

**Physician, Health Care Professional,
Facility and Ancillary
Handbook**

Louisiana Medicaid Program - Coordinated Care Network-Shared Savings (CCN-S)
uhcommunityplan.com



UnitedHealthcare Community Plan™

This handbook is a draft pending review and approval from the State of LA

Welcome to UnitedHealthcare

This handbook is designed as a comprehensive reference source for the information you and your staff need to conduct your interactions and transactions with us in the quickest and most efficient manner possible. UnitedHealthcare publishes this handbook online at uhccommunityplan.com, which includes an overview of the program, toll free number to our provider services hotline, a removable quick reference guide, and a list of additional provider resources and incentives. Providers without internet access may request a hard copy of this handbook by contacting Provider Services at 866-675-1607.

PLEASE NOTE - This handbook only applies to your patients who are members covered under UnitedHealthcare Community Plan's CCN-S program.

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

If you have any questions about the information or material in this handbook or about any of our policies or procedures, please do not hesitate to contact Provider Services at 866-675-1607.

We greatly appreciate your participation in our program and the care you provide to your patient's who are members of UnitedHealthcare Community Plan.

Important information regarding the use of this handbook

In the event of a conflict or inconsistency between your applicable participation agreement and this handbook, the terms of this handbook shall control except for any requirements located in an applicable regulatory appendix pertaining to the Louisiana Medicaid program.

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

This handbook will be amended as operational policies change.

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UnitedHealthcare Corporate Overview

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 understands that health care cannot be delivered in a vacuum. That is why our services seek to address the social and economic factors that affect a person's health. Since 1989, UnitedHealthcare, through its predecessor affiliates, has served the public sector market. Today, we facilitate care for 3.4 million beneficiaries of government health care programs in more than 26 states, plus the District of Columbia.

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

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

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

UnitedHealthcare employs a diverse workforce, rooted in the communities we serve, with varied backgrounds and extensive practical experience that gives us a better understanding of our members and their needs.

Our Approach to Health Care

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

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

Through our Healthy First Steps® program, UnitedHealthcare helps women schedule prenatal care visits, select a pediatrician and get health services for their baby. Healthy First Steps helps expectant mothers get in-home health care if they need it, as well as medications and medical supplies.

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



How to Contact Us



uhcommunityplan.com

Click on Health Professionals;
choose your state

To review a patient's eligibility or benefits, check claims status, submit claims or review Directory of Physicians, Hospitals and other Health Care Professionals

Provider Services	866-675-1607	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 providers to: <ul style="list-style-type: none"> ▪ Answer general questions ▪ Verify member eligibility ▪ Check status of claims ▪ Ask questions about your participation or notify us of demographic and practice changes
Prior Authorization Notification	866-604-3267 uhcommunityplan.com	To request prior authorization or to notify us of the procedures and services outlined in the prior authorization/notification requirements section of this handbook
Case Management	866-675-1607	
Dental	866-675-1607	
Vision	866-675-1607	
Hospital inpatient services and concurrent reviews	866-675-1607	

For information about specialty behavioral health services prior to March 1, 2012, contact the Department of Health and Hospitals, Office of Behavioral Health at (225) 342-2540, or visit the website at: <http://new.dhh.louisiana.gov/index.cfm/subhome/10/n/6>.

For information about specialty behavioral health services beginning March 1, 2012, call Merit Health / Magellan Health Services at: (800) 424-4399 or TTY 800-424-4416.

Louisiana Provider Quick Reference Guide

Our claims process

To help ensure prompt payment:

- 1 Register for UnitedHealthcare Online (www.unitedhealthcareonline.com), our free Website for network physicians and health care professionals.** At UnitedHealthcare Online you can check eligibility, claims status – and submit claims electronically. To register, call (866) UHC-FAST (842-3278). Once you've registered, review the patient's eligibility on the Website at www.unitedhealthcareonline.com. To check patient eligibility by phone, call (877) 842-3210.

- 2 Review and copy** both sides of the member's ID card. UnitedHealthcare Community and State 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.

- 3 Notify** the prior authorization department of planned procedures and services on our Prior Authorization list.

- 4 Prepare** a complete and accurate electronic or paper claim form (see "complete claims" below).

- 5 Submit** claims electronically on www.unitedhealthcareonline.com. Be sure to use our electronic payer ID 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 and State of Louisiana
PO Box 31341
Salt Lake City, UT 84131-0341

M43884 9/11 ©2011 United HealthCare Services, Inc.

How to contact us
uhcommunityplan.com
Verify member eligibility
Provider Services
866-675-1607

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 providers to:

- Answer general questions
- Verify member eligibility
- Ask questions about your participation, or
- For PCP's notify us of demographic and practice changes
- For PCP's request information regarding credentialing

Prior Authorization

For a complete and current list of prior authorizations, go to uhcommunityplan.com or call 866-604-3267.

Case Management

866-675-1607
Case Management Intake – Pain Management; Medication; Utilization Management

Disease Management

866-675-1607

Member Services Helpline

866-675-1607
Member Service Representatives in our call center will be available to answer Member calls Monday through Friday from 8:00 a.m. to 6:00 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

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 provider performing the service, as in your contract document
- National Provider Identifier (NPI) number
- Physician's or provider's tax ID number
- CPT-4 and HCPCS procedure codes with modifiers where appropriate
- ICD-9 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 OS 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:

UnitedHealthcare Community shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. UnitedHealthcare Community Plan shall 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, shall not be included in any pharmacy benefit limits established for pharmacy services.

For vaccine information, please reference page 50, the section titled "Vaccines for Children (VFC) Billing".

Louisiana Provider Quick Reference Guide

Other Important Information

Claim Appeals and Utilization Management Appeals mailing address

UnitedHealthcare Community and State
Attention: Claims Administrative Appeals
PO Box 31364
Salt Lake City, UT 84131-0364

Notify Health Services within the following time frames:

Emergency Inpatient Admission

Within 48 hours of an emergency or urgent admission.

After Ambulatory Surgery

Within 48 hours of an inpatient admission after ambulatory surgery

Non-Emergency Care (except maternity)

At least five business days prior to non-emergency, non-urgent hospital admissions and/or outpatient services.

Return calls from Health Service Coordinators and Medical Directors and provide complete health information within one business day.



Compliance

National Provider Identification (NPI)

Federal Regulations and many state agencies require the use of your National Provider Identifier, NPI, on all electronic and paper claim submissions effective May 23, 2008.

Therefore, you must include a valid NPI on all claims submitted to us for payment. To assist us in expediting this process, please also include your provider name, address, and TIN.

If you have not yet applied for and received your NPI, please do so immediately by visiting "<http://www.nppes.cms.hhs.gov/>" www.nppes.cms.hhs.gov.

If you have not yet provided your NPI to us, please do so immediately by going to www.unitedhealthcareonline.com and choose National Provider Identifier from the Most Visited section. There are downloadable forms on the Website for you to fill in the appropriate information.

NPI information can also be faxed to 877-265-4877.

Benefits

The following are services covered by Louisiana Medicaid and LaCHIP for Louisiana CCN-S members.

Medical Services	What is included	Who qualifies	How to access service
Denture Services	Dentures, denture relines, and denture repairs; Exams and x-rays are covered if in conjunction with the construction of a Medicaid-authorized denture	Members 21 and older	Call Louisiana Department of Health and Hospitals 1-800-488-2917
Ambulatory Surgical Centers	Coverage of certain surgical procedures and related lab services	Covered, all members	Authorization required Phone: 1-866-604-3267 Fax: 1-888-310-6858
Audiological Services	Diagnosis and treatment of conditions related to hearing	Covered, all members	No referral number required PCP to Coordinate Care with Specialist
Behavioral Health – Basic	Screening, prevention, early intervention, medication management, and referral services	Covered, all members	Need BHH Telephone Numbers
Behavioral Health – Specialized	Services provided by a psychiatrist, psychologist and/or mental health rehabilitation provider for members with a primary diagnosis of a mental and/or behavioral disorder.	Covered, all members	Call Louisiana Department of Health and Hospitals 1-800-488-2917
Chemotherapy Services	Medically necessary manual manipulations of the spine only based on a referral from PCP or a KIDMED medical screening provider	Covered, all members	No referral number required PCP to Coordinate Care with Specialist
Chiropractic Services	Medically necessary manual manipulations of the spine only based on a referral from PCP or a KIDMED medical screening provider	Covered for members 0 - 20 yrs of age	Contact your PCP
Dental Care Services	Limited to Dentures: EPSDT Dental Services; and Expanded Dental Services for Pregnant Women	Covered, all members	Call Louisiana Department of Health and Hospitals 1-800-488-2917
Durable Medical Equipment (DME)	Medical equipment and appliances such as wheelchairs, leg braces, etc.		
Medical supplies such as ostomy supplies, etc.	Covered, all members	Call Louisiana Department of Health and Hospitals 1-800-488-2917	
Early Steps Program	<p>Program for children ages birth to three who have a developmental delay</p> <p>Covered Services under Medicaid include:</p> <ul style="list-style-type: none"> • Family Support Coordination • Occupational Therapy • Physical Therapy • Speech/Language Therapy • Psychology • Audiology <p>Additional services covered under Early Steps includes:</p> <ul style="list-style-type: none"> • Nursing Services/Health Services (only to enable an eligible child/family to benefit from the other EarlySteps services) <p style="text-align: right;">(continued)</p>	Covered, all members	<p>Call Louisiana Department of Health and Hospitals 1-800-488-2917</p> <p>For more info: http://new.dhh.louisiana.gov/index.cfm/subhome/1</p>

Medical Services	What is included	Who qualifies	How to access service
Early Steps Program (continued)	<ul style="list-style-type: none"> • Medical Services for diagnostic and evaluation services only • Special Instruction • Vision Services • Assistive Technology devices and services • Social Work • Counseling Services/Family Training • Transportation • Nutrition • Sign language and cued language services 		
Expanded Dental Services for Pregnant Women (EDSPW)	Services include x rays, cleaning, certain restorative services that may affect gum tissue; certain periodontal services and certain oral/maxillofacial surgery services	Pregnant women 21 – 59 providing proof via Form 9-M completed by the physician providing pregnancy care.	Call Louisiana Department of Health and Hospitals 1-800-488-2917
EPSDT Dental Services	Bi-annual screening with exam, x-rays, cleaning, topical fluoride treatment and oral hygiene instruction	Covered Members 0 - 21 years of age	Call Louisiana Department of Health and Hospitals 1-800-488-2917
ESDT Personal Care Services (See Long Term- Personal Care Services (LT-PCS) for Medicaid recipients ages 65 or older, or age 21 or older with disabilities)	<p>Basic personal care-toileting and grooming activities;</p> <p>Assistance with bladder and/or bowel requirements or problems;</p> <p>Assistance with eating and food preparation;</p> <p>Performance of incidental household chores, only for the recipient;</p> <p>Accompanying, not transporting, recipient to medical appointments.</p> <p>Does not cover any medical tasks such as medication administration, tube feedings.</p>	<p>Covered Medicaid members 0 - 20 years of age not receiving Individual Family Support services</p> <p>For Medicaid members 65 or older, or members 21 or older with disabilities, this service falls under 'Long Term Care'</p>	Call Louisiana Department of Health and Hospitals 1-800-488-2917
EPSDT Psychological and Behavioral Services (PBS)	<p>Services include: psychological and behavioral evaluations, assessments, individual therapy and family therapy; which include but are not limited to the following:</p> <p>Screening, prevention, early intervention, medication management, and referral services.</p>	Covered Members under age 21, who meet the criteria for Pervasive Development Disorder (PDD)	No referral number required PCP to Coordinate Care with Specialist
EPSDT Psychological and Behavioral Services (PBS) - Specialized	Services provided by a psychiatrist, psychologist and/or mental health rehabilitation provider for members with a primary diagnosis of a mental and/or behavioral disorder.	Covered Members under age 21, who meet the criteria for Pervasive Development Disorder (PDD)	Call Louisiana Department of Health and Hospitals 1-800-488-2917
Eyeglass Services	Exams for vision correction and refraction error; eyewear, contacts if the only means to restore vision	Covered, Members 0 - 20 years of age	Call Louisiana Department of Health and Hospitals 1-800-488-2917

