practices or behavior, and procedures for investigation of and corrective action for any unlawful or inappropriate activity. The UnitedHealth Group Ethics and Integrity Program incorporates the required seven elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

- Oversight of the Ethics and Integrity Program,
- Development and implementation of ethical standards and business conduct policies,
- Creating awareness of the standards and policies by education of employees,
- Assessing compliance by monitoring and auditing,
- Responding to allegations or information regarding violations,
- Enforcement of policies and discipline for confirmed misconduct or serious neglect of duty,
- Reporting mechanisms for employees, managers and others to alert management and/or the Ethics and Integrity Program staff to violations of law, regulations, policies and procedures, or contractual obligations.

UnitedHealthcare has compliance officers located in each health plan. In addition, each health plan has an active Compliance Committee, consisting of senior managers from key organizational functions. The Committee provides direction and oversight of the program with the health plan.

Reporting and Auditing

Any unethical, unlawful or otherwise inappropriate activity by a UnitedHealthcare Community Plan employee which comes to your attention should be reported to a UnitedHealthcare senior manager in the health plan or directly to the Corporate Compliance Department.

UnitedHealthcare's Special Investigations Unit (SIU) is an important component of the Corporate Compliance Program. The SIU focuses on proactive prevention, detection, and investigation of potentially fraudulent and abusive acts committed by care providers and plan members. This department is responsible for the conduct and/or coordination of anti-fraud activities in all UnitedHealthcare health plans. To facilitate the reporting process of any questionable incidents involving plan members or care providers, call 800-557-9933. Please refer to the Fraud and Abuse section of this guide for additional details about the UnitedHealthcare Fraud and Abuse Program.

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

Let us know if the government investigates you or asks you for documents about your practice. (This does not apply to a routine regulatory request). Also let us know what gave rise to the inquiry.

Quality Management

Record Retention, Reviews and Audits

You must agree to maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to covered persons. Records must be maintained for a period of not less than 10 years from the close of the CHIP program agreement between the state and us, or such other period as required by law. If records are under review or audit, they must be retained until the review or audit is complete. UnitedHealthcare and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the disposition of records under review or inspection.

To help ensure members receive quality services, you must agree to cooperate and comply with requests for onsite reviews conducted by the state. During these reviews, the state will address your ability to meet CHIP program standards.

You must cooperate with the state or any of its duly authorized representatives, the Mississippi Division of Medicaid, the Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency prior-approved by the state, at any time during the term of your applicable provider agreement.

These entities will, at all reasonable times, have the right to enter onto your premises. You agree to allow access to and the right to audit, inspect, monitor, and examine any pertinent books, documents, papers, and records and/or to otherwise evaluate (including periodic information systems testing) your performance and charges.

All reviews and audits will be performed in such a manner that will not unduly delay the work of the care provider. If you refuse to allow access to all documents, papers, letters, or other materials, this will constitute a breach of your applicable provider agreement.

You must keep records for a period of six years after final payment under your applicable provider agreement, unless the state authorizes in writing their earlier disposition. You agree to refund to the state any overpayment disclosed by any such audit.

However, if any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the six-year period, you agree to retain the records until completion of the action and resolution of all issues which arise from it and for one year thereafter. The state will also retain the right to perform financial, performance, and other special audits on such records maintained by the care provider during regular business hours throughout the term of your applicable provider agreement.

Delegating and Subcontracting

If you delegate or subcontract any function, the subcontract or delegation must include all requirements of your applicable provider agreement and this manual.

Our Claims Process

Claims Billing Procedures

Electronic claims reduce errors and shorten payment cycles. For electronic claims submission requirements, please contact us by phone at 800-210-8315 or by email at ac_edi_ops@uhc.com. To obtain more information regarding electronic claims, please refer to the EDI section of this manual or the care provider section of the website at UHCprovider.com/EDI.

If you must send a paper claim, send it to:
UnitedHealthcare Community Plan
PO Box 5032
Kingston, NY 12402-5032

Claims Format

You must submit medical or hospital service claims using the standard CMS1500 (formerly known as HCFA 1500), UB-04 (also known as CMS1450), or respective electronic format. We recommend black ink when completing a CMS 1500. Black ink on a red CMS 1500 form will allow for optimal scanning into the claims processing system. No matter which format you use to submit the claim, help ensure all appropriate secondary diagnosis codes are captured and indicated for line items. This allows for proper reporting on encounter data.

Claims Processing Time

Please allow 30 days before inquiring about claims status. The standard turnaround time for clean claims is less than 10 business days, measured from date of receipt.

Claims Submission Rules

We prefer electronic claim submissions. If you do not have a vendor or clearinghouse, submit claims through the Provider Portal, including claim reconsiderations and corrected claims. Some claims may require supporting documentation; submit these on paper or electronically through the reconsideration process.

- Timely filing reconsideration requests
- CCI edit reconsideration
- Unlisted procedure codes if sufficient information is not sent in the notes field

Please do not send claims on paper or with attachments unless requested by the health plan.

Paper claim specific rules include:

- Submit corrected claims electronically; however the words “corrected claim” must be in the notes field. Your software vendor can instruct you on correct placement of all notes. You can also do this through the Provider Portal by choosing the reconsideration process.
- Submit unlisted procedure codes with a sufficient description in the notes field. Your software vendor can instruct you on correct placement of all notes. If sufficient information cannot be submitted in the notes field, paper must be submitted. X-ray, lab and drug claims with unlisted procedure codes should be submitted with notes.

