MississippiCAN 2016

Physician, Health Care Professional, Facility and Ancillary Care Provider Manual
Welcome to the Community and State (C&S) plan manual. This comprehensive and up-to-date reference PDF (manual/guide) allows you and your staff to find important information such as processing a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Care provider tools are available online through Link at UnitedHealthcareOnline.com. Link allows you to access information you need without jumping between websites or picking up the phone. Get member eligibility, benefits and claims information quickly and easily from a single, secure online location.

- Click here to access the UnitedHealthcare Administrative Guide for Medicare Advantage member information. Some states may also have Medicare Advantage information in their C&S manual.
- Click here for West capitated provider information, or go to uhcwest.com > Provider, then click Library at the top of the screen. The Provider Administrative Guides link is on the left.
- Click here to select a different C&S manual, or go to uhccommunityplan.com, then click For Health Care Professionals at the top of the screen. You can then select the desired state.

You may easily find information in the manual using the following steps:

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

Depending on your version of Adobe Reader, you may have a binocular icon on your screen which you can use to search as well.

We greatly appreciate your participation in our program and the care you provide to our members.
This manual 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. Much of this material, as well as operational policy changes and additional electronic tools, are available on our website at UHCCommunityPlan.com.

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

If you have any questions about the information or material in this manual or about any of our policies or procedures, please do not hesitate to contact Provider Services at 877-743-8734.

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

**Important information regarding the use of this manual**

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

In addition to this reference document, information is provided to members outlining their benefits, rights, and responsibilities at: uhccommunityplan.com/content/dam/communityplan/plandocuments/handbook/en/MS-CAN-Member-Handbook.pdf

This manual will be amended as operational policies change.
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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.

UnitedHealthcare does not require or request any care provider to enter into an exclusive relationship with UnitedHealthcare or any of its business affiliates.

**UnitedHealthcare Dual Complete (HMO SNP)**

# How to Contact Us

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>877-743-8734</td>
<td>To review a patient’s eligibility or benefits, check claims status, submit claims or review Directory of Physicians, Hospitals and other Health Care Professionals.</td>
</tr>
</tbody>
</table>
|                              |                 | 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 for care providers to: • 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           | 866-604-3267    | To request prior authorization or to notify us in accordance with the prior authorization/notification requirements section of this Guide. |
| Notification                  | Fax 888-310-6858|                                                                    |
| Pharmacy Services             | 877-305-8952    | OptumRx Pharmacy Help Desk  
|                              |                 | Available 24 hours a day, 7 days a week                           |
| Pharmacy Services             | 877-743-8731    |                                                                    |
| Behavioral Health Services    | UBH Customer Service:  
|                              | 866-673-6315 UBH  
|                              | Prior Authorization:  
|                              | 877-743-8731      |                                                                    |
| Dental                        | 800-508-4862    |                                                                    |
| Vision                        | 800-877-7195    |                                                                    |
| Hospital Inpatient Services   | 866-604-3267    |                                                                    |
| and Concurrent Reviews        | Fax 888-310-6858|                                                                    |
| Transportation                | 866-331-6004    |                                                                    |
Our Claims Process

To help ensure prompt payment:

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

2. Notify UnitedHealthcare’s Health Services of planned procedures and services on the Prior Authorization list.

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

4. Submit claims electronically to reduce costs, ensure faster processing and reduce claim entry errors. 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
   PO Box 5032
   Kingston, NY 12402-5032

Complete Claims

A complete claim includes the following:

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

Injectable drugs provided in an office/clinic setting:

The Health Plan shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to care providers providing both home infusion services and the drugs and biologics. The Health Plan 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 LIN segment of the HIPAA 837 electronic form. Services reimbursed by the Health Plan shall not be included in any pharmacy benefit limits established for pharmacy services.

How to Contact Us

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

Provider Services: 877-743-8734
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 for care providers to:

- Ask questions about benefits.
- Verify member eligibility.
- Check claim status.
- Ask questions about your participation or notify us of demographic and practice changes.
- Request information regarding credentialing.

Prior Authorization: 866-604-3267
Available Monday-Friday 8 a.m. – 5 p.m. (CT), 24 hours for emergency. For a complete and current list of prior authorizations, go to UnitedHealthcareOnline.com.
Fax prior authorizations to 888-310-6858

Utilization Management: 877-743-8731
Staff is available Monday through Friday, 8 a.m. to 5 p.m. (ET), to assist with routine prior authorizations, admissions, discharges and coordination of members’ care. On-call staff is available 24/7 for emergency prior authorization purposes.