Medical Services	What is included	Who qualifies	How to access service
Family Planning	Doctor visits to assess the patient's physical status and contraceptive practices; nurse visits; physician counseling regarding sterilization; nutrition counseling; social services counseling regarding the medical/family planning needs of the patient; contraceptives; and certain lab services	Covered for female members age 10 - 60 years of age	No referral number required
Federally Qualified Health Centers (FQHC)	Professional medical services furnished by physician, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists; Immunizations are covered for recipients under age 21; Includes regular encounter visits, KIDMED screening services; EPSDT Dental, Adult Denture, and Expanded Dental for Pregnant Women	Covered, all members	No referral number required PCP to Coordinate Care with Specialist
Hearing Aids	Includes hearing aids, batteries, earpieces and any related ancillary equipment if the hearing aid was paid for by Medicaid	Covered, Members 0 - 20 years of age	Call Louisiana Department of Health and Hospitals 1-800-488-2917
Hemodialysis Services- See OP Services	Includes routine lab, dialysis, medically necessary non-routine lab work, and medically necessary injections	Covered, all members	No referral number required PCP to Coordinate Care with Specialist
Home Health	Includes intermittent/part time nursing, including skilled bursting; aide visits; PT/OT/ST; and medically necessary extended home health for multiple hours of skilled nursing	Covered, all members, No Limit on # of Visits	Authorization required Phone: 1-866-604-3267 Fax: 1-888-310-6858
Hospice Services	Medicare allowable services	Covered Eligibility must be authorized by LA Medicaid	1-888-503-3204; Louisiana DHH
Hospital- Inpatient Services	Inpatient hospital care needed for the treatment of an illness or injury which can only be provided safely and adequately in a hospital setting	Covered	Authorization required General Inpatient Notification Phone: 1-866-604-3267 General Inpatient Notification Fax: 1-888-310-6858 Maternity Inpatient Notification Fax: 1-877-353-6913
Hospital- Outpatient Services	Diagnostic and therapeutic outpatient services, including outpatient surgery and rehabilitation services; Therapeutic and diagnostic radiology services	Covered	

Medical Services	What is included	Who qualifies	How to access service
Hospital- Emergency Room Services	Emergency Room Services	Covered, Members 0 - 20 years of age = No Service Limits Members 21 and older = Limit of 3 ER visits per calendar year (Jan 1 - Dec 31)	No authorization or referral number required
Immunizations		Covered	No referral number required
KIDMED Child Health Screenings/Checkups (EPSDT Screening Services)	Screenings include vision, hearing, dental screening, periodic and interperiodic screenings	Covered Members age 0 -20 years of age	No referral number required
Laboratory Tests and Radiology Services	Most diagnostic testing and radiological services ordered by the attending or consulting physician; Portable (mobile) x-rays are covered only for recipients who are unable to leave their place of residence without special transportation or assistance to obtain physician ordered x-rays	Covered, all members	Authorization required on specific services Phone: 1-866-604-3267 Fax: 1-888-310-6858
Long Term- Personal Care Services	Basic personal care-toileting and grooming activities; Assistance with bladder and/or bowel requirements or problems; Assistance with eating and food preparation; Performance of incidental household chores, only for the recipient; Accompanying, not transporting, recipient to medical appointments. Does not cover any medical tasks such as medication administration, tube feedings.	Covered for Medicaid members 65 or older, or members 21 or older with disabilities	Call Louisiana Department of Health and Hospitals 1-800-488-2917
Medical Transportation Emergent	Emergency ambulance service may be reimbursed if circumstances exist that make use of any conveyance other than an ambulance medically inadvisable for transport of the patient	Covered, all members	No referral number required
Medical Transportation Non Emergent	Transportation to and from medical appointments; The medical provider the recipient is being transported to, does not have to be a Medicaid enrolled provider but the services must be Medicaid covered services. The dispatch office will make this determination; Recipients under 17 years old must be accompanied by an attendant	Covered	Members should call their regional dispatch office 48 hrs prior to appointment: Alexandria - 800-446-3490 Baton Rouge - 800-259-1944 Lafayette/Lake Charles - 800-864-6034 Monroe - 800-259-1835 New Orleans - 800-836-9587 Shreveport - 800-259-7235

Medical Services	What is included	Who qualifies	How to access service
Mental Health Clinics	Include but are not limited to the following: Screening, prevention, early intervention, medication management, and referral services. This includes all services provided in the member's PCP or medical office; OP non-psychiatric hospital services, those BH services for members whose need for such services is secondary to a primary medical condition in any given episode of care.	Covered No age restrictions	Need BHH Telephone Numbers
Mental Health Clinics - Specialized	Specialized BH services, for which LA DHH is responsible, include but are not limited to: Services provided by a psychiatrist, psychologist and/or mental health rehabilitation provider for members with a primary diagnosis of a mental and/or behavioral disorder.	Covered, no age restrictions	Call Louisiana Department of Health and Hospitals 1-800-488-2917
Mental Health Rehabilitation Services		Covered Must meet program eligibility requirement; contact DHH	Call 1-877-455-9955 Covered by Louisiana Department of Health and Hospitals
Midwife Services (Certified Nurse Midwife)	See FQHC; Physician/Professional Services; Rural Health Clinics	Covered, all members	No referral number required PCP to Coordinate Care with Specialist
Nurse Practitioners/ Clinical Nurse Specialists	See FQHC; Physician/Professional Services; Rural Health Clinics	Covered, all members	No referral number required PCP to Coordinate Care with Specialist
Occupational Therapy Services	See Early Steps; Home Health; Outpatient Services; Rehabilitation Services; Therapy Services	Covered	Authorization required Phone: 1-866-604-3267 Fax: 1-888-310-6858
Optical Services	Exams for vision correction and refraction error; eyewear, contacts if the only means to restore vision	Covered Members 0 -20 years of age	Call Louisiana Department of Health and Hospitals 1-800-488-2917
Orthodontic Services	See Dental Care Services	Covered, all members	Call Louisiana Department of Health and Hospitals 1-800-488-2917
Pediatric Day Health Care (PDHC)	Nursing care, Respiratory care, Physical Therapy, Speech-language therapy, occupational, personal care services and transportation to and from PDHC facility	Covered for Members 0 -21 years of age who have a medically fragile condition	Call Louisiana Department of Health and Hospitals 1-800-488-2917
Program of All Inclusive Care for the Elderly (PACE)*	All Medicaid and Medicare services, both acute and long-term care	Covered for members age 55 or older who live in the PACE provider service area and are certified to need nursing facility level of care. Contact DHHS for details.	Call Louisiana Department of Health and Hospitals 1-800-488-2917

Medical Services	What is included	Who qualifies	How to access service
Pharmacy Services	Co-pays of .50 to \$3.00 apply to members EXCEPT those under age 21, pregnant women, and those in LTC Covers prescription drugs except: Cosmetic drugs (except Accutane) Cough and cold preparations Anorexics (except for Xenical) Fertility drugs when used for fertility treatment Experimental drugs Compounded prescriptions Vaccines covered in other programs Drug Efficacy Study Implementation (DESI) drugs Over the counter (OTC) drugs with some exceptions Narcotics prescribed only for narcotic addiction	Covered	Call Louisiana Department of Health and Hospitals 1-800-488-2917
Physical Therapy	See Early Steps; Home Health; Hospital Outpatient Services; Rehabilitation Clinic Services; Therapy Services	Covered	Authorization required Phone: 1-866-604-3267 Fax: 1-888-310-6858
Physician/ Professional Services	Professional medical services including those of a physician, nurse, midwife, nurse practitioner, clinical nurse specialists, physician assistant, audiologist; Immunizations are covered for recipients under age 21 Certain family planning services when provided in a physician's office	Covered	No referral number required PCP to Coordinate Care with Specialist
Podiatry Services	Office visits Certain radiology and lab procedures and other diagnostic procedures	Covered Some services may require Prior Authorization if performed outside of provider office (i.e. OP, ASC)	Authorization required on specific services Phone: 1-866-604-3267 Fax: 1-888-310-6858
Pre-Natal Care Services	Office visits Other pre- and post-natal care and delivery. Lab and radiology services	Covered Contact HFS (Healthy First Steps)	No referral number required PCP to Coordinate Care with Specialist For Maternity Case Management call HFS: 1-800-599-5985 HFS Fax: 1-877-353-6913
Psychiatric Hospital Care Services	See Hospital-Inpatient Services	Covered	Call Louisiana Department of Health and Hospitals 1-800-488-2917
Psychological Evaluation and Therapy Services	See EarlySteps; EPSDT Psychological and Behavioral Services; FQHC' Rural Health Clinics; Therapy Services – School Boards		

Medical Services	What is included	Who qualifies	How to access service
Rehabilitation Clinic Services	Occupational Therapy Physical Therapy Speech, Language and Hearing Therapy	Covered; all services must be prior authorized	Authorization required Phone: 1-866-604-3267 Fax: 1-888-310-6858
Rural Health Clinics	Includes regular encounter visits, KIDMED screening services; EPSDT Dental, Adult Denture, and Expanded Dental for Pregnant Women	Covered	No referral number required PCP to Coordinate Care with Specialist
Sexually Transmitted Disease Clinics (STD)	Includes testing, counseling, and treatment. Confidential HIV testing.	Covered	No referral number required PCP to Coordinate Care with Specialist
Speech and Language Evaluation and Therapy	See Early Steps; Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services; Therapy Services	Covered	Authorization required Phone: 1-866-604-3267 Fax: 1-888-310-6858
Substance Abuse Services	Services include: individual, group, and family counseling; medical treatment; medical injections; psychological, psychiatric, medical evaluations	Covered Members age 0 -21 years of age	1-800-662-4357 Covered by LA DHH
Therapy Services	Audiological Services (available in rehabilitation clinic and hospital-outpatient settings only) Occupational Therapy Physical Therapy Speech and Language Therapy	Covered birth through 20 years of age	Covered birth through 20 years of age Authorization required on specific services Phone: 1-866-604-3267 Fax: 1-888-310-6858
Transportation	See Medical Transportation Emergent and Medical Transportation Non-Emergent	Covered	Call Louisiana Department of Health and Hospitals 1-800-488-2917
Tuberculosis Clinics	Treatment and disease management services including physician visits, medications and x-rays	Covered, all members	No referral number required PCP to Coordinate Care with Specialist
X-Ray Services	X-Ray Services See Laboratory Tests and X-Ray Services		
Out of Network	All services provided by a Out of Network Physician, Ancillary Provider, Clinic or Facility	Covered, all members for Medically Necessary Services that cannot be obtained by an In Network Provider	Authorization required Phone: 1-866-604-3267 Fax: 1-888-310-6858

Prohibited or Excluded Services under the Louisiana Medicaid Program

- Elective abortions and related services,
- Experimental/investigational drugs, procedures or equipment,
- Elective cosmetic surgery, and
- Services for treatment of infertility.

NurseLineSM 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 NurseLine 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, 365 days/year.
- Access to caring registered nurses who have an average of 15 years' clinical experience
- Trusted, physician-approved information to guide health care decisions

When a member calls 877-440-9409, 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 his/her needs.

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.

Find a doctor or hospital.

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

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 866-675-1607.

Online Resources

Members also have access to a wealth of information online. Members can visit uhccommunityplan.com for health and well-being news, tools, resources and more. Members can even chat with a nurse any time about health questions or concerns.

Prior Authorization

The list of covered services is important in developing treatment plans and in obtaining prior authorization when necessary. For a list of services that require prior authorization, refer to the Benefits and Prior Authorization Grid. All physicians, facilities, and agencies providing services that require prior authorization should call the Prior Authorization Department at 866-675-1607 – Friday, 8:00 A.M. – 5:00 P.M. or enter request into I-Exchange®, a web-based authorization system. In advance of performing the procedure or providing service(s) to verify UnitedHealthcare has issued an authorization number.

Please note: A reference number is a tracking number and is an indication the physician has called to notify us and/or make a service request which is subject to a medical necessity determination prior to formal authorization.

UnitedHealthcare Community Plan Community Plan staff performs concurrent review on inpatient stays in acute, rehabilitation and skilled nursing facilities, as well as prior authorization reviews of selected services and pharmaceuticals. A Primary Care Physician or specialist can telephone or fax a prior authorization request to UnitedHealthcare Community Plan. A physician or pharmacist reviews all cases in which the care does not appear to meet criteria or guidelines which are adopted by UnitedHealthcare Community Plan's Medical Policy Committee. Decisions regarding coverage are based on the appropriateness of care and service and existence of coverage. Practitioners or other individuals are not rewarded, nor receive incentives for issuing denials of coverage or service. A copy of the prior authorization list is also available on our provider website.