OT/ST/PT/Dialysis/MHSA claims require the date of service by line item. We do not accept span dates for these types of claims.

Tax Identification Numbers/ Care Provider IDs

Please submit standard transactions using your tax identification number and your National Provider Identifier (NPI). To help ensure proper claims adjudication, please use the ID that best represents the care provider who performed the service. If you have any questions about IDs, please call your local office or EDI Customer Service at 800-210-8315.

Coordination of Benefits

If you know the member has other creditable insurance coverage, submit to that carrier first if that insurance is

Our Claims Process

primary. If Mississippi CHIP is the secondary insurer, we will consider claims for payment after the primary insurance payments are applied.

Electronic Claims Submission and Billing

All documents, frequently asked questions and other information regarding electronic claims submission can be found at UHCprovider.com/EDI.

Claim Submission Methods

Practice Management System (PMS) and Hospital Information System (HIS): Physicians or facilities can use this software for scheduling, registration, billing and account receivables management. Create claim files individually or in batch for electronic submission. Submit claims directly from the system or upload claim files to another source for transmission to payer(s).

Direct Data Entry (DDE): Direct Data Entry solutions are ideal for those without a Practice Management System and want to submit claims electronically. Direct Data Entry lets you enter information into an online claim form for electronic submission.

Clearinghouse: A clearinghouse functions as the intermediary that accepts care provider electronic claims and forwards them to insurance payers. Clearinghouses check claims for errors, and validate information required both by HIPAA and the payer. This review process is called claim scrubbing and helps to prevent time-consuming processing errors.

Claim Submission Connections Clearinghouse:

UnitedHealthcare Community Plan accepts participating and non-participating professional (CMS-1500) and institutional (UB-04) claims electronically from clearinghouses, submitted as 837P and 837I transactions. You may use any clearinghouse with a connection to UnitedHealthcare Community Plan for claim submissions. Review the [Clearinghouse Options](#) to help determine your practice or facility's EDI needs.

Optum Intelligent EDI: A multi-payer web service and clearinghouse solution you can submit UnitedHealthcare Community Plan professional and institutional claims electronically to at no cost. Submit claim information in an online claim form or upload claims from a practice management or hospital information system. Dashboard reporting provides real-time reports to manage claims quickly and easily. For more information about Optum Intelligent EDI go to optum.com. Or call 866-367-9778 and select option 3 to get started with Optum Intelligent EDI.

This excludes Harvard Pilgrim, The Alliance, TRICARE West and NDC Home Infusion Specialty Pharmacy Claims; charges apply for an all payer solution.

UHCprovider.com: Registered Provider Portal users can securely submit professional CMS-1500 claims by submitting claim information using our online form.

Your software vendor can help in establishing electronic connectivity. Please note the following:

- Contact us at 800-210-8315 to establish clearinghouse connectivity.
- When calling, please specify if you are asking about Mississippi CHIP, Mississippi CAN, Commercial, etc.
- Our Payer ID is 87726.
- Clearinghouse Acknowledgment Reports and Payer specific Acknowledgment Reports identifying claims failing to successfully transmit electronically.
- We follow CMS NUCC and NUBC guidelines for placement of data for HCFA/CMS 1500 & UB-04.

Importance & Usage of EDI Acknowledgment/Status Reports

Software vendor reports only show the claim left the care provider's office and either was accepted or rejected by the vendor. Your software vendor report does not confirm claims have been received or accepted at clearinghouse or by the health plan. Acknowledgment reports show you the status of your electronic claims after each transmission. Analyzing these reports, you will know if your claims have reached the health plan for payment or if claim(s) have been rejected for an error or additional information.

Our Claims Process

You should review your reports, clearinghouse acknowledgment reports and the health plan's status reports to eliminate processing delays and timely filing penalties for claims that have not reached the health plan.

How do I correct errors?

If you have a claim that rejects, you can correct the error and retransmit the claim electronically the same day, causing no delay in processing. It is very important that clearinghouse reports are reviewed and worked after each transmission. These reports should be kept if you need documentation for timely filing later.

IMPORTANT: If a claim is rejected and corrections are not received by the health plan within 180 days from date of service or EOB from primary carrier, the CLAIM WILL BE CONSIDERED LATE BILLED and denied as not allowed for timely filing.

EDI Companion Documents

The health plan's Companion Guides convey information within the framework adopted by HIPAA. The companion guides identify the data content being requested when data is electronically transmitted. The Companion Documents are located on our website at UHCprovider.com > [EDI 837: Electronic Claims](#).

e-Business Support

UnitedHealthcare MS CHIP offices will be staffed and open during normal business hours 8:30 a.m. - 5:30 p.m., Monday through Friday. Additional hours extend to 8 p.m. each Wednesday and the first weekend of each month. In addition, our interactive voice response (IVR) telephone system is available to members 24 hours a day, seven days a week. Our nurse triage hotline is available through our IVR for health-related issues.

For electronic business support, please contact us by phone at 800-210-8315 or by email at ac_edi_ops@uhc.com.

Contact your software vendor and/or clearinghouse prior to contacting us.