Case Management: 877-743-8731
Disease Management: 877-743-8731

Pharmacy Prior Authorization:
Go to UnitedHealthcareOnline.com for a copy of the pharmacy provider authorization form. Call 800-310-6826 or fax pharmacy prior authorization to 866-940-7328

Vision: 800-877-7195
Transportation: 866-331-6004

Behavioral Health
BH Claims: 866-673-6315
BH Prior Authorization: 877-743-8731

Member Services Helpline: 877-743-8731
Available to answer member calls Monday through Friday, 8 a.m. to 6 p.m. (CT). In addition, our interactive voice response (IVR) system is available 24 hours a day, 7 days a week, and our nurse triage hotline is available through our IVR for health-related issues.
MississippiCAN Care Provider Quick Reference Guide

Other Important Information

Claim Reconsideration Request
UnitedHealthcareOnline.com > Claims and Payments > Claims Reconsiderations

Claim mailing address
P.O. Box 5032
Kingston, NY 12402-5032

Fraud and Abuse Division: 877-743-8734

UnitedHealthcare Online Support Services:
UnitedHealthcareOnline.com
HelpDesk: 866-842-3278

Pharmacy
- Preferred Drug List (PDL)
  877-743-8734
  UHCCommunityPlan.com
- Pharmacy Prior Authorization
  800-310-6826
  UHCCommunityPlan.com
- Pharmacy (OptumRx) Technical Help Desk
  877-305-8952
- Network Pharmacy Locator
  UHCCommunityPlan.com

Notify UnitedHealthcare's Health Services Within the Following Time Frames:

Non-Emergency Care (except maternity)
At least five business days prior to non-emergent, non-urgent hospital admissions and/or outpatient services.

Emergency Care:
Urgent or emergent admissions do not require a prior authorization. HOWEVER, Urgent/Emergent inpatient admissions do require notification within 24 hours of admission.

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

NPI Compliance

National Provider Identification (NPI)
Federal Regulations and many state Medicaid 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 nppes.cms.hhs.gov. If you have not yet provided your NPI to us, please do so immediately by going to UnitedHealthcareOnline.com and choose 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 866-455-4068 or 414-721-9006.

Please note that all care providers must provide to UnitedHealthcare the NPI that aligns with their MS Medicaid ID. Failure to do so may impact claims payment.

Medicaid ID Requirement

Please note that all care providers must be enrolled in Mississippi Medicaid, and have a state provider Medicaid ID in order to be reimbursed for services provided to a MississippiCAN member.

An enhanced claim denial edit ensures that no payments are made to providers without a Mississippi Medicaid ID on file. If your claims have denied due to missing Medicaid ID and you have a current Mississippi Medicaid ID, please contact Provider Services hotline at 877-743-8734 so that we can facilitate updating your records and adjusting applicable claims.

If you do not have a current Mississippi Medicaid ID, a provider Enrollment application can be found at: msmedicaid.acs-inc.com/msenvision/index.do
The Services Listed Below are Covered by Mississippi Medicaid

Federally Mandated Covered Services:
EPSDT and Expanded EPSDT Services.
Family Planning Services.
Federally Qualified Health Centers Services.
Home Health Services.
Inpatient Hospital Services.
Laboratory and X-Ray Services.
Nurse Midwife Services.
Nurse Practitioner Services (Pediatric and Family).
*Nursing Facility Services.
Outpatient Hospital Services.
Physicians Services.
Rural Health Clinic Services.
Transportation Services.

State-Covered Optional Services:
Ambulatory Surgical Center Services.
Behavioral Health Services.
Chiropractic Services.
Christian Science Sanatoria Services.
Dental Services.
Disease Management Services.
Durable Medical Equipment.
Eyeglasses.
Freestanding Dialysis Center Services.
Hospice Services.
Inpatient Psychiatric Services.
Physical Therapy.
Occupational Therapy.
Pediatric Skilled Nursing Services.
Podiatrist Services.
Prescription Drugs.
*Psychiatric Residential Treatment Facilities Services.
Speech Therapy.
State Department of Health Clinic Services.
Targeted Case Management Services for Children With Special Needs.

* These services are provided through the Mississippi Division of Medicaid Fee-For-Service program.

All benefits are subject to change at the discretion of Mississippi Medicaid.