Prior Authorization Fax Form



Prior Authorization Fax Request

Fax Number 888-310-6858

This FAX form has been developed to streamline the Prior Authorization request process, and to give you a response as quickly as possible. Please complete all fields on the form, and refer to the listing of services that require authorization; you only need to request authorization for services on that list. Please select the appropriate health plan and refer to provider materials.

Date: _____ Contact Person _____

Telephone #: _____ Fax #: _____

Requesting Provider: _____ Telephone #: _____

Initial request Urgent Routine

Request for an extension Urgent Routine

Urgent is defined as "significant impact to health of the member if not completed within 72 hours"

Member Information:

Member Name: _____ Member ID/JD# _____ Date of Birth: _____

Patient Name: _____ Member ID/JD# _____ Date of Birth: _____

Is request related to MVA or work-related injury? Does member have other insurance?

Yes No

Yes No

Medicare Part A Part B

Other insurance name and policy # _____

Servicing Provider Information:

Date of Service: _____ Provider ID: _____

Physician or Servicing Provider: _____ Phone #: _____

Address: _____ Fax #: _____

Facility: _____ PAR or Non-PAR (please circle one)

If Non-par will provider accept Medicaid/Medicare default rate - Yes No

Type of Service:

DME – Purchase

Cosmetic or Reconstructive

Home Health/Hospice Services

DME – Rental

Surgery

Skilled Nursing Facility

Prosthetic / Orthotics

PT / OT / ST

Hysterectomy

Inpatient Elective Surgery

MRI, MRA or PET Scan

Out Of Network (please explain)

Transplantation Evaluation

Gastric Bypass Eval/Surgery

Other _____

Clinical Information:

Diagnoses: _____ ICD-9 Codes: _____

CPT/HCPCS Codes: _____

Procedures: _____

Number of visits: _____ Duration: _____ Frequency: _____

Number of previous visits: _____ Service name/code for previous visits: _____

Medical Management

Referral Guidelines

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. Process for referral of members for services that are outside of the core benefits and services which will continue to be provided by enrolled Medicaid providers. The PCP/Medical Home will coordinate referrals that are outside of the members core benefit. However, the health plan will require notification prior to the referral.

Providers are expected to monitor the progress of referred members' care and ensure that members are returned to their care as soon as medically appropriate. Providers are prohibited from making referrals for designated health services to entities with which the provider or a member of the provider's family has a financial relationship. It is also expected that the PCP/Medical Home refers to a Medicaid provider who has the appropriate training or expertise to meet the particular health needs of the member. 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
- Medically necessary services are not available within network.

Out of network referrals are monitored on an individual basis and trends related to individual physicians or geographical locations are reported to Network Provider Services to assess root causes

for action planning. No referrals are required for the following services:

- EPSDT screening services
- Access to an in-network women's health specialist for routine and preventive women's health care services and prenatal care.

Emergency Care

View [uhcommunityplan.com](http://www.uhcommunityplan.com) for online prior authorization. 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 online at [HYPERLINK "http://www.uhcommunityplan.com/"](http://www.uhcommunityplan.com/) www.uhcommunityplan.com, or by calling 866-604-3267 within 48 business hours of admission. Nurses in the Health Services Department review emergency admissions within one (1) working day of receipt of clinical information. UnitedHealthcare Community Plan uses evidence based, nationally accredited, clinical criteria for determinations of appropriateness of care.

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.

"Emergency services" are defined as covered inpatient and outpatient services that are: (1) furnished by a provider qualified to furnish those services under the Medicaid program; and (2) needed to evaluate or stabilize an emergency medical condition.

An "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could

reasonably expect the absence of immediate medical attention to result in the any of the following:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

The Patient-Centered Medical Home

The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care to patients. The PCMH is a health care setting that facilitates relationships between individual patients, their physicians, and when appropriate, the patient's family. A medical home is defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

This new clinical model is at the heart of Health Care Reform and delivery system transformation. Engaging patients in Communities of Care will improve the efficiency and effectiveness of the health care system. This model expands our relationship with providers from just payment model to clinical value-added services in delivering more efficient and effective care to our members. It also improves trust and satisfaction with our network community. UnitedHealthcare Community & State (UHCCS) is uniquely positioned with many existing tools and capabilities to support Primary Care Physicians (PCP's) in this new process. UnitedHealthcare supports activities such as risk stratification, evidence-based interventions and advanced analytics. The core principal characteristics of a PCMH are based on the following:

- Personal Physician
- Physician Directed Practice
- Whole Person Care Orientation
- Coordinated Care
- Quality and Safety
- Enhanced Care Access
- Optimization through health information technology integration (e.g., Rx, patient registry)
- Each patient has a personal physician
- Practice operates as a team
- Scope of services is comprehensive

Key Aspects of the PCMH

Primary Care Practice Transformation: A practice team commits to:

- **Expanding patient access & engagement** – the practice has a process for same day appointments for routine and urgent care based on practices triage of members.
 - i. The practice can provide timely clinical advise by phone or email during office hours and documents the phone or email into the member's clinical record;
 - ii. Members must have access after hours.
 - iii. Electronic access to information (e.g., clinical summaries, secure electronic medical records);
 - iv. Continuity of Care – Must have a process to assign members to personal clinician or team; maintain record of members; monitoring the proportion of member visits that occur with an assigned physician/team

- v. Developing a member/PCP partnership in the care of the members condition(s); documents and explains what a medical home is and how it functions; how to use it the PCMH (e.g., patient self-management and support and how this is holistic approach)
 - vi. Explain how to use the medical home (referrals hours of operation, how to seek help after hours)
 - vii. Explain the role of the member (e.g., members sharing information about their medications, change in condition, symptoms, self-care needs, etc.)
 - viii. The practice must engage in activities that demonstrate an understanding of and meets cultural and linguistic needs of the members in their practice;
 - ix. The practices care team manages the members in defining their roles internally, meets on members who are in their care and has a clear communication process, trainings
- **Improving chronic condition population management** – UnitedHealthcare will help participating practices to not only identify at risk members, but also develop strategies to achieve successful outcomes;
 - **Providing team-based care** that focuses on care transitions & coordination;
 - **Monitoring performance** on key quality/utilization measures and effectively;
 - **Utilizing available technologies** including patient registries and e-prescribing where available.

Primary Care Practice Support:

UnitedHealthcare will commit to assisting participating PCMH practices in their transformation and acquisition of their NCQA PPC©-PCMH™ certification by;

- Providing enabling technologies
- Providing timely/actionable patient clinical data
- Providing/supporting care coordination through Care Management services

We also support the Medical Home in the tracking and monitoring of specific aspects of the members' care and status of their condition in our clinical systems. This data provides the basis for alerting health care professionals if early intervention is warranted, reinforces members' disease-specific education, and further promotes behavior change, compliance, and improved quality of care. The UHCCS Care Management Program defines quality care as treatment that:

- Improves the member's physical and emotional status;
- Promotes health and healthy lifestyles and behaviors;
- Encourages early detection and treatment;
- Involves members in informed decision-making;
- Is provided by a health care team sensitive to illness-related issues;
- Is based on evidence-based medical principles;
- Uses technology and other resources effectively;
- Is accessible to members in a timely fashion; and,
- Is sufficiently documented in medical records.

In support of the PCMH we also provide consultative support by assigning a Medical Home Consultant who works directly with the leadership of their assigned physician practices. This committed roll is designed to support the practice transformation from a reactive model of patient care to a proactive Medical Home, using data to effectively measure, monitor and manage care of priority, high-risk members and present results and outcomes to the Practice's executive leadership.

We have also integrated workflows across the entire continuum of care with special emphasis on Transition of Care, and integrate and leverage resources from UHCCS to communicate on members who may be hospitalized.

Upon launch of the Medical Home, UHCCS will establish:

- a clear set of goals around the gaps to be addressed
- goal setting that needs to be done with the CEO, CMO and COO of the practices.

On a monthly basis, UHCCS assigned staff will jointly assess interventions to drive goals to results.

Practices engaging in the PCMH model will be creating a comprehensive approach to managing care and a positive approach to better patient outcomes.

Determination of Medical Necessity

The CCN shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the CCN can provide the service through an in-network or out-of-network provider for a lower level of care. UnitedHealthcare evaluates medical necessity according to the following standard.

- A. Medically necessary services are defined as those health care services that are in accordance with generally accepted evidence-based medical standard or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.
- B. In order to be considered medically necessary, services must be:
 1. deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and
 2. those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient.
- C. Any such services must be clinically appropriate, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time.

D. Although a service may be deemed medically necessary, it does not mean the service will be covered under the Medicaid program. The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services at his discretion on a case-by-case basis. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

1. The Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at his discretion on a case-by-case basis. **AUTHORITY NOTE:** Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act. **HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2563 (November 2010), repromulgated LR 37:341 (January 2011).

The determination of medical necessity is made by qualified and trained practitioners in accordance with state and federal regulations and is based on valid and reliable clinical evidence, expert pediatric, psychiatric and medical opinion, and medical/pediatric community acceptance.

UM decision making is based only on appropriateness of care and service and existence of coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Disease Management

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

Member Identifications

The 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 and issues across multiple domains of care.
- **Level 3:** High risk members who are medically fragile, have multiple co-morbidities and need complex care management.

Stratification

There are two forms of risk stratification, a proactive approach using the HRA and a reactive approach, using the risk stratification tool. The HRA process is described in the previous section, where members are stratified based upon their response to the questions in the HRA. In the case of the predictive modeling tool, a score is assigned based upon historical information on the members. The assigned risk score is then placed into one of three levels. Members stratified as level 1 (one) – low risk, have scores equal to or less than 5 (five), Level 2 (two) – moderate risk, are scores between 6-10 (six to ten), and Level 3 (three) – high risk, scores are equal or greater to 10 (ten). The highest predicted score or HRA level determines the hierarchy. High level stratification are within the top 1%, moderate are within the top 10% of targeted diagnoses and low risk members are addressed with targeted disease specific mailings.

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 also 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

DM interventions are executed when the members condition situation requires it. 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 providers, ER staff, and hospital discharge planners to refer members for a greater intensity and frequency of DM interventions when the situation requires it. Providers may also refer members for case or chronic care management by contacting our provider services department. When a member’s condition requires ongoing care from a specialist, the PCP/Medical Home has the ability to provide ongoing referrals, when appropriate. A provider services representative will perform a warm transfer to a health plan representative who can assist with the referral. We also rely on partnering programs and agencies to identify those members most at need. 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 PCP/specialist office and reviewing prior authorization information, and sending written correspondence. We document and track contacts to 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 member 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 provider identifying the member's involvement, intervention and point of contact for the DM program.
- Additional and/or specific interventions are also conducted in order 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, 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.

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 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 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 in order to continually improve
- To communicate effectively with the primary care provider/specialist and other 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 ensure that the member continues to receive an appropriate level of care. The care manager will involve the provider caring for 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.

Coordination of Care with Providers

Each member is encouraged to select a medical home for community-based health and preventive services. Providers caring for our members receive reports regarding the health status of members participating in specific DM programs. As this link is established, we involve the provider in the plan of care development process and assist them in directing the course of treatment in accordance with evidence-based clinical guidelines.

The care manager collaborates with the member's provider on an ongoing basis to ensure integration of physical and behavioral health issues. In addition, the care manager will ensure the plan of care supports the member's/caregiver's preferences for psychosocial, educational, therapeutic and other non-medical services. The care manager ensures the plan of care supports providers' 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 manager recognizes that 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 provider/specialist, offer potential solutions and integrate provider feedback
- Facilitate agreement for change between all parties and monitor progress of the change.

As the member's medical home, the provider caring for our member is 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. The provider receives 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, the provider receives 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 the provider's request and provide training for providers and their staff on how best to integrate practice guidelines into everyday physician practice. When a provider demonstrates a pattern of non-compliance with clinical practice guidelines, the medical director may contact the provider by phone or in person to review the guideline and identify any barriers that can be resolved.