Span Dates

Exact dates of service are required when the claim spans a period of time. Please indicate the specific dates of service in Box 24 of the CMS1500, Box 45 of the UB-04, or the Remarks field. This will eliminate the need for an itemized bill and allow electronic submission.

Effective Date/Termination Date

Coverage will be effective on the date the member is effective with the health plan, as assigned by the Division of Medicaid. Coverage will terminate on the date the member's benefit plan terminates with the health plan. If a portion of the services or confinement take place prior to the effective date, or after the termination date, an itemized split bill will be required.

Please be aware effective dates for Mississippi CHIP members are frequently revised, as individual members re-verify with the Division of Medicaid. You should verify eligibility at each visit to assure coverage for services.

Overpayments

If you have made an overpayment, please include reference to the Claim Number or Member ID and Date of Service. The best way to handle a potential overpayment is to call a provider relations consultant at 877-743-8734.

Our claim processing system automatically deducts any overpayment made from the next remittance advice. If an overpayment is identified, contact the local provider relations consultant who will submit an overpayment request. Checks should not be sent to us for overpayment-related issues unless specifically requested or prior arrangements have been made.

Subrogation

We may override timely filing denials based on decisions received from third-party carriers on subrogation or workers' compensation claims. At the time of service, please submit all claims to us for processing.

Our Claims Process

Through recovery efforts, we will work to recoup dollars related to subrogation and workers' compensation.

In addition, if your office receives a third-party payment, notify Customer Service. The overpayment will be recouped.

Care Provider/Member Cost Sharing Responsibilities

Mississippi CHIP members are only responsible for the costs allowed under the State of Mississippi's Children's Health Insurance Program Rules and Regulations as valid cost sharing responsibilities.

You will collect from the member any applicable Mississippi CHIP copayments, and payments for non-covered services. Reasonable efforts to collect should include referral to a collection agency and, where appropriate, court action. Documentation of the collection efforts must be maintained and made available to us upon request.

Cost Sharing

No premiums are charged to members for coverage under CHIP. For children in families with annual income at or below 150% of the FPL, there are no cost sharing requirements in the plan of benefits. Likewise, there are no cost sharing requirements in the plan of benefits for children of Native Alaskan or Native American descent, regardless of the poverty level. We pay for covered expenses at 100%.

For members in families with annual income greater than 150% up to 200% of the FPL, cost sharing requirements are imposed in the form of copayments up to an out-of-pocket maximum.

The out-of-pocket maximums are as follows:

- MPC01-\$0
- MPC02-\$800
- MPC03-\$950

There are no cost sharing requirements for routine well-baby and well-child care visits, including administration

of immunizations, vision and hearing examinations, eyeglasses, hearing aids and preventive and diagnostic dental care and routine dental fillings. Also, under federal law, the total amount of copayments for all covered members cannot exceed 5% of the family income in any benefit period. The out-of-pocket maximums have been designed to comply with the federal limits on cost sharing.

Timely Filing and Late Bill Criteria

Timely filing guidelines are generally 180 days from date of services. Please refer to your contract for your timely filing and late billing criteria.

Reconsideration Requests

If you have questions relating to claims payments please use our online resources on the Provider Portal at UHCprovider.com then click Sign In, or call Customer Service at 800-557-9933. A representative may be able to assist you without requiring additional administrative work. If you are requested to submit a payment reconsideration, submit requests online through the Provider Portal or forward them to P.O. Box 5032, Kingston, NY, 12402-5032. A copy of the claim and supporting documentation will be required for review.

Mark the claim as a "Payment Reconsideration" to make sure the claim is routed to the appropriate area for review. Claims marked as "appeal," "corrected claim," etc. may result in the claim being forwarded to another area of the health plan and potentially delay the claim review process.

Care Provider Complaints and Claims Payment Disputes

We have a procedure to resolve any disputes between us and you involving either partially or totally denied claims that result in written requests for reconsideration.

Our Claims Process

We resolve a minor complaint within one calendar day. If your dispute is more serious in nature and constitutes a grievance, we acknowledge and provide an expected date of resolution within five calendar days. We resolve the grievance within 30 calendar days of receipt. If necessary, this may be extended by 14 days; members have the right to file a grievance if they disagree with health plan's request to extend the timeframe in accordance with 42 C.F.R. § 438.408(c). We acknowledge formal appeals within 10 calendar days and resolve them within 30 calendar days. The response may be a letter acknowledging the receipt of the request with the estimated time frame in which we will complete the investigation. Should we not respond to the reconsideration request or resolve to your satisfaction, you may file a request to submit the claim denial to an independent reviewer.

A **complaint** is an expression of dissatisfaction received by any employee. This can be orally or in writing, and is less serious in nature.

A **grievance** is an expression of dissatisfaction received by an employee, orally or in writing, about any matter or aspect of UnitedHealthcare Community Plan or our operation, other than an adverse benefit determination. This may include, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a care provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by us to make an authorization decision.

An **appeal** is defined as a request for review, by us, of an adverse benefit determination related to a member or care provider review by the contractor of an adverse benefit determination. In the case of a member, the adverse benefit determination may include determinations on the health care services a member believes they are entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member). In the case of a care provider, the adverse benefit determination

may include, but is not limited to, delay or non-payment for covered services.