For more comprehensive information on benefits, please visit the website at medicaid.ms.gov
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Limitation</th>
<th>Prior Authorization*</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Ambulatory Surgical Center Services</td>
<td>Not required</td>
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<tr>
<td>Ambulance Services</td>
<td>Emergency: not required</td>
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<tr>
<td>Non-emergency &amp; fixed-wing requires prior auth:</td>
<td>ph: 866-604-3267</td>
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<tr>
<td>Non-Emergency Transportation Services</td>
<td>Limited to Medicaid-covered services only. Excluded if service limits have been met. Excluded if beneficiary has transportation resources</td>
<td>Three days notice required by calling MTM at: 866-331-6004</td>
<td>Requests must be made at least three business days in advance. Services currently Provided by MTM at: 866-331-6004</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$700 maximum per calendar year</td>
<td>Not required</td>
<td></td>
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<tr>
<td>Christian Science Sanitoria Services</td>
<td>Not required</td>
<td></td>
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<tr>
<td>Cosmetic and Reconstructive Surgery- Outpatient</td>
<td>Yes ph: 866-604-3267 fax: 888-310-6858</td>
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<tr>
<td>Dialysis Outpatient Center Services</td>
<td>Not required</td>
<td></td>
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<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Medicaid policy restrictions apply ph: 866-604-3267 fax: 888-310-6858</td>
<td></td>
<td>Additional DME information can be found at: <a href="https://www.medicaid.ms.gov">medicaid.ms.gov</a> <a href="https://www.medicaid.ms.gov/priorauth/MS_CAID_CAN_PA_PCA16844_120115.pdf">PriorAuth/MS_CAID_CAN_PA_PCA16844_120115.pdf</a></td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Maximum of six diapers/underpads per day for ages three and up with medical condition causing incontinence of bowel and/or bladder</td>
<td>Yes for more than six diapers/underpads per day for ages three and up ph: 866-604-3267 fax: 888-310-6858</td>
<td>Medicaid provides one month supply at a time</td>
</tr>
<tr>
<td>EPSDT†</td>
<td>Limited to beneficiaries under 21 years of age</td>
<td>Not required</td>
<td></td>
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<tr>
<td>Expanded EPSDT Services†</td>
<td>Limited to beneficiaries under 21 years of age</td>
<td>Not required</td>
<td></td>
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<tr>
<td>Family Planning Services</td>
<td>Not required</td>
<td></td>
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<tr>
<td>Federally Qualified Health Center Services</td>
<td>Not required</td>
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<tr>
<td>Benefit</td>
<td>Limitation</td>
<td>Prior Authorization*</td>
<td>Notes</td>
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<tr>
<td>Genetic Testing</td>
<td></td>
<td>Yes</td>
<td>ph: 866-604-3267 fax: 888-310-6858</td>
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<tr>
<td>Health Department Services</td>
<td></td>
<td>Not required</td>
<td>Includes certain pharmacy services through MS State Dept. of Health (MSDH), Early Intervention Program (EIP), Perinatal High Risk Management/Infant Services (PHRM/ISS)</td>
</tr>
<tr>
<td>Hearing Services</td>
<td>Limited to beneficiaries under 21 years of age through EPSDT services</td>
<td>Required for services outside of EPSDT and hearing aids ph: 866-604-3267 fax: 888-310-6858</td>
<td>This does not apply to physical, occupational, speech therapies, DME, orthotics, or prosthetics. See those sections for additional information</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Children - unlimited Adults - 25 visits per calendar year</td>
<td>Children visits over 25 per calendar year require prior auth; Adults no prior auth required ph: 866-604-3267 fax: 888-310-6858</td>
<td>Medicaid preferred drug list can be accessed: medicaid.ms.gov/providers/pharmacy/preferreddrug-list/preferred-drug-list-archive/</td>
</tr>
<tr>
<td>Home Infusion</td>
<td></td>
<td>Certain medications may require prior auth, depending on Medicaid preferred drug list</td>
<td>Medicaid preferred drug list can be accessed: medicaid.ms.gov/providers/pharmacy/preferreddrug-list/preferred-drug-list-archive/</td>
</tr>
<tr>
<td>Hospice -Inpatient -Outpatient</td>
<td>Limited to diagnoses that include six months or less life expectancy as certified by physician</td>
<td>Not required</td>
<td>UnitedHealthcare will provide benefits for Hospice Services unless concurrent of an inpatient stay</td>
</tr>
<tr>
<td>Hospital Services -Inpatient Days -Swing Bed Services -Emergency Dept</td>
<td></td>
<td>Required for admissions ph: 866-604-3267 fax: 888-310-6858</td>
<td>To request authorization online: unitedhealthcareonline.com/b2c/Login.do?page=signin</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>For age 21 years and older</td>
<td>Yes</td>
<td>ph: 866-604-3267 fax: 888-310-6858</td>
</tr>
<tr>
<td>Laboratory</td>
<td></td>
<td>Not required</td>
<td></td>
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<tr>
<td>Benefit</td>
<td>Limitation</td>
<td>Prior Authorization*</td>
<td>Notes</td>
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<tr>
<td>Non-Contracted Provider Services (Outpatient Facility &amp; Professional)</td>
<td>Yes ph: 866-604-3267 fax: 888-310-t6858</td>
<td>Care provider and/or outpatient facility services are payable only with prior authorization</td>
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<tr>
<td>Nurse Practitioner Services</td>
<td>Not required</td>
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<tr>
<td>Nursing Facility Services</td>
<td>Yes Benefits provided through Division of Medicaid. eQHealth Solutions: ph: 866-740-2221 ms.eqhs.org/Home.aspx</td>
<td>Services are not administered by UnitedHealthcare although member is entitled to all Medicaid benefits</td>
<td></td>
</tr>
<tr>
<td>Othotics and Prosthetics</td>
<td>Limited to beneficiaries under 21 years of age. Coverage does not include arch supports</td>
<td>Yes ph: 866-604-3267 fax: 888-310-t6858</td>
<td>Medicaid does not cover treatment for flat feet (including arch supports) for adults 21 years of age and older so it is not a covered service by UnitedHealthcare</td>
</tr>
<tr>
<td>Outpatient Physical, Occupational, and Speech Therapies (PT, OT, SLP)</td>