Care Management

We use retrospective and prospective methods to 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, Rx data and referrals from providers, members and their family/caregivers as well as UnitedHealthcare 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—UnitedHealthcare uses numerous data sources to identify members with a diagnosis for which we have a DM program as well as those whose utilization reflects high-risk and/or complex conditions (level 3). These data sources include but are not limited to:

- 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 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 UnitedHealthcare Community Plan and Louisiana Medicaid 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 are assigned to the appropriately qualified staff.

Clinical Practice Guidelines

UnitedHealthcare uses nationally recognized, evidence-based clinical criteria to guide our medical necessity decisions, including Milliman Healthcare Management Guidelines and CMS policy guidelines. Milliman 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 guidelines are integrated into our clinical system. The clinical criteria guidelines used in the decision making are available upon request by calling 866-675-1607.

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.

Nationally accepted evidence based guidelines (dpcpg) are used to monitor and improve the quality of care provided by participating providers. The clinical practice guidelines are reviewed and revised annually. The UnitedHealthcare Executive Medical Policy National Medical Care Management Committee reviews and approves nationally recognized clinical practice guidelines. The guidelines are then distributed to the National Medical Care Management Committee (NMCM) and the Health Plan Quality Management Committee.

Medical guidelines are available and shared with providers upon request and are available on the provider website, uhcommunityplan.com. Policies and guideline updates are communicated through provider notices prior to implementation.

Maternity Care

Pregnant UnitedHealthcare Community Plan's members should receive care from UnitedHealthcare participating providers only. UnitedHealthcare Community Plan will consider exceptions to this policy if 1) the woman was in her second trimester of pregnancy when she became an UnitedHealthcare member, and 2) if she has an established relationship with a non-participating obstetrician. Providers should call Prior Authorization at 866-675-1607, to obtain global authorization. For all other questions, contact Healthy First Steps (HFS) at 866-675-1607.

Providers should notify UnitedHealthcare Community Plan promptly of a member's confirmed pregnancy to ensure appropriate follow-up and coordination by the UnitedHealthcare HFS coordinator.

To notify us of deliveries, call 866-675-1607. Providers need to contact HFS by submitting an American College of Gynecology (ACOG) or any initial prenatal visit form.

The following information must be provided to UnitedHealthcare Community Plan within one business day of the visit when the pregnancy is confirmed:

- Patient's name and Member ID number
- Obstetrician's name, phone number, and Member ID number
- Facility name
- Expected date of confinement (EDC)
- Planned vaginal or Cesarean delivery

- Any concomitant diagnoses that could affect pregnancy or delivery
- Obstetrical risk factors
- Gravida
- Parity
- Number of living children
- Previous care for this pregnancy

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

Healthy First Steps (Maternity Care)

We provide high risk pregnancy management and discharge planning for NICU-admitted babies through our HFS program. HFS nurses conduct in-home post-discharge management of high-risk mothers and babies. Perinatal home care services are available for 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 Maternal Case Manager can assist obstetricians and providers 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 Louisiana services.

Obstetrical Admissions

Obstetricians and providers caring for the members are expected to notify UnitedHealthcare Community Plan as soon as a pregnancy is confirmed.

Newborn Admissions

The hospital must notify UnitedHealthcare 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:

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

Concurrent Review

UnitedHealthcare performs concurrent review on all hospitalizations for the duration of the stay based on contractual arrangements with the hospital. UnitedHealthcare performs fax, telephonic or onsite utilization reviews at the facility.

UnitedHealthcare uses evidence based, nationally accepted, clinical criteria guidelines for determinations of appropriateness of care.

The Inpatient care manager may certify extension of the length of stay, but may not deny any portion of the stay. Only a medical director or physician advisor can deny an extension of the length of stay.

UnitedHealthcare Community Plan notifies the facility when the Inpatient care manager refers a hospital stay for review by a medical director or

physician advisor. If a medical director or physician advisor determines that the extended stay is not justified, UnitedHealthcare Community Plan notifies the facility by phone and fax within one (1) working day.

The provider, attending physician, or the facility may appeal any adverse decision, according to the procedures in the Appeals and Grievances section.

Discharge Planning and Continuing Care

The Inpatient Care Manager discharge manager and case manager work as a team to effectively discharge a member and transition them to a lower level of care into the community. The case manager contacts the provider caring for the member, the attending physician, the member, and member's family to assess needs and develop a plan for continuing care beyond discharge, if medically necessary. UnitedHealthcare Inpatient Care Managers facilitate coordination of care across multiple sites of care. The Inpatient Care Managers work with the member, family members, physicians, hospital discharge planners, rehabilitation facilities, and home care agencies. They evaluate the appropriate use of benefits, oversee the transition of patients between levels of care, and refer to community-based services as needed.

Preventive Health Care Standards

UnitedHealthcare goal is to partner with providers to ensure that members receive preventive care. UnitedHealthcare endorses and monitors the practice of preventive health standards recommended by recognized medical and professional organizations. Preventive health care standards and guidelines are available at uhccommunityplan.com. Standards such as well child, adolescent and adult visits, childhood and adolescent immunizations, lead screening, and

cervical and breast cancer screening are included in the website. Education is provided to both members and providers 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.

Recommended Childhood Immunization Schedules

The childhood and adolescent immunization schedule and the catch-up immunization schedule have been approved by Advisory Committee on Immunization Practices (ACIP), American Academy of Family Physicians (AAFP), and the American Academy of Pediatrics (AAP).

Government Childhood and Adolescent Immunizations Guide:

cdc.gov/vaccines/recs/schedules/childschedule.htm

Government Quick Reference Guide:

cdc.gov/vaccines/recs/schedules/

Source: CDC and Advisory Committee on Immunization Practices

Grievances and the State Fair Hearing Process

UnitedHealthcare Community Plan maintains a grievance system for members that ensures receipt and prompt resolution of informal and formal member grievances and access to the state fair hearing process.

Our grievance system is HIPAA compliant and conforms to applicable federal and state laws, regulations and policies. Under the CCN-S program, all appeals received by UnitedHealthcare Community Plan are directly forwarded to the state fair hearing process. UnitedHealthcare Community Plan assists DHH in handling appeals of members through the state fair hearing process. We also work with DHH toward simultaneous resolution of any appeals brought to our attention.

Informing Members

We encourage members to follow the grievance process appropriately and make information available to members via the UnitedHealthcare Community Plan Member Handbook, new member packet, and online through the UnitedHealthcare Community Plan website. UnitedHealthcare Community Plan gives members any reasonable assistance in completing forms and taking other procedural steps related to the grievance and state fair hearing process. This includes providing interpreter services and toll-free telephone numbers with adequate TTY/TTD and interpreter capability. We inform members of the grievance and state fair hearing process in prevalent non-English languages, via oral interpretation in any language and via TTY/TTD services. We provide members with our Member Grievance Policy; forms, if requested, and assistance with filing grievances. UnitedHealthcare Community Plan informs providers of the member grievance and state fair hearing process through the this Guide and UnitedHealthcare Community Plan provider website.

Definitions

- **Grievance.** A “grievance” is an expression of dissatisfaction about any matter other than an

“action” (as that term is defined below). Possible subjects for grievances include but are not limited to: (1) quality of care or services provided; (2) aspects of interpersonal relationships (e.g., rudeness of a provider or employee); or (3) failure to respect a member’s rights.

- **Action.** An “action” is a termination, suspension, or reduction (which includes denial of a service as specified in federal regulations) of Medicaid eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.
- **Appeal.** An “appeal” is a request for review of an action (as that term is defined above).

Filing a Member Grievance

A member, a representative of the member's choice, or a CCN-S provider, acting on behalf of the member with the member's written consent, may file a grievance with UnitedHealthcare Community Plan. Grievances may be filed orally by calling the toll-free number for our Member Services Call Center 866-675-1607 or in writing by mailing the grievance to our Regional Mail Operations (RMO) UnitedHealthcare P.O. Box 31364, Salt Lake City, UT 84131-0364. We route telephonic/verbal grievances through our technology that identifies call type and routes to other databases according to category. When the system identifies the call as a grievance, the information is logged into the system, and forwarded to a triage team who puts the information into our tracking system where a case file is created and populated. On receipt of a written grievance, appropriate personnel scan them into the tracking system and create a case file. Per our Member Grievance Policy, and on initial contact, we log and track criteria including member

name/identification number, date received/acknowledged, whether the grievance was determined valid and The date of member notification, description, staff assigned, disposition, tentative disposition date, etc. We provide written acknowledgement of each member grievance filed in writing no later than 5 days from initial receipt. Acknowledgement of grievances filed orally is considered complete at the time the oral grievance is received.

An individual or a provider on the member's behalf may file an appeal in response to an unresolved grievance. Additionally, members, or their authorized representatives, may appeal an adverse decision made by UnitedHealthcare. The member has 30 days from the date of the Notice of Action to file an appeal. UnitedHealthcare accepts appeals in writing or verbally. The information is routed to the tracking system, where a case file is created. A notification letter is generated in one working day for expedited appeals and in five working days for standard appeals. No punitive action is taken against a provider who supports a member's appeal or requests an expedited resolution.

Process for Resolving a Grievance

Our Member Services Call Center receives calls to address various issues, including member grievances. All calls related to member grievances are recorded in our system. The CCN's staff is educated concerning the importance of the State Fair Hearing procedures and the rights of the member and providers. The majority of member grievances are resolved during the initial call and we maintain the data from these calls. Those not resolved are forwarded to our Grievances & Appeals Department. We educate our resolving analysts on grievance procedures, importance of the State Fair Hearing procedures and the rights of the member and

providers. On notification of a grievance, our resolving analysts investigate the member's issue.

UnitedHealthcare Community Plan will resolve member grievances and notify the member in writing of the resolution in a timely manner that is as expeditiously as the member's health condition requires. All standard grievances will be resolved and the member will be notified within 90 calendar days of our original receipt of the grievance, with the possibility of an extension of up to 14 calendar days upon the member's request or if we demonstrate to the satisfaction of DHH (if requested) that there is a need for additional information and the delay is in the member's interest. For extensions not requested by a member, we will give the member written notice of the reason for the delay. Written notice of the resolution of the grievance will be mailed to the member within two days of the resolution. The notice will comply with DHH requirements and will include the following: The circumstances under which expedited resolution is available and how to request it.

The member's right to have benefits continues pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services.

- Name(s), title(s) and, in the case of a grievance with a clinical component, qualifying credentials of the person(s) completing the review of the grievance. The circumstances under which expedited resolution is available and how to request it
- UnitedHealthcare Community Plan's decision in clear terms and sufficient detail for the member to respond further to the decision. If applicable, the contract basis or medical rationale shall be given. whether the grievance was determined valid and The date of member notification.

- A reference to the evidence or documentation used as the basis for the decision, if appropriate.
- An explanation that, if the member does not agree with UnitedHealthcare's decision, he or she may request a State Fair Hearing and a number to call for free Legal Advice and directions on how to submit such a request. DHH has the right to make final decisions regarding the resolution of any grievance. A statement in Spanish and Vietnamese that translation assistance is available at no cost and they can call the toll free number 866-675-1607 to receive translation of the notice

State Fair Hearing Process

A member, a representative of a member's choice, or a CCN-S provider, acting on behalf of the member with the member's written consent, may request a state fair hearing in order to appeal an action (as defined above). Requests for a state fair hearing should be made directly to the to the Louisiana state entity responsible for administering state fair hearings. If UnitedHealthcare Community plan receives a request for a state fair hearing, it will promptly forward it to the designated state entity.

A request for a state fair hearing must be made within 30 calendar days from the date on the notice of action mailed to the member. However, if the member wishes to have continuation of benefits during the state fair hearing, the request must be made within 10 calendar days of the date on the notice of action. The member, or a representative or provider acting on behalf of the member, may file for a State Fair hearing with the designated state entity either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed State Fair Hearing request.

The parties to the state fair hearing will include UnitedHealthcare Community Plan, the member and the member's authorized representative or the legal representative of a deceased member's estate.

Concurrent Appeal Review

UnitedHealthcare Community Plan will conduct an internal concurrent review of an action whenever a member requests a state fair hearing. The purpose of the concurrent review is to expedite the resolution of the appeal to the satisfaction of the member, if possible, prior to the state fair hearing. UnitedHealthcare Community Plan will notify the state fair hearing entity of concurrent reviews resulting in a resolution in favor of the member. The internal concurrent review by UnitedHealthcare Community Plan shall not delay UnitedHealthcare Community Plan's submission of an appeal to the state fair hearing entity, nor shall it delay the review of the appeal in the state fair hearing.