Care provider complaints for other issues are also handled within 60 days. Please call the Provider Services line at 800-557-9933 to initiate any requests for resolution of complaints.

The Correct Coding Initiative

We perform coding edit procedures, based primarily on the CCI (Correct Coding Initiative) and other nationally recognized and validated sources.

The edits basically fall into one of two categories:

1. Comprehensive and Component Codes.

Comprehensive and component code combination edits apply when the code pair(s) in question appears to be inclusive of each other in some way. This category of edits can be further broken down into subcategories that explain the bundling rationale in more detail. Some of the most common causes for denials in this category include:

- Separate procedures. Codes that are, by CPT definition, separate procedures should only be reported when they are performed independently, and not when they are an integral part of a more comprehensive procedure.
- Most extensive procedures. Some procedures can be performed at different levels of complexity. Only the most extensive service performed should be reported.
- With/without services. It is contradictory to report code combinations where one code includes and the other excludes certain other services.
- Standards of medical practice. Services and/or procedures that are integral to the successful accomplishment of a more comprehensive procedure are bundled into the comprehensive procedure, and not reported separately.
- Laboratory panels. Individual components of

Our Claims Process

panels or multichannel tests should not be reported separately.

- Sequential procedures. When procedures are often performed in sequence, or when an initial approach is followed by a more invasive procedure during the same session, only the procedure that achieves the expected result should be reported.

2. Mutually Exclusive Codes.

These edits apply to procedures that are unlikely or impossible to perform at the same time, on the same patient, by the same care provider. There is a significant difference in the processing of these edits versus the comprehensive and component code edits.

CCI guidelines are available in paper form, on CD ROM, and in software packages that will edit your claims prior to submission. Your CPT and ICD-9 vendor probably offers a version of the CCI manual, and many specialty organizations have comprised their own publications geared to address specific CCI issues within the specialty. CMS's authorized distributor of CCI information is the U.S. Department of Commerce's National Technology Information Service, or NTIS. They can be reached at 800-363-2068, or on the web at [ntis.gov](https://www.ntis.gov).

We require appropriate CLIA (or waived) documentation for billed laboratory services.

Immunizations Billing

We provide administration of all mandated childhood immunizations according to the recommended schedule of the Advisory Committee on Immunization Practices (ACIP) standards.

All vaccines for members will be provided through the Vaccine For Children (VFC) program administered by the Mississippi State Department of Health. It distributes vaccines to you if you are willing to participate in the vaccine program.

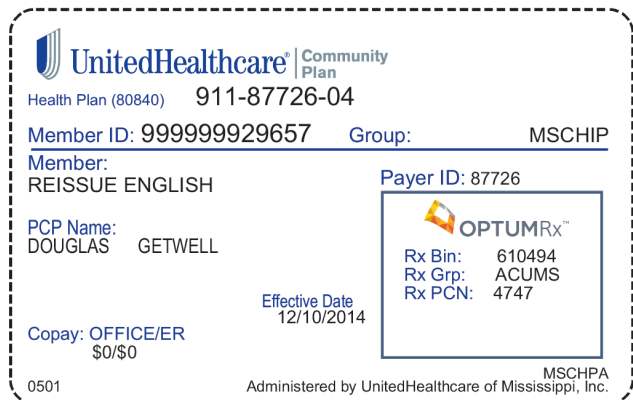
The cost of the vaccine is not billed to us. The only cost associated with immunizations to be reimbursed

under the policy will be the cost to administer the vaccine. Vaccines may be administered by network care providers, including school-based nurses, by a non-participating provider to whom UnitedHealthcare Community Plan has referred the member, or by the Mississippi State Department of Health. To administer a CHIP vaccine, you must agree to participate in the State's Immunization Registry. UnitedHealthcare Community Plan must reimburse you on a fee-for-service basis for the cost of administering any immunizations you provide to members. Other non-routine immunizations, such as influenza vaccine or tetanus boosters provided pursuant to an injury, will be covered as any other covered service.

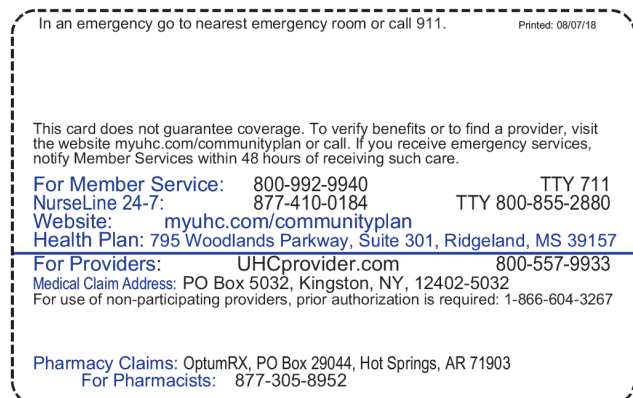
Member Identification Cards

UnitedHealthcare Community Plan members receive an ID card containing information that helps you submit claims accurately and completely.

Be sure to check the member's ID card at each visit and



UnitedHealthcare Community Plan
Health Plan (80840) 911-87726-04
Member ID: 999999929657 Group: MSCHIP
Member: REISSUE ENGLISH Payer ID: 87726
PCP Name: DOUGLAS GETWELL
Effective Date: 12/10/2014
Copay: OFFICE/ER \$0/\$0
OPTUMRx™
Rx Bin: 610494
Rx Grp: ACUMS
Rx PCN: 4747
MSCHPA
0501 Administered by UnitedHealthcare of Mississippi, Inc.