<td>Not required except for services provided by home health agencies (see Home Health Services) ph: 866-604-3267 fax: 888-310-t6858</td>
<td>These benefits are not covered through the home health program for beneficiaries 21 years of age and older</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing and Private Duty Nursing Services</td>
<td>Limited to beneficiaries under the age of 21 years</td>
<td>Yes ph: 866-604-3267 fax: 888-310-t6858</td>
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<tr>
<td>Perinatal High Risk Management Services</td>
<td>Not required</td>
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<tr>
<td>Physician Assistant Services</td>
<td>Not required</td>
<td></td>
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<tr>
<td>Physician Services for Long-Term Care Visits</td>
<td>36 visits per year</td>
<td>Yes Benefits provided through Division of Medicaid. eQHealth Solutions: ph: 866-740-2221 <a href="http://ms.eqhs.org/Home.aspx">http://ms.eqhs.org/Home.aspx</a></td>
<td>Services are not administered by UnitedHealthcare although member is entitled to all Medicaid benefits</td>
</tr>
<tr>
<td>Physician Services in Medical Offices (Primary and Specialty Care)</td>
<td>Not required</td>
<td></td>
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<tr>
<td>Podiatrist Services</td>
<td>Not required</td>
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<tr>
<td>Prescribed Pediatric Extended Care (PPEC)</td>
<td>Limited to beneficiaries under the age of 21 years</td>
<td>Yes ph: 866-604-3267 fax: 888-310-t6858</td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>Limitation</td>
<td>Prior Authorization*</td>
<td>Notes</td>
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<tr>
<td>Prescription Drugs</td>
<td>Five per month with no more than two of them being brand name drugs. &lt;br&gt;Beneficiaries under age 21 can receive more than the monthly limit with a medical necessity prior authorization</td>
<td>Yes for beneficiaries under age 21 if therapy exceeds limitations. &lt;br&gt;ph: 800-310-6826 &lt;br&gt;fax: 866-940-7328 &lt;br&gt;Note that some drugs on the preferred drug list (PDL) may still require prior authorization</td>
<td>Medications can be dispensed as an emergency 72-hour supply when drug therapy must not be delayed and prior-authorization is not available. This applies to non-preferred drugs and any drug affected by a need for prior authorization. &lt;br&gt;See: <a href="http://www.uhccommunityplan.com/health-professionals/ms/pharmacy-program.html">http://www.uhccommunityplan.com/health-professionals/ms/pharmacy-program.html</a></td>
</tr>
<tr>
<td>Rural Health Clinic Services</td>
<td>Not required</td>
<td></td>
<td></td>
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<tr>
<td>Sleep Studies</td>
<td>Yes &lt;br&gt;ph: 866-604-3267 &lt;br&gt;fax: 888-310-6858</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterilization</td>
<td>For age 21 years and older</td>
<td>Yes &lt;br&gt;ph: 866-604-3267 &lt;br&gt;fax: 888-310-6858</td>
<td>Medicaid consent required and can be accessed: <a href="http://www.medicaid.ms.gov/resources/forms/">http://www.medicaid.ms.gov/resources/forms/</a></td>
</tr>
<tr>
<td>Surgery (Inpatient)</td>
<td>Yes &lt;br&gt;ph: 866-604-3267 &lt;br&gt;fax: 888-310-6858</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transplant Services</td>
<td>Yes &lt;br&gt;ph: 866-604-3267 &lt;br&gt;fax: 888-310-6858</td>
<td></td>
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</tr>
<tr>
<td>Eye Care Benefit</td>
<td>Two exams per year &lt;br&gt;Two pairs of glasses per year &lt;br&gt;Required only for 2nd pair of glasses within the year &lt;br&gt;ph: 800-877-7195</td>
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<tr>
<td>Children -Examination -Glasses</td>
<td>One exam per year &lt;br&gt;One pair of glasses every three years</td>
<td>Not required</td>
<td></td>
</tr>
<tr>
<td>Dental Benefit</td>
<td>$2500 maximum per calendar year for dental unless prior authorization is obtained &lt;br&gt;$4200 maximum per lifetime per child</td>
<td>Required for procedures such as crowns, root canals, dentures, orthodontics &lt;br&gt;ph: 800-508-4862</td>
<td>Included: Preventive &lt;br&gt;Diagnostic &lt;br&gt;Restorative &lt;br&gt;Orthodontia &lt;br&gt;Emergency pain relief</td>
</tr>
<tr>
<td>Adults</td>
<td>$2500 maximum per calendar year for dental unless prior authorization is secured</td>
<td>Required for procedures such as crowns, root canals, dentures, orthodontics &lt;br&gt;ph: 800-508-4862</td>
<td>Included: Preventive &lt;br&gt;Diagnostic &lt;br&gt;Restorative &lt;br&gt;Orthodontia &lt;br&gt;Emergency pain relief</td>
</tr>
<tr>
<td>Mental Health Benefit</td>
<td>Limitation</td>
<td>Prior Authorization*</td>
<td>Notes</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Community Mental Health Center (CMHC) Services</td>
<td>Yes for some services. Refer to Provider Administrative Guide beginning on page 29 ph: 877-743-8731</td>
<td></td>
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</tr>
<tr>
<td>Intermediate Care Facility for the Developmentally Delayed (ICF/DD) Inpatient Services</td>
<td>Therapeutic leave days limited to 90 days per year</td>
<td>No ph: 877-743-8731</td>
<td>Beneficiaries must be deemed eligible by MS Division of Medicaid to receive these services</td>
</tr>
<tr>
<td>Inpatient Psychiatric Services</td>
<td>Limited to beneficiaries under the age of 21 years</td>
<td>Yes ph: 877-743-8731</td>
<td></td>
</tr>
<tr>
<td>Physician Psychiatry Services</td>
<td>Yes for some services. Refer to Provider Administrative Guide beginning on page 29 ph: 877-743-8731</td>
<td></td>
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</tr>
<tr>
<td>Psychiatric Residential Treatment Facilities (PRTF)</td>
<td>Yes Benefits provided through Division of Medicaid eQHealth Solutions: ph: 866-740-2221 ms.eqhs.org/Home.aspx</td>
<td>Services are not administered by UnitedHealthcare although member is entitled to all Medicaid benefits Case management resources are provided through UnitedHealthcare ph: 877-743-8731</td>
<td></td>
</tr>
<tr>
<td>Psychological Evaluation and Testing by Licensed Psychologist</td>
<td>Yes for some services. Refer to Provider Administrative Guide beginning on page 29 ph: 877-743-8731</td>
<td></td>
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</tr>
<tr>
<td>Therapeutic and Evaluative Mental Health Services for Children</td>
<td>Yes for some services. Refer to Provider Administrative Guide beginning on page 29 ph: 877-743-8731</td>
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</tbody>
</table>