Continuation of Benefits During a State Fair Hearing

Members have the right to request continuation of benefits while a state fair hearing is pending. If the member requests a state fair hearing before the date of the action or within 10 days from the postmark of the notice of action, DHH may not terminate or reduce services until a decision is rendered after the hearing unless:

- It is determined that the sole issue is one of federal or state law or policy; or
- DHH or its designee promptly informs the member in writing that services are to be terminated or reduced pending the hearing decision.

If the state fair hearing determination is adverse to the member, DHH may recover the cost of the services furnished to the member during the pending appeal/state fair hearing process in accordance with federal regulations.

Quality Management

Provider Participation in Quality Management

UnitedHealthcare has a Quality Management Committee (QMC), chaired by the CEO or designee of the CEO, which meets monthly and has oversight responsibility for issues affecting health services delivery. The QMC is composed of UnitedHealthcare management staff and reports its recommendations and actions to the UnitedHealthcare Board of Directors. The Quality Management Committee has three standing sub committees:

- **Provider Advisory Committee** reviews and recommends action on topics concerning credentialing and recredentialing of providers and facilities, peer review activities, and performance of all participating providers. Participating providers give UnitedHealthcare advice and expert counsel in medical policy, quality management, and quality improvement. A Medical Director chairs the Provider Advisory Committee.
- **Health Care Utilization Management Subcommittee** reviews statistics on utilization, provides feedback on utilization management and case management policies and procedures, and makes recommendations on clinical standards and protocols for medical care. UM staff is available eight hours a day during normal business hours for inbound calls to discuss UM issues.
- **Service Quality Improvement Subcommittee** reviews timely tracking, trending and resolution of member administrative complaints and grievances. This subcommittee oversees member and provider intervention for quality improvement activities as needed.

Quality Improvement Program

The Quality Improvement Program at UnitedHealthcare is a comprehensive program under the leadership of the Chief Executive Officer and the Chief Medical Officer. A copy of our Quality Improvement Program and information on our progress in meeting our program goals is available upon request. The Quality Improvement Program consists of the following components:

- 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, member and provider satisfaction)
- Health Plan performance information analysis and auditing (e.g., HEDIS[®], CAHPS[®])
- Care CoordinationSM
- Educating members and physicians
- Risk management
- Compliance with all external regulatory agencies

Your participation is an integral component of UnitedHealthcare's Quality Improvement Program.

As a participating physician, you have a structured forum for input through representation on our Provider Advisory Committee and through individual feedback via 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 providers of care and UnitedHealthcare 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.

Provider Satisfaction

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

- Annual Provider Satisfaction Surveys and Targeted Improvement Plans
- Regular visits to providers
- Provider town meetings

Objectivity is our utmost concern in the survey process. To this end, UnitedHealthcare works with Survey Research Solutions, a product of our sister segment, Ingenix and vendors expert in survey research to conduct our annual provider satisfaction survey(s). The randomly drawn survey samples of eligible physicians working within UnitedHealthcare's networks are from lists provided by Ingenix.

Survey results from all UnitedHealthcare health plans are aggregated annually and reported to the health plan 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

UnitedHealthcare Community Plan is required to credential each health care professional prior to the professional providing services to UnitedHealthcare members.

Provider Responsibilities

Providers shall immediately notify UnitedHealthcare in writing if their 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's credentialing process uses standards set forth by the DHH and National Committee for Quality Assurance (NCQA), <http://www.ncqa.org/>, including primary verification of training/experience, office site visits, etc. Each provider must be re-credentialed at least every three (3) years or such other time period as established by the NCQA. It is the applicant's responsibility to supply all requested credentialing documentation in a form that is satisfactory to UnitedHealthcare. Applications that are lacking supporting documentation will not be considered. UnitedHealthcare will process the initial application within 90 days upon receipt of a completed application. 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, UnitedHealthcare will make every effort to obtain such information as soon as possible.

UnitedHealthcare will notify the provider of the missing information, via 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.

Resolving Complaints

Toll-free provider help line Monday-Friday, from 7am - 7pm CST. 866-675-1607

A procedure is in place for the resolution of any Complaints between the health plan and providers by allowing providers thirty (30) days to file a written complaint to the health plan, where the health plan will respond to such provider complaints within thirty (30) business days of receiving the written complaint. If unable to resolve in 30 business days the health plan will document why the issue is unresolved and provide response within ninety (90) business days.

The provider may send their written complaint by sending us a letter containing the details to: United Healthcare PO Box 31364 Salt Lake City, UT 84131 or in person at the Local Health Plan office.

HIPAA Compliance

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 is a “covered entity” under the regulations as are all health care providers who 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. All providers who conduct business electronically are required to do so utilizing the standard formats adopted under HIPAA or to utilize a clearinghouse to translate proprietary formats into the standard formats for submission to UnitedHealthcare.

2. Unique Identifiers

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

3. Privacy of Individually Identifiable Health Information

The privacy regulations 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 health information. The regulations protect medical records and other individually identifiable health information, whether it is electronic, paper or oral.

4. Security

The security regulations require covered entities to meet basic security objectives, including the following:

1. Ensure the confidentiality, integrity and availability of all electronic protected health information 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. Ensure compliance with the security regulations by the covered entity's workforce.

5. Individual Rights

The HIPAA privacy regulations give individuals a fundamental right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice of privacy practices that provides a clear explanation of: (1) how a covered entity may use and disclose protected health information about

the individual; and (2) an individual's rights and the covered entity's obligations with respect to that information. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

UnitedHealthcare expects all participating providers to be in compliance with the HIPAA regulations that apply to their practice or facility within the established deadlines. Additional information on HIPAA regulations can be obtained at cms.hhs.gov.

Member Rights and Responsibilities

We tell our members they have certain rights and responsibilities, all of which are intended to help uphold 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 providers need in order to provide care
- 2) A responsibility to follow plans and instructions for care that they have agreed to with their providers
- 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, and are listed below for your reference.

Your Rights

UnitedHealthcare will follow all federal and state laws about your rights. We will make sure that we and our providers respect those rights. As a member of UnitedHealthcare, you have a right to:

- Be treated with respect and with due consideration for your dignity and privacy no matter what your health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- Receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- Be told where, when and how to get the services you need from UnitedHealthcare Community Plan and receive health care services that are accessible.
- Be told by your providers what is wrong, what can be done for you, and what is likely to happen, in a language you understand.
- Learn about all treatment choices, in a way appropriate to your condition and ability to understand regardless of cost or benefit.
- Get a second opinion about your care by a provider in or out of the UnitedHealthcare Community Plan network, at no cost.
- Participate in treatment decisions, including the right to get complete information about your condition and treatment options, such as the right to receive services in a home, community or institutional setting, if desired. You have the right to give your OK to any treatment or plan for your care after that plan has been fully explained to you.
- Refuse treatment and be told what you may risk if you do.
- Get information about available experimental treatments and clinical trials and how to access such research.
- Assistance with care coordination from your primary care provider's office.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Choose a primary care provider from the UnitedHealthcare Community Plan network, and refuse care from specific providers.
- Get a copy of your medical record, and talk about it with your primary care provider. Ask, if needed, that your medical record be corrected as allowed under law.
- Be sure that your medical record is private and that it will not be shared with anyone except as required or permitted by law, or with your approval.
- Express a concern about UnitedHealthcare Community Plan or the care it provides, or appeal a UnitedHealthcare Community plan decision, and receive a response in a reasonable time.
- Exercise your rights without without fear of retaliation or any negative effect on your treatment by DHH, UnitedHealthcare Community Plan or its providers or contractors.
- Use the state fair hearing system.
- Allow someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive kind and respectful care in a clean and safe place free of unnecessary restraints.
- Ask for and get information about physician incentives.

- Ask for and get information about UnitedHealthcare Community Plan, its services, the providers providing care, and members' rights and responsibilities.
- Make recommendations regarding UnitedHealthcare Community plan's member rights and responsibilities policy
- Receive information on and prepare advance directives. You have the right to file a complaint with DHH regarding UnitedHealthcare Community Plan's or a provider's non-compliance with advance directive requirements.

National Provider Identifier

NPI is the standard unique identifier (a 10 character number with no imbedded intelligence) for health care providers under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which covered entities must accept and use in standard transactions.

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

The NPPES assists providers with their application, processes the application and returns the NPI to the provider.

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 providers may enumerate based on location, taxonomy or department.

Only 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:

Health care providers can apply for NPIs in one of three ways:

- For the most efficient application processing and the fastest receipt of NPIs, use the web-based application process. Simply log onto the National Plan & Provider Enumeration System - Home Page and apply online at <https://nppes.cms.hhs.gov/NPPES>.
- Health care providers can agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so.
- Health care providers may wish to 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. Health care providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of these ways:

- Phone: 1-800-465-3203 or
TTY: 1-800-692-2326
- Mail: NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

How to share your NPI with us:

Once you have NPI, it is imperative that it be communicated to UnitedHealthcare immediately by going to unitedhealthcareonline.com and choosing National Provider Identifier from the Most Visited section. There are downloadable forms on the Website for you fill in the appropriate information.

NPI information can also be faxed to 877-265-4877. To assist us in expediting this process, please also include your provider name, address, and TIN.

Fraud, Waste and Abuse

Fraud, waste and abuse by providers, members, health plans, employees, etc. hurts everyone. Your assistance in notifying us about any potential fraud, waste and abuse that comes to your attention and your cooperation with evolving UnitedHealthcare policies and initiatives to detect, prevent and combat fraud, waste and abuse, as well as with any review of such a situation is vital and appreciated. We consider this an integral part of our mutual ongoing efforts to provide the most effective health outcomes possible for all our members.

Definitions of Fraud, Waste and Abuse

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

Waste: An action or expenditure that, either directly or indirectly, results in unnecessary costs to a health care organization or government program.

Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid 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 Medicaid program.

Examples of fraud, waste 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, waste and Abuse

If you suspect another provider or a member has committed fraud, waste or abuse, you have a responsibility and a right to report it. Reports of suspected fraud, waste or abuse can be made in several ways.

- Call UnitedHealthcare at 866-675-1607

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

- Name, address and phone number of provider
- Provider identification number (e.g., Medicaid number; NPI)
- Type of 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 & Integrity

Introduction

UnitedHealthcare is dedicated to conducting business honestly and ethically with members, providers, suppliers and governmental officials and agencies. The need to make sound, ethical decisions as we interact with physicians, other

health care providers, regulators and others 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 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 employee which comes to the attention of a provider 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 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 providers call 866-675-1607. 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 operations and implementing reviews and audits to ensure compliance with law, regulations, and Policies/contracts. When informed of potentially irregular, inappropriate or potentially fraudulent practices within the plan or by our providers, UnitedHealthcare will conduct an appropriate investigation. Providers 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 provider office staff. If activity in violation of law or regulation is established, appropriate governmental authorities will be advised.

If a provider becomes the subject of a governmental inquiry or investigation, or a government agency requests or subpoenas documents relating to the provider's operations (other than a routine request for documentation from a regulatory agency), the provider must advise the UnitedHealthcare plan of the details of this and of the factual situation which gave rise to the inquiry.

Our claims process

Claims Billing Procedures

If you are a practitioner, physician facility, or medical group, you must only bill for services that you or your staff perform. The CCN must accept and pre-process claims within two (2) business days of receipt. Preprocessed approved claims will be paid on a fee-for-service (FFS) basis by DHH.

We know that you want to be paid promptly for the services you provide. Below is what you can do to help promote prompt payment:

- Register for UnitedHealthcare Online service (unitedhealthcareonline.com), our free service for network physicians and health care professionals.
- At UnitedHealthcare Online, you can check eligibility, check claims status, request a claim adjustment, update demographic changes, recredential or review the physician and health care professional directory – and submit claims electronically, for faster claims payment. To register, call (866) UHC-FAST (842-3278).
- Once you've registered, review the member's eligibility on the Website at unitedhealthcareonline.com.
- To check member eligibility by phone, call the member service number on the back of the Member ID Card.
- Notify us of planned procedures and services on our notification list.
- Prepare a complete and accurate claim form (see "Complete Claims".)
- Submit the claim online at unitedhealthcareonline.com or use another electronic option:
 - If you currently use a vendor to submit claims electronically, be sure to use our electronic payer ID 87726 to submit claims to us. For more information, contact your vendor or our Electronic Data Interchange (EDI) unit at 800 842-1109.
- For those claims that UnitedHealthcare Community and State cannot accept electronically, mail paper claims to the claims address on the member's ID card.
- Claims should be submitted within 120 days from the date of service.