In an emergency go to nearest emergency room or call 911. Printed: 08/07/18
This card does not guarantee coverage. To verify benefits or to find a provider, visit the website myuhc.com/communityplan or call. If you receive emergency services, notify Member Services within 48 hours of receiving such care.
For Member Service: 800-992-9940 TTY 711
NurseLine 24-7: 877-410-0184 TTY 800-855-2880
Website: myuhc.com/communityplan
Health Plan: 795 Woodlands Parkway, Suite 301, Ridgeland, MS 39157
For Providers: UHCprovider.com 800-557-9933
Medical Claim Address: PO Box 5032, Kingston, NY, 12402-5032
For use of non-participating providers, prior authorization is required: 1-866-604-3267
Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 877-305-8952

Care Provider Standards and Policies

Primary Care Providers

Primary care providers (PCPs) are an important partner in the delivery of care. CHIP members have the freedom to seek services from any participating care provider. We assign PCPs to CHIP members and encourage the medical home as the first point of contact for non-emergent medical needs. Members are encouraged to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a “medical home” that they can access to optimize their care.

Role of the Primary Care Provider

The PCP plays a vital role as a case manager in the UnitedHealthcare Community Plan system by improving health care delivery in four critical areas—access, coordination, continuity, and prevention. The PCP is responsible for the provision of initial and basic care to members, makes recommendations for specialty, urgent and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide 24-hours/seven days coverage and backup coverage when they are not available.

UnitedHealthcare Community Plan expects all care providers involved in the member’s care to communicate with each other and work to coordinate the member’s care; this includes communicating significant findings and recommendations for continuing care.

Females can choose any of our OB/GYN or midwives to deal with women’s health issues. They never need a referral for family planning, well-women care, or care during pregnancy. Women can have routine check-ups (twice a year), follow-up care if there is a problem, and regular care during pregnancy.

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

PCP Responsibilities

In addition to the requirements applicable to all care providers, the responsibilities of the PCP include:

- Offer access to office visits on a timely basis, in conformance with the standards outlined in the Timeliness Standards for Appointment Scheduling section of this manual.
- Follow-up with members who are not compliant with the well-child screening requirement and well-child services. See the well-child section in this manual for more information.
- Conduct a baseline examination during the member’s first appointment. This should occur within the first 6 months of a new member’s enrollment. The PCP should attempt to schedule this appointment if the member fails to do so.
- Treat general health care needs of members. Use nationally recognized clinical practice guidelines as a guide for treatment of important medical conditions. Such guidelines are referenced at UHCCommunityPlan.com/MS.
- Encourage all members to receive all necessary and recommended preventive health procedures in accordance with the Agency for Healthcare Research and Quality, US Preventive Services Task Force Guide to Clinical Preventive Services, ahcpr.gov/clinic/uspstfix.htm.
- Use any member lists supplied by us indicating which members appear to be due preventive health procedures or testing.
- Be sure to timely submit all accurately coded claims or encounters.
- Call Provider Services at 800-557-9933 for questions related to member lists, practice guidelines, medical records, government quality reporting, HEDIS, etc.
- Provide preventive care services to all members in accordance with age, gender, and health status. These services can be found at: UHC.com.
- Copayments are not required for well-child checkups or preventive visits. Consider payment from us as payment in full.

Care Provider Standards and Policies

- Provide all well-baby/well-child services to members up to 19 years old, which include:
 - Comprehensive unclothed physical exam
 - Comprehensive health and developmental history (including assessment of both physical and mental development)
 - Measurements (e.g. head circumference for infants, height, weight, body mass percentile index)
 - Immunization appropriate to age and health history
 - Assessment of nutritional status
 - Laboratory tests (e.g. tuberculosis screening and federally required blood lead screenings)
 - Vision screening
 - Hearing screening
 - Dental and oral health assessment
 - Development and behavioral assessment
 - Age appropriate and risk-based screenings
- Screen members for behavioral health problems using the Behavioral Health Toolkit for the PCP found at providerexpress.com. File the completed screening tool in the patient's medical record.
- Coordinate each member's overall course of care.
- Be available personally to accept our members at each office location at least 16 hours a week.
- Be available to members by phone 24 hours a day, seven days a week, or have arrangements for telephone coverage by another participating PCP or an answering machine directing the member to a live voice.
- Respond to after-hour patient calls within 30–45 minutes for non-emergent symptomatic conditions and within 15 minutes for emergency situations.
- Educate members about appropriate use of emergency services.
- Discuss available treatment options and alternative courses of care with members.
- Refer services requiring prior authorization to the Prior Authorization department, Behavioral Health Unit, or Pharmacy as appropriate.
- Inform UnitedHealthcare Community Plan Case Management at 800-557-9933 of any member showing signs of End Stage Renal Disease.
- Admit our members to the hospital when necessary and coordinate the medical care of the member while hospitalized.
- Respect the advance directives of the patient and document in a prominent place in the medical record whether or not a member has executed an advance directive form.
- Provide covered benefits in a manner consistent with professionally recognized standards of health care and in accordance with standards established by UnitedHealthcare Community Plan.
- Document procedures for monitoring patients' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Copies of members' medical records must be provided to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records at no cost, per contract requirements for purposes such as: medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA regulations.
- Maintain staff privileges at a minimum of one participating hospital.
- Report infectious diseases, lead toxicity, and other conditions as required by state and local laws and regulations.
- Enable members to change PCPs through a member-selected or contractor-reassignment process. This can be due to a variety of reasons including when a care provider terminates relationship with UnitedHealthcare Community Plan or Medicaid, when a member chooses to seek a new care provider, or a

Care Provider Standards and Policies

formal grievance or complaint is filed.