*Prior Authorization is initiated by the care provider who is performing the requested services
† EPSDT Services can only be performed by a care provider certified by the MS Division of Medicaid.
Services include:
- a comprehensive unclothed physical exam
- comprehensive family/medical/developmental history
- immunization status, any shots that are needed
- lead assessment and testing
- necessary blood and urine screening
- TB skin test
- developmental assessment
- nutritional assessment/counseling
- adolescent counseling
- vision testing/screening
- hearing testing/screening
- dental referral services
### Benefit Exclusions

- Items or services which are furnished gratuitously without regard to the individual’s ability to pay and without expectation of payment from any source, such as free X-rays provided by a health department.

- Any operative procedure, or any portion of a procedure, performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

- Routine physical examinations, such as school, sports, or employment physicals that are not part of the well child screening program for beneficiaries under 21 years of age or are not covered.

- Services of a physical therapist or speech therapist are not covered for Medicaid beneficiaries 21 years of age or older, except when provided as an outpatient hospital service, or as a nursing facility service. Therapy services are not covered in a nursing facility when performed by a home health agency.

- Prosthetic and orthotic devices, and orthopedic shoes for beneficiaries 21 years of age or older, except for crossover claims allowed by Medicare.

- Vitamin injections, except for B-12 as specific therapy for certain anemias such as fish tapeworm anemia, other B-12 complex deficiencies, pernicious anemia, vitamin B-12 deficiency anemia, atrophic gastritis, idiopathic steatorrhea, sprue, blind loop syndrome, partial or total gastrectomy, pancreatic steatorrhea, and other specified intestinal malabsorption.

- Prescription vitamins and mineral products are excluded except for prenatal vitamins for obstetrical patients.

- Services denied by eQHealth Solutions.

- Routine circumcisions for newborn infants.

- Interest on late pay claims.

- Physician assistants prior to July 1, 2001.

- Freestanding substance abuse rehabilitation centers and psychiatric facilities for beneficiaries 21 years of age or older.

- Reimbursement for services provided to only Qualified Medicare Beneficiaries (QMB) except for Medicare/Medicaid crossover payments of Medicare deductibles and coinsurance.

- Medicare deductibles and co-insurance will not be paid for QMBs in non-Medicaid eligible facilities.

- Reimbursement for any Medicaid service for Specified Low-income Medicare Beneficiaries (SLMB) and Qualified Individuals (QI). These individuals are entitled only to payment or partial payment of their Medicare Part B premium.

- Ambulance transport to and from dialysis treatment.