Electronic claims reduce errors and shorten payment cycles. For electronic claims submission requirements, please see our companion documents located at uhcommunityplan.com. This documentation should be shared with your software vendor.

To obtain more information regarding electronic claims, please refer to the EDI section of this handbook or the provider section of the Website at uhcommunityplan.com, or you may call our EDI Customer Service at 800-210-8315.

If a claim must be submitted on paper, you should send claims to the following address:
UnitedHealthcare Community and State of Louisiana
PO Box 31341
Salt Lake City, UT 84131-0341

Complete Claims – from UnitedHealthcare Community Plan Administrative Guide

Whether you use an electronic or a paper form, complete a CMS 1500 (formerly HCFA 1500) or UB-04 form. A complete claim includes the following information:

- Patient's name

- Patient's address
 - Patient's gender
 - Patient's date of birth
 - Patient's relationship to subscriber
 - Subscriber's name (enter exactly as it appears on the health care ID card)
 - Subscriber's ID number
 - Subscriber's employer group name
 - Subscriber's employer group number
 - Rendering Physician, Health Care Professional, or Facility Name
 - Rendering Physician, health Care Professional, or Facility Representative's Signature
 - Address where service was rendered
 - Physician, Health Care Professional, or Facility "remit to" address
 - Phone number of Physician, Health Care Professional, or Facility performing the service (provide this information in a manner consistent with how that information is presented in your agreement with us)
 - Physician's, Health Care Professional's or Facility's NPI and federal TIN
 - Referring physician's name and TIN (if applicable)
 - Date of service (s)
 - Place of service(s) (for more information see: cms.hhs.gov/PlaceofServiceCodes/Downloads/placeofservice.pdf)
 - Number of services (day/units) rendered
 - Current CPT-4 and HCPCS procedure codes, with modifiers where appropriate
 - Current ICD-9-CM (or its successor) diagnostic codes by specific service code to the highest level of specificity (it is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item)
 - Charges per service and total charges
 - Detailed information about other insurance coverage
 - Information regarding job-related, auto or accident information, if available
 - Retail purchase cost or cumulative retail rental cost for DME greater than \$1,000
 - Current NDC (National Drug Code) 11-digit number for all claims submitted with drug codes. The NDC number must be entered in the 24D field of the CMS-1500 Form or the LIN03 segment of the HIPAA 837 Professional electronic form.
 - Method of Administration (Self or Assisted) for Hemophilia Claims – the method of administration must be noted and submitted with the claim form with applicable J-CODES and hemophilia factor, in order to ensure accurate reimbursement. Method of administration is either noted as self or assisted.
- Additional information needed for a complete UB-04 form
- Date and hour of admission
 - Discharge date and hour of discharge
 - Patient status-at-discharge code
 - Type of bill code (3 digits)

- Type of admission (e.g., emergency, urgent, elective, newborn)
- Current four-digit revenue code(s)
- Current principal diagnosis code (highest level of specificity) with the applicable Present on Admission (POA) indicator on hospital inpatient claims per CMS guidelines
- Current other diagnosis codes, if applicable (highest level of specificity) with the applicable Present on Admission (POA) indicator on hospital inpatient claims per CMS guidelines
- Current ICD-9-CM (or its successor) procedure codes for inpatient procedures
- Attending physician ID
- Bill all outpatient procedures with the appropriate revenue and CPT or HCPCS codes
- Provide specific CPT or HCPCS codes and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic) for outpatient services
- Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449) submitted on a UB-04
- Submit claims according to any special billing instructions that may be indicated in your agreement with us
- On an inpatient hospital bill type of 11x, the admission date and time should always reflect the actual time the Patient was admitted to inpatient status
- If charges are rolled to the first surgery revenue code line on hospital outpatient surgery claims, a nominal monetary amount (\$.01 or \$1.00) must be reported on all other surgical revenue code lines to assure appropriate adjudication

- Include the condition code designated by the National Uniform Billing Committee (NUBC) on claims for outpatient preadmission non-diagnostic services that occur within 3 calendar days of an inpatient admission and are not related to the admission (effective April 1, 2011)

Also need to include anesthesia minutes and EOBs from other payers.

For examples of a complete CMS 1500 claim form, please see appendix.

Mail re-submitted claims to:

UnitedHealthcare Community and State of Louisiana
P.O. Box 31341
Salt Lake City, UT 84131-0341

Claims Pre-processing

As it relates to the CCN Program, is the processing of all claims by a CCN for services provided to CCN members by Medicaid providers to verify service authorizations and ensure only clean claims are submitted to the Fiscal Intermediary for payment. Pre-processing will include, but not be limited to the following steps:

- Receipt of paper and EDI claims from providers
- Receipt of paper attachments necessary to substantiate a claim, if necessary
- Claims imaging, Image indexing, OCR and archiving
- Claims data capture
- Validation of eligibility
- Validation of prior authorization number
- Validation that visits do not exceed the number authorized or allowed by the CCN

Helpful Hints for Submitting Paper Claims

- **Do not use red ink pens, red stamps, highlighters, “post-it notes,” stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink will not be picked up in the scanning process. Highlighters may obscure data depending on the color. Vital data will not be recognized.
- **Use standard typewritten fonts.** Do not mix character fonts on the same claim form. Do not use italics or script.
- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**
- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.
- **Total each claim form separately.** Do not indicate the entire total (for all claims) on the last claim form. Do not indicate “continued” on claim forms.

Claims Submission Rules

The following claims **MUST** be submitted on paper due to required attachments:

- Timely filing reconsideration requests
- Correct Coding Initiative (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.

The following claims may be submitted electronically without specific rules:

- 59 Modifier

Paper claim specific rules include:

- Corrected claims may be submitted electronically; however the words “corrected claim” must be in the notes field. Your software vendor can instruct you on correct placement of all notes.
- Unlisted Procedure Codes may be submitted 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 electronically with notes.
- OT/ST/PT/Dialysis/MHSA claims require the Date of Service by line item.

UnitedHealthcare Community Plan does not accept span dates for these types of claims.

Tax Identification Numbers/ Provider IDs

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

Coordination of Benefits

If the provider is aware that the member has other creditable insurance coverage, the provider should refer the member to DHH to verify eligibility and

coverage and notify UnitedHealthcare Community Plan of the potential coverage. Coordination of benefits does not occur in the CCN-S program.

Electronic Claims Submission and Billing

All documents, frequently asked questions and other information regarding electronic claims submission can be found at uhcommunityplan.com under Physicians, EDI Services.

Please share this information with your software vendor. Your software vendor can help in establishing electronic connectivity. Please note the following:

- Clearinghouse connectivity is ICS Ingenix Connectivity Solutions at ingenix.com/connectivity for our Payer ID of 87726.
- Our Payer ID is 87726.
- Providers should monitor their Clearinghouse Acknowledgement Reports as well as the Payer Specific Acknowledgement Reports. These reports will identify claims that failed and the reason why they failed. Provider should correct and retransmit the claims electronically.
- We follow CMS NUCC Handbook guidelines for placement of data for both HCFA 1500 & UB04

CMS NUCC HCFA 1500 Handbook:
http://www.nucc.org/index.php?option=com_content&task=view&id=72&Itemid=46

CMS NUCC Handbook UB04:
http://www.nucc.org/index.php?option=com_content&task=view&id=72&Itemid=46

Questions can be addressed to Customer Service at 866-675-1607.

Importance & Usage of EDI Acknowledgment/Status Reports

Software vendor reports only show that the claim left the 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 UnitedHealthcare Community Plan. Acknowledgement reports show you the status of your electronic claims after each transmission. Analyzing these reports, you will know if your claims have reached UnitedHealthcare Community Plan for payment or if claim(s) have been rejected for an error or additional information.

Providers **MUST** review their **reports, clearinghouse acknowledgement reports** and UnitedHealthcare Community Plan's status reports to eliminate processing delays and timely filing penalties for claims that have not reached the UnitedHealthcare Community Plan.

How do I get these reports?

Your software vendor is responsible for establishing your connectivity to our clearinghouse ICS Ingenix Connectivity Solutions at ingenix.com/connectivity, and will instruct you in how your office will receive Clearinghouse Acknowledgement Reports.

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 UnitedHealthcare Community Plan within the

time frame required under your provider participation agreement, the CLAIM WILL BE CONSIDERED LATE BILLED and denied as not allowed for timely filing.

EDI Companion Documents

UnitedHealthcare Community Plan's Companion Guides are intended to convey information that is within the framework of the ASC X12N Implementation Guides(IG) adopted by HIPAA. The Companion Guides identify the data content being requested when data is electronically transmitted. The Companion Guides are located on our Website at uhccommunityplan.com.

UnitedHealthcare Community Plan utilizes the Companion Guides to:

- Clarify data content that meets the needs of UnitedHealthcare Community Plan's business purposes when the IG allows multiple choices.
- Outline which situational elements UnitedHealthcare Community Plan requires.
- Provide values that the Health Plan will return in outbound transactions.

Section 1 provides general information.

Section 2 provides specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements.

As UnitedHealthcare Community Plan makes information available on various transactions, we will identify our requirements for those transactions in Section 2 of the Companion Guide. Additional comments may also be added to Section 1 as needed. Changes will be included in Change Summary located in each section of the Companion Document.

e-Business Support

UnitedHealthcare Community Plan offices will be staffed and open during normal business hours 8:00 a.m. to 5:00 p.m., Monday through Friday. Our Member Service Representatives in our call center will be available to answer member calls Monday through Friday from 8:00 a.m. to 6:00 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.

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 UB04, 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 UnitedHealthcare Community Plan, as assigned by the DHH. Coverage will terminate on the date the member's benefit plan terminates with UnitedHealthcare Community 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 that effective dates for Louisiana Medicaid members are frequently revised, as individual members re-verify with DHH. You should verify eligibility at each visit, to assure coverage for services.

Provider/Member Cost Sharing Responsibilities

Members are only responsible for the costs allowed under the State of Louisiana's Children's Health

Insurance Program Rules and Regulations as valid cost sharing responsibilities.

A contracted provider shall collect from the member any allowable co-payments, and payments for non-covered services. Reasonable efforts to collect should include, but are not limited to, referral to a collection agency and, where appropriate, court action. Documentation of the collection efforts must be maintained and made available to the Health Plan upon request.

Cost Sharing

No premiums are charged to members for coverage. 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. All covered expenses are 100% paid by UnitedHealthcare Community Plan.

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

Please refer to your contract for your timely filing and late billing criteria.

Reconsideration Requests

Please refer to the Department of Health and Hospitals Fiscal Intermediary Website at lamedicaid.com

The Correct Coding Initiative

The Health Plan performs 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 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 physician. 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 handbook, 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 @ ntis.gov.

Immunizations Billing

UnitedHealthcare Community Plan must provide for administration of all mandated childhood immunizations according to the recommended

schedule of the Advisory Committee on Immunization Practices (ACIP) standards, a current copy of which is included on uhccommunityplan.com.

All vaccines for members will be provided through the Louisiana State Department of Health, which will distribute vaccines to providers who are willing to participate in the vaccine program.

The cost of the vaccine will not be billed to UnitedHealthcare Community Plan. The only cost associated with immunizations to be reimbursed by UnitedHealthcare Community Plan shall be the cost to administer the vaccine. Vaccines may be administered by network providers, including school-based nurses, by a non-participating provider to whom UnitedHealthcare Community Plan has referred the member, or by the Louisiana State Department of Health. The CCN and its network providers shall utilize the Louisiana Immunization Network for Kids Statewide (LINKS) web-based immunization reporting system for the reporting of all adult and child vaccinations.