- For members younger than 3 years old, PCPs can apply fluoride varnish as part of routine preventive care.

For any reason, including panel size, if the PCP is unable to assume care for assigned member(s), the PCP should notify us through the Provider Portal, calling, or by regular mail:

UnitedHealthcare Community Plan
c/o Medical Director
795 Woodlands Parkway-Suite 301
Ridgeland, MS 39157

24-Hours, Seven-Days-a-Week Coverage

PCPs and obstetricians must be available to members by telephone 24 hours a day, seven days a week, or have arrangements for telephone coverage by another participating PCP or obstetrician. A medical director or physician reviewer must approve coverage arrangements that vary from this requirement. We expect PCPs and obstetricians to respond to after-hour member calls within 30-45 minutes for non-emergent symptomatic conditions and within 15 minutes for crisis situations.

UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability. We also conduct periodic access surveys to monitor for 24/7 after-hours access. You are required to participate in all survey-related activities.

Specialist Responsibilities

In addition to the requirements applicable to all care providers, the responsibilities of specialists include:

- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by the member's PCP or who self-refer.
- Provide the PCP copies of all medical information, reports, and discharge summaries resulting from the specialist's care.
- Communicate, in writing, to the PCP all findings and

recommendations for continuing patient care and note them in the patient's medical record.

- Maintain staff privileges at a minimum of one participating hospital.
- Report infectious diseases, lead toxicity, and other conditions as required by state and local laws and regulations.

Medical Residents in Specialty Practice

Specialists may use medical residents in specialty care in all settings supervised by fully credentialed UnitedHealthcare Community Plan specialty attending physicians.

Timeliness Standards for Appointment Scheduling

Offer the same office hours to UnitedHealthcare Community Plan members as those offered to our commercial plan members. Additionally, you must comply with the following appointment availability standards:

Emergency Care

Immediately upon the member's presentation at a service delivery site

Urgent Care

Not to exceed 24 hours

Primary Care

PCPs and care providers should arrange appointments for:

- Urgent cases will be seen within 24 hours of PCP notification.
- Routine cases will be seen within seven days of PCP notification.
- Well-care visits will be scheduled within 30 calendar days of PCP notification.

Care Provider Standards and Policies

Specialty Care

Specialists and specialty clinics should arrange appointments not to exceed 45 calendar days.

Dental Care

- Routine visits - not to exceed 45 calendar days.
- Urgent care - not to exceed 48 hours.

Behavioral Health (Mental Health and Substance Use Disorder (SUD))

Behavioral health care providers should arrange appointments for:

- Emergency care (non-dangerous to self or others) immediately upon presentation
- Urgent problems within 24 hours of member's request
- Routine visit - not to exceed 21 calendar days
- Post-discharge from an acute psychiatric hospital when the UnitedHealthcare Community Plan is aware of the member's discharge - not to exceed 7 calendar days

Prenatal Care

Providers of prenatal care should arrange appointments for the initial prenatal visit:

- First trimester – within three weeks of the member's request
- Second trimester – within two weeks of the member's request
- Third trimester – within one week of the member's request

Check member eligibility each time you render services as pregnant members may switch to other coverage during pregnancy.

Timeliness Standards for Notifying Members of Test Results

Notify members of laboratory or radiology test results

within 24 hours of receipt of results in urgent or emergent cases. Notify members of non-urgent, non-emergent laboratory and radiology test results within 10 business days of receipt of results.

Allowable Office Waiting Times

Members with appointments should not routinely be made to wait longer than one hour.

Care Provider Office Standards

UnitedHealthcare Community Plan requires a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards. Financial incentives for completing physical improvements to meet ADA accessibility standards are available to care providers that qualify as small businesses (up to 30 FTE employees or less than \$1 million gross revenue). Tax credits are available for "access expenditures" ranging from \$250 to \$10,250 and tax deductions are available up to \$15,000 per year for expenses associated with the removal of barriers. For more information, provider relations representatives may conduct periodic site visits to identify PCP offices that meet ADA standards. If a PCP is planning to relocate an office, a representative may perform a site visit before care can be rendered at the new location.

Care Provider Standards and Policies

Medical Record Charting Standards

You are required to maintain medical records in a complete and orderly fashion, which promotes efficient and quality patient care. As part of this process, you are required to participate in our quality review of medical records and meet the following requirements for medical record keeping.