- Reversal of sterilization, artificial or intrauterine insemination and in vitro fertilization.
### Benefit Exclusions

- Services, procedures, supplies or drugs which are still in clinical trials and/or investigative or experimental in nature.
- Routine foot care in the absence of systemic conditions.
- Gastric surgery (any technique or procedure) for the treatment of obesity or weight control, regardless of medical necessity.
- Telephone contacts/consultations and missed or cancelled appointments.
- Wigs.
- Services ordered, prescribed, administered, supplied or provided by an individual or entity that has been excluded by DHHS.
- Services ordered, prescribed, administered, supplied or provided by an individual or entity that is no longer licensed by their governing board.
- Services outside the scope and/or authority of a practitioner’s specialty and/or area of practice.
- Services not specifically listed or defined by Medicaid are not covered.
- Any exclusion listed elsewhere in the Mississippi Medicaid Provider Policy Manual, bulletins, or other Mississippi Medicaid publications.

### Acronyms

- MH - Mental Health
- MS - Medical Services
- NET - Non-Emergency Transportation
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 at 877-370-4009 Health Information Library Pin Number: 466;
● Access to caring registered nurses who have an average of 15 years’ clinical experience; and
● Trusted, physician-approved information to guide health care decisions.

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

Choose appropriate medical care.

● Understand a wide range of symptoms;
● Determine if the emergency room, a doctor visit or self-care is right for his/her needs;

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.

Understand treatment options.

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

Achieve a healthful lifestyle.

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

Ask medication questions.

● Learn how to take medication safely and avoid interactions.

Members can call a NurseLine nurse any time for health information and support — all at no cost — at 877-370-4009. Health Information Library Pin Number: 466

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.

Pharmacy Services

(1) The following drugs and medical supplies are covered:

(a) Legend drugs (federal law requires these drugs be dispensed by prescription only);
(b) Compounded medication of which at least one ingredient is a legend drug;
(c) Disposable blood glucose testing agents;
(d) Disposable insulin needles/syringes;
(e) Growth hormones;
(f) Insulin;
(g) Lancets;
(h) Legend contraceptives;
(i) Retin-A (tretinoin topical);
(j) Smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms (e.g., Nicorette, NicoDerm, etc.).
The following are excluded:

(a) Anabolic steroids (e.g., Winstrol, Durabolin);
(b) Anorectics (any drug used for the purpose of weight loss) with the exception of Dexadrine and Adderall for Attention Deficit Disorder;
(c) Anti-wrinkle agents (e.g., Renova);
(d) Charges for the administration or injection of any drug;
(e) Dietary supplements;
(f) Infertility medications (e.g., Clomid, Metrodin, Pergonal, Profasi);
(g) Minerals (e.g., Potaba);
(h) Medications for the treatment of alopecia, e.g. (Rogaine);
(i) Non-legend drugs other than those listed as covered;
(j) Pigmenting/de-pigmenting agents;
(k) Drugs used for cosmetic purposes;
(l) Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed as covered, such as insulin needles and syringes;
(m) Any medication not proven effective in general medical practice;
(n) Investigative drugs and drugs used other than for the FDA-approved diagnosis;
(o) Drugs that do not require a written prescription;
(p) Prescription drugs if an equivalent product is available over the counter; and
(q) Refills in excess of the number specified by the practitioner or any refills dispensed more than one year after the date of practitioner's original prescription.

Pharmacy Prior Authorization

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

To request pharmacy prior authorization, please call the Optum Rx Pharmacy HelpDesk at 800-310-6826 or fax your authorization request to 866-940-7328.

Prior authorization requests are reviewed and notification is sent back within 24 hours.

Prescription Limitations

All Medicaid beneficiaries are limited to five prescriptions per month with no more than two being brand-name drugs, including refills.

Children under the age of 21 can receive more than the monthly prescription limits with a medical necessity prior authorization. Requests for these exceptions should be made either in writing by the prescriber and faxed to 866-940-7328, or called into UnitedHealthcare’s Pharmacy Prior Authorization Services at 800-310-6826. A prior authorization request form is available at UHCCommunityPlan.com and should be used for all prior authorization requests if possible.

Pharmacy - Preferred Drug List (PDL)

MississippiCAN PDL is determined and maintained by the Division of Medicaid (DOM).
The PDL is organized by therapeutic class. Care providers are required to prescribe and encourage the substitution of generic drugs included in the PDL whenever appropriate. If a non-preferred medication is required for a member's treatment, the care provider must call the Pharmacy Prior Authorization Service at 800-310-6826, or fax a Pharmacy Prior Notification Request form to 866-940-7328 to make the request. The request will be promptly reviewed and the care provider will be notified of the decision.

Care providers may also initiate requests to add a drug to the PDL. To submit a PDL addition request for consideration, the prescriber should contact the Provider Service Center and the request will be forwarded to the Pharmacy Director. The requests will be considered at the Pharmacy and Therapeutic Committee meeting. Results of the review will be sent to the requesting care provider.

PDL information, including updates of when changes occur, will be provided in advance to care providers and a summary of changes posted to the plan's website. The PDL and Pharmacy Prior Notification Request form can be found on the plan's website at UHCCommunityPlan.com. To obtain a print copy of the PDL, contact the Provider Service Center.