Providers administering the vaccine must agree to participate in the State's Immunization Registry. UnitedHealthcare Community Plan must reimburse these providers on a fee-for-service basis for the cost of administering any immunizations they provide to members. Other non-routine immunizations, such as influenza vaccine or tetanus boosters provided pursuant to an injury, shall be covered as any other covered service. UnitedHealthcare Community Plan shall submit a monthly report containing a list of providers, their contact information, claimant information and corresponding vaccine administrations to the Louisiana State Department of Health.

Member identification cards

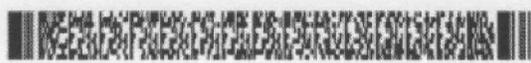
UnitedHealthcare Community Plan members receive an ID card containing information that helps you submit claims accurately and completely.

Be sure to check the member's ID card at each visit and to copy both sides of the card for your files.

Sample Member ID Card


Health Plan (80840) 999-99999-99
Member ID 99999999999 Group: 99999
Member: Subscriber Brown Payer ID: 99999
PCP Name: Provider Brown
PCP Phone: (999) 999-9999
PCP address main st. DOB: 99/99/9999
PCP city, ST zip
Administered by UnitedHealthcare Community Plan

In an emergency go to the nearest emergency room or call 911. Printed 01/01/01



This card does not guarantee coverage. By using this card you agree to the release of medical information as stated in your Member handbook. To find a provider visit the website www.UHCCommunityPlan.com.

For Members:	866-675-1607	TTY: 711
NurseLineSM	800-542-8630	TTY: 711
Report Fraud:	800-488-2917	

For Providers: www.uhccommunityplan.com 999-999-9999
Medical Claims: PO Box 9999, City, ST 99999-9999

Physician Standards & Policies

Primary care physicians (PCPs) are an important partner in the delivery of care. Members have the freedom to seek services from any participating physician and the program does not require members to be assigned to PCPs. While PCPs are not assigned, 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.

Cultural Competency

Providers are required to deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, and to provide for interpreters in accordance with 42 CFR §438.206.

Role of the Primary Care Physician

The PCP plays a vital role as a physician case manager in the UnitedHealthcare 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 and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide 24-hours / 7-days coverage and backup coverage when he or she is not available.

UnitedHealthcare Community Plan expects all physicians 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 providers to ensure that all participants understand, support, and benefit from the primary care case management system.

Responsibilities of the Primary Care Physician

In addition to the requirements applicable to all providers, the responsibilities of the PCP include but not be limited to:

- Managing the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner;
- Monitoring and follow-up of care provided by other medical service providers for diagnosis and treatment;
- Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through fee-for-service Medicaid;
- Maintaining a medical record of all services rendered by the PCP and other referral providers.
- Providing for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions;
- Providing case management services to include, but not be limited to, screening and assessment, development of a treatment plan of care to address risks and medical needs and other responsibilities as defined in the Contract;
- Prohibiting discrimination in enrollment, disenrollment, and re-enrollment, based on the recipient's health status or need for health care services.

- 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 Guide.
- Conduct a baseline examination during the member's first appointment.
- 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 on the uhcommunityplan.com website.
- Take steps to 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, <http://www.ahcpr.gov/clinic/uspstfix.htm>.
- Make use of any member lists supplied by UnitedHealthcare Community Plan indicating which members appear to be due preventive health procedures or testing.
- Be sure to timely submit all accurately coded claims or encounters.
- For questions related to member lists, practice guidelines, medical records, government quality reporting, HEDIS, etc., call Provider Services at 866-675-1607.
- Provide all EPSDT/well child services.
- Screen members for behavioral health problems, using the Behavioral Health Toolkit for the PCP found on our website. uhcommunityplan.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 UnitedHealthcare Community Plan members at each office location at least 16 hours a week.
- 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 Case Management at 866-675-1607 of any member showing signs of End Stage Renal Disease.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary and coordinate the medical care of the member while hospitalized.
- Respect the advance directives of members 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.
- Physician will notify the CNN when they are not accepting new patients
- Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. The CCN is required to provide one (1) free copy of any part of member's record upon member's request.
- Allow timely access for DHH or their designee member medical records as described in your provider participation agreement 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 UnitedHealthcare Community Plan participating hospital.

- Report infectious diseases, lead toxicity, and other conditions as required by state and local laws and regulations.

24-Hours, 7-Days-a-Week Coverage

PCPs and obstetricians must be available to members by telephone 24 hours a day, 7 days a week, or have arrangements for telephone coverage by another UnitedHealthcare participating PCP or obstetrician. A UnitedHealthcare Community Plan Medical Director or Physician Reviewer must approve coverage arrangements that vary from this requirement. PCPs and obstetricians are expected to respond to all after-hour patient calls within 30 minutes. Physician offices must have a phone message or answering service available to members after office hours that instruct the member how to contact the physician for urgent or emergency conditions.

Unacceptable after hours response are as follows:

- You will reach the PCP's answering machine that will direct the member to proceed to the nearest hospital emergency room.
- The PCP's office telephone number will ring continuously without an answer

UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability. The physician hours of operation offered to Medicaid members are no less than those offered to Commercial members.

UnitedHealthcare Community Plan also conducts periodic access surveys to monitor for 24/7 after-hours access. PCPs and obstetricians are required to participate in all activities related to these surveys.

Timeliness Standards for Appointment Scheduling

Providers shall comply with the following appointment availability standards:

Emergency Care: Immediately upon the member's presentation at a service delivery site. Follow-up visits shall be scheduled in accordance with the ER attending provider's discharge instructions.

Urgent Care: within 24 hours

Non-urgent Sick Care: Within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition

Specialty Care Consultation: Within one month of referral or as clinically indicated.

Lab and X-ray Services (usual & customary):

Not to exceed three weeks for regular appointments and 48 hours for urgent care or as clinically indicated.

Maternity Care

Providers of prenatal care should arrange appointments for the newly enrolled member's initial prenatal visit according to the following timetable:

- First trimester – within one to four days
- Second trimester – within seven days
- Third trimester – within three days
- High risk pregnancies - within three days of identification of high risk by UnitedHealthcare Community Plan or the maternity care provider, of immediately if an emergency exists.
- Initial appointments for members who become pregnant must occur within 42 days.

Timeliness Standards for Notifying Members of Test Results

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

Allowable Office Waiting Times

In office waiting time for scheduled appointments should not routinely exceed 45 minutes.

Providers may be delayed when they “work in” urgent cases, when a serious problem is found with a previous patient, or when a previous patient requires more services or education than was described at the time the appointment was scheduled. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment.

Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

Walk-in patients with urgent needs should be seen within twenty-four (24) hours.

Provider Office Standards

UnitedHealthcare 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 may be available to providers that qualify as small businesses under federal law. Certain tax credits may be available for “access expenditures” and certain tax deductions may be available for expenses associated with the removal of barriers. 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 Provider Relations Representative may perform a site visit before care can be rendered at the new location.

Medical Record Charting Standards

All participating primary care UnitedHealthcare Community and State practitioners are required to maintain medical records in a complete and orderly fashion which promotes efficient and quality patient care. Participating practitioners are subject to UnitedHealthcare Community and State’s periodic quality review of medical records to determine compliance to the following medical record keeping requirements.

* An explanation and interpretation of the standards for Louisiana providers follows this table.

<p>Confidentiality of Records</p>	<p>Office policies and procedures exist for the following:</p> <ul style="list-style-type: none"> ▪ Confidentiality of the patient medical record ▪ Initial and periodic training of office staff concerning medical record confidentiality ▪ Release of information ▪ Record retention ▪ Availability of medical record when housed in a different office location (as applicable)
<p>Record Organization</p>	<p>An office policy exists that addresses a process to respond to and provide medical records upon request of patients to include a provision to provide copies within 48 hours in urgent situations Medical records are maintained in a current, detailed, organized and comprehensive manner. Organization should include evidence of:</p> <ul style="list-style-type: none"> ▪ Identifiable order to the chart assembly ▪ Papers are fastened in the chart ▪ Each patient has a separate medical record <p>Medical records are:</p> <ul style="list-style-type: none"> ▪ Filed in a manner for easy retrieval ▪ Readily available to the treating practitioner where the member generally receives care ▪ Promptly sent to specialty providers upon patient request and within 48 hours in urgent situations. <p>Medical records are:</p> <ul style="list-style-type: none"> ▪ Stored in a manner that ensures protection of confidentiality ▪ Released only to entities as designated consistent with federal requirements. ▪ Kept in a secure area accessible only to authorized personnel
<p>Procedural Elements</p>	<p>Medical records are legible*</p> <ul style="list-style-type: none"> • All entries are signed and dated • Patient name/identification number is located on each page of the record. • Linguistic or cultural needs are documented as appropriate • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the patient’s first language is something other than English • Mechanism for monitoring and handling missed appointments is evident • An executed advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information regarding advance directives. • A problem list includes a list of all significant illnesses and active medical conditions • A medication list includes prescribed and over the counter medications and is reviewed annually* • Documentation of the presence or absence of allergies or adverse reactions is clearly documented *
<p>History</p>	<p>An initial history (for patients seen three or more times) and physical is present to include:</p> <ul style="list-style-type: none"> ▪ Medical and surgical history * ▪ A family history that minimally includes pertinent medical history of parents and/or siblings ▪ A social history that minimally includes pertinent information such as occupation, living situations, education, smoking, ETOH, and/or substance abuse use/history beginning at age 11 ▪ Current and history of immunizations of children, adolescents and adults <p>(continued)</p>

History (continued)	<p>Screenings of/for:</p> <ul style="list-style-type: none"> ▪ Recommended preventive health screenings/tests ▪ Depression ▪ High risk behaviors such as drug, alcohol and tobacco use; and if present, advise to quit ▪ Medicare patients for functional status assessment and pain ▪ Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate
Problem Evaluation and Management	<ul style="list-style-type: none"> • Documentation for each visit includes: <ul style="list-style-type: none"> – Appropriate vital signs (Measurement of height, weight, and BMI annually) – Chief complaint* – Physical assessment* – Diagnosis* – Treatment plan* • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines • Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets • Treatment plans are consistent with evidence-based care and with findings/diagnosis <ul style="list-style-type: none"> – Timeframe for follow-up visit as appropriate – Appropriate use of referrals/consults, studies, tests • X-rays, labs consultation reports are included in the medical record with evidence of practitioner review • There is evidence of practitioner follow-up of abnormal results • Unresolved issues from a previous visit are followed up on the subsequent visit • There is evidence of coordination with behavioral health provider • Education, including lifestyle counseling is documented • Patient input and/or understanding of treatment plan and options is documented • Copies of hospital discharge summaries, home health care reports, emergency room care, physical or other therapies, as ordered by the practitioner are documented.

* Denotes a Must Pass Element

Screening and Documentation Tools

Most of these tools were developed by UnitedHealthcare 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, UnitedHealthcare Community Plan will conduct a review of the medical records you maintain for our members. Physicians are expected to achieve a passing score of 85% or better. Auditors will be trained on the State of Louisiana's medical record documentation expectations below as in the narrative. Medical records should include:

- Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable)
- Primary language spoken by the member and any translation needs of the member
- Initial health assessment, including a baseline comprehensive medical history, which should be completed in less than two (2) 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
- Date of service, service site, and name of service provider
- 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 abuse (12 years and older).
- Documentation of advance directives, as appropriate;
- 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 (treatment prescribed, therapy prescribed and drugs administered or dispensed)
- Processes to ensure monitoring and documentation of specialty health care services and follow up are included in the PCP's member medical record. There must be written evidence of the communication of the patient results/information to the referring physician by the specialty health care provider or continued communication of patient information between the specialty health care provider and the primary care provider
- Lab and other studies as appropriate
- Patient 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 initialed by primary physician to indicate review
- Consultation and abnormal studies including follow-up plans
- Documentation of emergency and/or after-hours encounters and follow-up
- Signed and dated consent forms (as applicable)
- Documentation of each visit must include:
 - Date and begin and end times of service
 - Chief complaint or purpose of the visit
 - Diagnoses or medical impression
 - Objective findings
 - Patient assessment findings
 - Studies ordered and results of those studies (e.g., laboratory, x-ray, EKG)
 - Medications prescribed
 - Health education provided
 - Name and credentials of the provider rendering services (e.g., MD, DO, OD) and the signature or initials of the provider
 - Initials of providers must be identified with correlating signatures.
- Documentation of EPSDT requirements including but not limited to:
 - Comprehensive health history
 - Developmental history
 - Unclothed physical exam
 - Vision, hearing and dental screening
 - Appropriate immunizations
 - Appropriate lab testing including mandatory lead screening
 - Health education and anticipatory guidance.