Confidentiality	<ul style="list-style-type: none"> • The office has a policy in place that addresses the confidentiality of the patient medical record • Office staff receive initial and periodic training in maintaining the confidentiality of patient records • Medical records are released only to the patient and/or entities as designated in accordance with HIPAA regulations • Medical records are stored in a manner that helps ensure patient confidentiality. Records are kept in a secure area which is only accessible to authorized personnel
Organization	<ul style="list-style-type: none"> • Medical records are filed in a manner in which they are easily retrievable • Medical records are readily available to the treating physician whenever the patient is seen at the site where they generally receive care • Medical records are sent promptly to specialty providers upon patient request. For urgent issues, records are made available within 48 hrs. • There is a policy for medical record retention • The contents of medical records must be organized in such a manner that reports, problem lists, immunization records, etc. are easily retrievable and are located in the same area in each record • There is one medical record per patient • Pages in the medical record are secure
Medical Record Documentation Standards	<ul style="list-style-type: none"> • The chart is legible • The chart contains at a minimum the following patient identifiers: name, sex, address, phone # and DOB • The patient name/ID # is located on each page of the medical record • Each entry is dated and signed by the treating care provider(s) • An initial history & physical is present • Documentation of the presence or absence of allergies or adverse reactions is clearly noted • Screenings for high-risk behaviors such as drug, alcohol and tobacco use are present • Screening for behavioral health issues including depression • Documentation of the presence or absence of an executed advanced directive • An updated Problem List includes medical and psychological conditions • A Medication List includes current and past meds • Progress notes from each visit that document the reason for the visit, the physical findings, the diagnosis, and treatment plan • Documentation of need for follow-up visits • Documentation of member input and/or understanding of the treatment plan • Documentation that reflects compliance with EPSDT standards for all pediatric patients • Maintenance of a current immunization record for all pediatric patients • Tracking and referral for age appropriate preventive health screenings such as mammography, pap smears, colorectal screen and flu shots are noted • Appropriate use of lab testing (HBA1c, LDL, lead screen) • Results of lab, X-ray, and other tests as ordered by the care provider including indication of physician review • Notation of treating specialists (including behavioral health) as well as copies of consultant reports ordered by the care provider • Continuity of care demonstrated by evidence of copies of Home Health Nursing reports, hospital discharge summaries, emergency room visits, and physical or other therapies as ordered by the care provider • Use of Clinical Practice Guidelines or flowsheets for the management of chronic conditions (diabetes, asthma, etc.) • Mechanism for tracking and management of no-shows

Care Provider Standards and Policies

Screening and Documentation Tools

Most of these tools were developed by us with assistance from the Provider Affairs Subcommittee to help you comply with regulatory requirements and practice in accordance with accepted standards.

Medical Record Review

On a routine basis, we will conduct a review of the medical records you maintain for our members. You are expected to achieve a passing score of 85% or better. Medical records should include:

- Initial health assessment, including a baseline comprehensive medical history, which should be completed in less than two visits and documented, and ongoing physical assessments documented on each subsequent visit.
- Problem list, includes the following documented data:
 - Biographical data, including family history
 - Past and present medical and surgical intervention
 - Significant illnesses and medical conditions with dates of onset and resolution
 - Documentation of education/counseling regarding HIV pre- and post-test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions are prominently noted. Also note if there are no known allergies or adverse reactions.
- Past medical history is easily identified and includes serious illnesses, injuries and operations (for patients seen three or more times). For children and adolescents (18 years or younger), past history relates to prenatal care, birth, operations and childhood illnesses.
- Medication record includes name of medication, dosage, amount dispensed and dispensing instructions.

- Immunization record
- Document tobacco habits, alcohol use and substance use (12 years and older).
- Copy of advance directive, or other document as allowed by state law, or a notation that patient does not want one.
- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits
- Diagnosis and treatment plans consistent with findings
- Lab and other studies as appropriate
- Member education, counseling and/or coordination of care with other physicians or health care professionals
- Notation regarding the date of return visit or other needed follow-up care for each encounter
- Consultations, lab, imaging and special studies initiated by primary physician to indicate review
- Consultation and abnormal studies including follow-up plans

Member hospitalization records should include, as appropriate:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- Documentation of appropriate preventive screening and services
- Documentation of behavioral health assessment

Care Provider Standards and Policies

Medical Record Documentation Standards Audit Tool

Provider Name:									
Provider ID#:					Provider Specialty:				
Reviewer Name:				Review Date:			Score:		
Member Name/Initials:						Member ID#:			

Criteria	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. Does the office have a policy regarding medical record confidentiality?									
2. Has staff been trained in medical record confidentiality?									
3. Is there a Release of Information form in use requiring patient signature?									
4. Is there a policy for medical record retention?									
5. Are medical records stored in an organized fashion for easy retrieval?									
6. Is there a policy in place for timely transfer of medical records to other locations/care providers?									
7. Are records stored in a secure location only accessible by authorized personnel?									
8. Is there a policy for monitoring and addressing missed appointments?									
9. Is there one medical record per patient?									
10. Is the chart legible?									
11. Is the medical record kept in an organized fashion?									
12. Are pages secure in the record?									
13. Is there patient biographical/demographic information in the chart?									
14. Do all pages of the record contain the patient name or ID#?									
15. Are all entries dated?									
16. Are all entries signed?									
17. Is there an H&P in the chart?									
18. Are the presence/absence of allergies or adverse reactions clearly displayed?									
19. Is there screening of high-risk behaviors - drug, alcohol and tobacco use?									
20. Is there screening for behavioral health issues including depression?									