**Dental**

(1) Benefits are provided for preventive and diagnostic dental care as recommended by the American Academy of Pediatric Dentistry (AAPD). The following Covered Dental Services are limited to $2,500 per fiscal year maximum (July 1-June 30):

(a) Bitewing X-rays as needed but no more frequently than one per fiscal year (July 1-June 30);

(b) Complete mouth X-ray and panoramic X-ray – as needed, but no more frequently than once every 24 months;

(c) Prophylaxis- two times every fiscal year (July 1-June 30) and must be at least five months apart;

(d) Fluoride Treatment – two times every fiscal year (July 1-June 30) and must be at least five months apart;

(e) Space Maintainers – limited to permanent teeth through age 20;

(f) Sealants – covered through age 20 for permanent first and second and pre-molars, one per every five years. Sealants on primary teeth with prior authorization.

(2) Benefits are also provided for restorative, endodontic, periodontic and surgical dental services as indicated below:

(a) Amalgam, Composite, Sedative, and Composite Resin Fillings including the replacement of an existing restoration;

(b) Stainless steel crowns on posterior and anterior primary teeth when Amalgam and Composite restoration are insufficient;

(c) Porcelain crowns to anterior teeth only;

(d) Simple and surgical extraction;

(e) Extraction of symptomatic impacted teeth;

(f) Pulpotomy, pulpectomy and root canal;

(g) Gingivectomy, gingivoplasty and gingival curettage, periodontal scaling and root planing once per quadrant per fiscal year.

(3) Orthodontic Treatment - Orthodontic services are restricted to Medicaid-eligible beneficiaries under age 21.

UnitedHealthcare will consider orthodontic authorization requests for beneficiaries through age 20 who meet at least one of the following pre-qualifying criteria:

- Cleft lip, cleft palate and other craniofacial anomalies;
- Overjet of nine millimeters or more;
– Reverse overjet of two millimeters or more;
– Extensive hypodontia with restorative implications (more than one tooth per quadrant) requiring pre-prosthetic orthodontics;
– Anterior openbites greater than four millimeters;
– Upper anterior contact point displacement with greater than four millimeters;
– Individual anterior tooth cross bites with greater than a two-millimeter discrepancy between retruded contact position and intercuspal position. For all orthodontic services, the member must complete the course of treatment by their 21st birthday. Approved cases subject to a lifetime maximum for orthodontic services of $4,200.

Patients do not need a referral before the initial visit with their selected VSP doctor. Patients may call for an appointment or be seen immediately if the care provider determines urgent care is necessary.

Please refer patients to VSP’s toll-free Customer Service number at 800-877-7195.

Medical eyecare beyond the scope of PEC, to include surgical care, is provided through UnitedHealthcare’s contracted ophthalmologists as listed in the UnitedHealthcare Provider Directory. If medical eyecare is needed, please refer patients to a UnitedHealthcare-contracted ophthalmologist.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Limitation</th>
<th>Prior Auth</th>
<th>Contact for Prior Auth</th>
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<tbody>
<tr>
<td>Eyecare (Eye exams and glasses)</td>
<td>Children – two eye exams per fiscal year, one pair eyeglasses per fiscal year, plus one additional pair eyeglasses covered under repair/replacement coverage per fiscal year</td>
<td>Yes, for children after 1st pair per fiscal year</td>
<td>Member’s selected VSP Provider or VSP directly</td>
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<tr>
<td></td>
<td>Adults – one eye exam per fiscal year, one pair eyeglasses every three fiscal years</td>
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Adults age 21 and above have emergency dental benefits, some limitations and prior authorizations apply.

**Prior Authorization**

Prior authorization or other limitations may apply for some dental services such as crowns, periodontal or specific oral surgery procedures, and orthodontic treatment. Please contact Dental Provider Services for specific information at 800-508-4862.

**Vision**

Routine Vision, which includes a comprehensive eye exam and glasses or contacts, is provided through our third-party vendor, VSP. Additionally, the VSP network of ODs and MDs provides Primary Eyecare services. The Primary EyeCare (PEC) Plan provides supplemental coverage for non-surgical medical eyecare through a VSP doctor. Examples of services covered include diagnosis and tests for loss of vision, treatment for conditions such as conjunctivitis (pink eye), and management of glaucoma and diabetic retinopathy. VSP doctors may provide services, if covered, up to the optometry scope of licensure in the state of Mississippi in accordance with the covered benefits.
Behavioral Health

Members have statewide access for outpatient behavioral health services. Out-of-state behavioral health services are limited to specific emergency services. For information on referring patients for behavioral health services, you can call 866-673-6315. Members should also be referred to this number for assistance in finding a behavioral health care provider.

(1) Inpatient behavioral health services, other than services described under substance abuse services, but including services furnished in a state-operated behavioral health hospital and including residential or other 24-hour therapeutically planned structural services.