Patient 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 (CAGE, TWEAK)

* These explanations serve as details to the State of Louisiana's medical record documentation expectations.

Medical Record Documentation Standards Audit Tool

* This audit tool will incorporate the details to the State of Louisiana's medical record documentation expectations. Auditors will be trained on the State of Louisiana's medical record documentation expectations in this tool.

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

Confidentiality & Record Organization & Office Procedures	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. The office has a policy regarding medical record confidentiality that addresses office staff training on confidentiality; release of information; record retention; and availability of medical records housed in a different office location (as applicable).									
2. Staff are trained in medical record confidentiality									
3. The office uses a Release of Information form that requires patient signature									
4. There is a policy for timely transfer of medical records to other locations/providers									
5. There is an identified order to the chart assembly									
6. Pages are fastened in the medical record									
7. Each patient has a separate medical record									
8. Medical records are stored in an organized fashion for easy retrieval									
9. Medical records are available to the treating practitioner where the member generally receives care									
10. Medical records are released to entities as designated consistent with federal regulations									
11. Records are stored in a secure location only accessible by authorized personnel									
12. There is a mechanism to monitor and handle missed appointments									
Procedural Elements	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. The medical record is legible.*									
2. All entries are signed and dated									
3. Patient name/identification number is located on each page of the record									
4. Medical records contain patient demographic information									

Procedural Elements (continued)	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
5. Medical record identifies primary language spoken and any cultural or religious preferences if applicable									
6. Adults 18 and older, emancipated minors, and minors with children have an executed advance directive in a prominent part of the medical record.									
6a. OR If the answer to the above # 6 is No, then adults 18 and older, emancipated minors, and minors with children are given information about advance directives which is noted in a prominent part of the medical record?									
7. A problem list includes significant illnesses and active medical conditions									
8. A medication list includes prescribed and over-the-counter medications and is reviewed annually*									
9. The presence or absence of allergies or adverse reactions is clearly displayed*									
History									
1. Medical and surgical history is present*									
2. The family history includes pertinent history of parents and/or siblings									
3. The social history minimally includes pertinent information such as occupation, living situation etc.									
Problem Evaluation and Management Documentation for each visit includes:									
1. Appropriate Vital Signs (i.e., Weight, height, BMI measurement annually)									
2. Chief complaint*									
3. Physical assessment*									
4. Diagnosis*									
5. Treatment plan*									
6. Appropriate use of referrals/consults, studies, tests									
7. X-rays, labs, consultation reports are included in the medical record with evidence of practitioner review									
8. Timeframe for follow-up visit as appropriate									
9. Follow-up of all abnormal diagnostic tests, procedures, x-rays, consultation reports									
10. Unresolved issues from the first visit are followed-up on the subsequent visit									

Problem Evaluation and Management (continued)	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
11. There is evidence of coordination of care with behavioral health									
12. Education, including counseling is documented									
13. Patient input and/or understanding of treatment plan and options is documented									
14. Copies of hospital discharge summaries, home health care reports, emergency room care, physical or other therapies as ordered by the practitioner are documented. Treatment plans are consistent with evidence-based care and with findings/diagnosis PCP, BH & specialty providers?									

$$\begin{array}{ccccccc}
 138 & - & \underline{\hspace{2cm}} & = & \underline{\hspace{2cm}} & \div & \underline{\hspace{2cm}} & = & \underline{\hspace{2cm}} \\
 \text{(Questions)} & & \text{(\# N/A)} & & \text{(Adjusted \# of Questions)} & & \text{(\# Yes)} & & \text{(Adjusted \# of Questions)} & & \text{(Score)}
 \end{array}$$

If a provider scores less than 85%, review an additional 5 charts. Only review those elements that the 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.

* Items are MUST PASS

** These explanations serve as details to the State of Louisiana's medical record documentation expectations and will serve as a basis for the audit

Protect Confidentiality of Member Data

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. Providers must comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of member medical information. Provider agrees 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 applicable state laws and regulations. UnitedHealthcare uses member information for treatment, operations and payment.

Physician Communications & Outreach

The UnitedHealthcare provider education and training program is built on 27 years of experience with providers and multi-state managed care programs and includes the following training components:

- Provider website
- Provider forums/town hall meetings
- Provider office visits
- Provider newsletters and bulletins
- Provider handbook

Provider Website

UnitedHealthcare Community Plan promotes the use of web-based functionality among its provider population. UnitedHealthcare's Community Plan's web-based provider portal facilitates provider communications pertaining to administrative functions. Our interactive website enables providers 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 uhccommunityplan.com, which allows providers who have internet access the ability to request their medical prior authorizations online rather than telephonically. In the event a referral is made via the telephone, the CCN shall ensure that referral data, including the final decision, is maintained in a data file that can be accessed electronically by the CCN, the provider and DHH. The UnitedHealthcare website also contains an online version of this Guide, the Provider Directory, the Preferred Drug List (both searchable and comprehensive listing), clinical practice guidelines, quality and utilization requirements and educational materials such as newsletters, recent fax service bulletins and other provider information. UnitedHealthcare Community Plan also 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.

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 providers across the state. The prioritization and quantity of provider office visits by these staff is determined based on a variety of demographic 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.

Provider Newsletters and Bulletins

UnitedHealthcare Community Plan produces and distributes a Provider Newsletter to the entire Louisiana network at least three times a year. The newsletters contain program updates, claims guidelines, information regarding policies and procedures, cultural competency and linguistics information, clinical practice guidelines, information on special initiatives, and other articles regarding health topics of importance. The newsletters also include notifications regarding changes in laws, regulations and subcontract requirements. UnitedHealthcare Community Plan uses electronic bulletins, posted on the uhccommunityplan.com website, to rapidly disseminate urgent information that impacts the entire network.

Provider Administrative Guide

UnitedHealthcare publishes this Guide online, which includes an overview of the program, toll free number to our provider services hotline, a removable quick reference guide, and a list of additional provider resources and incentives. Providers without internet access may request a hard copy of this Guide by contacting Provider Services.

Appendix

Physician/provider demographic update fax form

Please use this form for demographic changes or to update your NPI information.

Please ensure that ALL pertinent information is completed as we will be unable to process incomplete forms. Complete all information pertaining to your practice.

Please reference the Table on page 3. UnitedHealthcare and its affiliates/alliances are listed by Fax Number/State. Please fax your completed form to the appropriate fax number.

Section I Group demographics

Practice/Organization Name _____ Current Tax ID (TIN) _____

National Provider Identifier _____ Date issued ____/____/____

Please refer to Section III (page 2) of this fax form for taxonomy code definitions

*Please list your NUCC Taxonomy Code(s) 1) _____ 2) _____ 3) _____ 4) _____ 5) _____

Basis for NPI (applies to organizations only, select only 1 per NPI):

Provider Name Tax ID only (entity whose name is in the W-9 form) License Number NUCC Taxonomy Code
 Place of Service Address Department Other (please explain)

Please check here if you have **multiple NPIs** representing your Practice or Organization.
Refer to **Section III** (page 2) of this fax form.

Name of individual completing this form _____

Telephone () _____ E-mail _____

Section II Practice/Organization information changes

The new tax ID number is: _____ Effective _____ (please attach a copy of the W-9)

We have moved. Our new address is effective _____

This new address is a: Practice Address Billing Address Both Practice & Billing Address Correspondence Address

Should this new address print in the directory? Yes No

New _____ **Old** _____

Telephone _____ Telephone _____

Fax _____ Fax _____

Email _____ Email _____

We have changed our practice name to: _____ Effective _____

These physicians/health care providers have left our practice (please provide the effective date and reason for leaving):

These physicians/health care providers have joined our practice effective _____ (please attach a copy of the W-9)



Section II continued

Change pertains to all physicians/health care providers under the Tax ID (TIN):

Specify physicians/health care providers affected by the change:

We are closing our practice to new patients effective

We are reopening our practice to new patients effective

Check this box if you do not have a private office and only see patients at the hospital

**Signature of Participating
Physician/Health Care Provider:**

Date

Section III National Provider Identification - Requested information

We would like to capture the "basis" or reason for each NPI, if the organization has more than one NPI or has sub-parts who have NPIs. Please use the grid below as a reference when filling in the "Basis for NPI" and Level Information columns in the NPI Collection Grid below (page 3).

If the Basis for your NPI is:	Then supply this information in the Level Information column	Instructional information
C = Entity whose name is on the W-9	Tax ID and Name Filed on W-9	If the organization or sub-part was enumerated strictly on the basis of the name associated with the Tax ID on the W-9 form, then use a "C" in the "Basis for NPI" column. (You will need to indicate whether the Tax ID is a Social Security number or if it is an employer identification number.) Place the Tax ID in the "Level Information" column.
D = Department	Department Name	If the organization or sub-part was enumerated on the basis of a particular department, provide the Department Name that the NPI was based on, and designate this with a "D" in the "Basis for NPI" column. Insert the Department Name in the "Level Information" column.
L = License	License Number and State or (state code)	If the organization or sub-part was enumerated by License, provide the state or (state code) and License Number that the NPI was based on, and designate this with an "L" in the "Basis for NPI" column. Insert the License Number and state or state code) in the "Level Information" column.
P = Place of Service Address	Place of Service Address (Street, City, State, ZIP + 4)	If the organization was enumerated by place of service address, provide the street address that the NPI was based on and designate this with a "P" in the "Basis for NPI" column. Insert the Place of Service address in the "Level Information" column.
T = Tax ID Number and Provider Name	Tax ID and Provider Name, where provider is not the name on the W-9, but bills using this TIN	If the organization or sub-part was enumerated by Tax ID <u>and</u> Provider Name, where the provider is not the name listed on the W-9, but uses this TIN, then designate this with a "T" in the "Basis for NPI" column. Place the Tax ID in the "Level Information" column and indicate whether the Tax ID is a Social Security number or if it is an employer identification number.
X = Taxonomy	NUCC Taxonomy Code	If the organization or sub-part was enumerated by a NUCC Taxonomy code, please provide the Taxonomy Code that the NPI was based on and designate this with an "X" in the "Basis for NPI" column. Place the NUCC Taxonomy Code in the "Level Information" column.
O = Other	Specify details for selecting 'Other'	Provide any other basis for NPI in the "Basis for NPI" column and designate as "O", with a description of the basis for that NPI in the "Level Information" column.
M = Name	Provider Name	This is intended for use by physicians and allied health professionals (people providers). Insert the name in the "Level Information" column.

This is an example of our requirements for a clean claim.

1500 HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 PICA		Payer Name Payer Address Payer Address 2 City ST Zip		CARRIER
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 99999999		PATIENT AND INSURED INFORMATION
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John T.		3. PATIENT'S BIRTH DATE MM DD YY 02 21 1967 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, John T.		5. PATIENT'S ADDRESS (No., Street) 123 Main Street		
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 123 Main Street		
8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		8. PATIENT STATUS Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY M F c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10d. RESERVED FOR LOCAL USE		
11. INSURED'S POLICY GROUP OR FECA NUMBER 123456		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY 02 21 1967 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 01/01/2011		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED Signature on File		
14. DATE OF CURRENT: MM DD YY 06 29 2011 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI		
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. RESERVED FOR LOCAL USE		
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 12345 3. 4.		
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPICOT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #		
1 06 22 11 11 12345 1 99.99 01 NPI		25. FEDERAL TAX I.D. NUMBER SSN EIN 123456789 <input checked="" type="checkbox"/>		PHYSICIAN OR SUPPLIER INFORMATION
26. PATIENT'S ACCOUNT NO. 12345		27. ACCEPT ASSIGNMENT? (For gmt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		
28. TOTAL CHARGE \$ 99.99		29. AMOUNT PAID \$		
30. BALANCE DUE \$		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		
32. SERVICE FACILITY LOCATION INFORMATION Sample Doctor 333 Main Street City ST 99999		33. BILLING PROVIDER INFO & PH # (555) 555 5555		
SIGNED DATE a. b.		SIGNED DATE a. 1234567890 b.		
NUCC Instruction Manual available at: www.nucc.org				APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