Care Provider Standards and Policies

Criteria	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
21. Is there documentation of presence/absence of an Advanced Directive?									
22. Is there an updated Problem List?									
23. Is there an updated Medication List?									
24. Do notes document patient complaint, physical findings, diagnosis and tx plan?									
25. Is there a time for a return visit or follow-up plan noted?									
26. Are there clinical tools or flow sheets for patients with chronic conditions?									
27. Do pediatric charts reflect compliance with EPSDT standards?									
28. Is there an updated immunization record in all pediatric charts?									
29. Is there documentation of preventive services - Paps, Mams, CR screens, Flu Shots?									
30. Are labs ordered as appropriate?									
31. Do lab and other reports reflect physician review?									
32. Is there evidence of continuity of care between PCP, BH and specialty care providers?									
33. Is continuity of care shown through Hospital/ER D/C summaries, home health reports, PT reports, etc.?									

$$99 - \underline{\hspace{2cm}} = \underline{\hspace{2cm}} \quad \underline{\hspace{2cm}} \div \underline{\hspace{2cm}} = \underline{\hspace{2cm}}$$

(Questions) (# N/A) (Adjusted # of Questions) (# Yes) (Adjusted # of Questions) (Score)

If a care provider scores less than 85%, review an additional five charts. Only review those elements that the care provider received a No on in the initial phase of the review. Upon secondary review, if a data element scores at 85% or above, that data element will be recalculated as all Yes in the initial scoring. If upon secondary review, a data element scores below 85%, the original calculation of that element will remain. A passing score is 85% or better.

Care Provider Standards and Policies

Advance Directives

An emancipated member or the member's parents have the right to make health care decisions and to execute advance directives (for the member). An advance directive is a formal document, written in advance of an incapacitating illness or injury. No member is required to have an advance directive and cannot be denied care if they do not have an advance directive.

Once completed, an emancipated member (or member's parents) keeps the original. Be aware of the advance directive and maintain in the member's medical record a copy of the member's completed directive. Do not send a copy to UnitedHealthcare Community Plan. If an emancipated member or the member's parents believe that you have not complied with an advance directive, they may file a complaint with the our medical director or physician reviewer.

safeguards of protected health information. Training is provided to all personnel on an annual basis and to all new employees within the first 30 days of employment.

Protect Confidentiality of Member Data

Our members have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates who need that information to fulfill our obligations and to facilitate improvements to our members' health care experience. We require our associates and business associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you as the holder of the medical records. You will comply with applicable regulatory requirements, including those relating to confidentiality of member medical information. You agree specifically to comply in all relevant respects with the applicable requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations, in addition to the applicable state laws and regulations. UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to prevent unintentional disclosure of protected health information (PHI). This includes policies and procedures governing administrative and technical

Care Provider Communications and Outreach

The UnitedHealthcare Community Plan care provider education and training program is built on experience with care providers and multi-state managed care programs and includes the following training components:

- Website
- Forums/town hall meetings
- Office visits
- Newsletters and bulletins
- Manual
- Provider Portal

These sources provide information about the most common care provider needs, such as cultural competency, disease management, behavioral health, etc.

Care Provider Website

UnitedHealthcare Community Plan promotes the use of web-based functionality among its care provider population. UnitedHealthcare Community Plan's Provider Portal facilitates communications pertaining to administrative functions. Our interactive website enables you to electronically determine member eligibility, submit claims, and ascertain the status of claims. UnitedHealthcare Community Plan has implemented an internet-based prior authorization system on UHCprovider.com/priorauth, which allows you, if you have internet access, the ability to request their medical prior authorizations online rather than telephonically. The website also contains an online version of the care provider manual, the provider directory, the Preferred Drug List (both searchable and comprehensive listing), clinical practice guidelines, quality and utilization requirements. In addition, it has educational materials such as newsletters, recent fax service bulletins and other information. UnitedHealthcare Community Plan posts notifications regarding changes in laws, regulations and subcontract requirements to the portal.

A web portal is also available to members including access to the Member Handbook, newsletters, provider search tool and other important plan bulletins.

Care Provider Office Visits

Provider service representatives visit PCP, specialist and ancillary provider offices on a regular basis. Each provider service representative is assigned to a geographic territory to deliver face-to-face support to our care providers across the state. The prioritization and frequency of office visits by these staff are determined based on a variety of factors, including size of member population, special cultural/linguistic needs, geography, and other special needs. Our primary reasons for face-to-face office visits are to create program awareness, promote program compliance, and minimize health care disparities.

Care Provider Newsletters and Network Bulletins

UnitedHealthcare Community Plan produces and distributes a care provider newsletter to the entire Mississippi network at least three times a year. The newsletters contain program updates, claims guidelines, information regarding Mississippi CHIP policies and procedures, cultural competency and linguistics information, clinical practice guidelines, information on special initiatives, and other articles regarding health topics of importance.

The Network Bulletin is a monthly publication that features important protocol and policy changes, administrative information and clinical resources.

View the latest news or sign up to receive the monthly bulletin at UHCprovider.com > News and Network Bulletin.

Care Provider Manual

We publish this manual online, which includes an overview of the program, toll-free number to our provider services hotline and a list of additional resources and incentives. Care providers without internet access may request a hard copy of this manual by contacting Provider Services.