(a) Benefits for covered medical expenses are paid for medically necessary inpatient psychiatric treatment of an enrolled child.

(b) Benefits for covered medical expenses are provided for partial hospitalization.

(c) Certification of medical necessity by the Utilization Management Program is required for admissions to a hospital.

(d) Benefits for behavioral health/nervous conditions do not include services where the primary diagnosis is substance abuse.

Substance Abuse

(1) Inpatient substance abuse treatment services and residential substance abuse treatment services:

(a) Benefits for covered medical expenses are provided for the treatment of substance abuse, whether for alcohol abuse, drug abuse or a combination of alcohol and drug abuse.

(b) Benefits for covered medical expenses are provided for Medically Necessary inpatient stabilization and residential substance abuse treatment.

(c) Certification of Medically Necessity by the Health Plan's Utilization Management Program is required for admissions to a hospital or residential treatment center.
Referral Guidelines

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

- Continuity of care issues; and
- 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 or action planning.

Emergency Care

Prior authorization is not required for emergency services. Emergency care should be rendered at once, with notification of any admission to:

866-604-3267
888-310-6858 (Fax)

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.

Inpatient admissions resulting from emergency services require notification to UnitedHealthcare within 24 hours from admission.

Care in the Emergency Room

UnitedHealthcare members who visit an emergency room should be screened to determine whether a medical emergency exists. Prior authorization is not required for the medical screening.

UnitedHealthcare provides coverage for these services without regard to the emergency care provider’s contractual relationship with UnitedHealthcare. Emergency services (i.e., physician and outpatient services furnished by a qualified care provider necessary to treat an emergency medical condition) are covered both within and outside UnitedHealthcare’s service area.

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

- Placing the health of the person afflicted with such condition in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child);
- Serious impairment to such person’s bodily functions; or
- Serious dysfunction of any bodily organ or part of such person.

Medicaid ID Requirement

Please note that all care providers must be enrolled in Mississippi Medicaid, and have a state provider Medicaid ID in order to be reimbursed for services provided to a MississippiCAN member.

An enhanced claim denial edit ensures that no payments are made to care providers without a Mississippi Medicaid ID on file. If your claims have denied due to missing Medicaid ID and you have a current Mississippi Medicaid ID, please contact Provider Services hotline at 877-743-8734 so that we can facilitate updating your records and adjusting impacted claims.

If you do not have a current Mississippi Medicaid ID, a Provider Enrollment application can be found at: msmedicaid.acs-inc.com/msenvision/index.do
Prior Authorization

**Determination of Medical Necessity**

UnitedHealthcare uses nationally recognized, evidence-based clinical criteria to guide our medical necessity decisions, including MCG Care Guidelines and Centers for Medicare & Medicaid Services (CMS) policy guidelines. MCG Care Guidelines is widely regarded for its scientific approach, using comprehensive medical research to develop recommendations on optimal length-of-stay goals, best-practice care templates, and key milestones for the best possible treatment and recovery.

UnitedHealthcare evaluates medical necessity according to the following standards:

Medically necessary services are services, supplies or equipment provided by a licensed health care professional that:

- are appropriate and consistent with the diagnosis or treatment of the member’s condition, illness, or injury;
- are in accordance with the standards of good medical practice consistent with the individual member’s condition(s);
- are not primarily for the personal comfort or convenience of the member, family or care provider;
- are the most appropriate services, supplies, equipment or levels of care that can be safely and efficiently provided to the member;
- are furnished in a setting appropriate to the member’s medical need and condition and, when applied to the care of an inpatient, further mean that the member's medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient;
- are not experimental or investigational or for research or education;
- are provided by an appropriately licensed practitioner; and
- are documented in the patient’s record in a reasonable manner, including the relationship of the diagnosis to the service.

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

The determination of medical necessity must be based on peer-reviewed publications, expert pediatric, psychiatric and medical opinion, and medical/pediatric community acceptance. In the case of pediatric members, the only limitation on services is that they are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an EPSDT screen, periodic or interperiodic, whether or not such services are covered or exceed the benefit limits under Mississippi Medicaid. All services determined to be medically necessary must be covered.

Our Utilization Management (UM) team is available Monday through Friday, 8 a.m. to 5 p.m. to answer any UM or prior authorization questions. The team can be reached by calling 877-743-8731. Assistance is also available after hours.

In order to provide a streamlined, simplified experience for care providers caring for members of our various health plans, UnitedHealthcare Community Plan medical policies have been aligned with the rest of UnitedHealthcare's medical policies and procedures.

Services which are not covered under the plan as described in the medical policies will be denied as unproven, experimental in nature, cosmetic or not medically necessary. The member must be held harmless in accordance with the terms of your Provider Agreement.
Clinical criteria are available in writing upon request to:

UnitedHealthcare of Mississippi Medical Director
795 Woodlands Parkway Suite 301
Ridgeland, MS 39157

UM decision-making is based only on the appropriateness of care and services and the existence of coverage. Care providers or other individuals are not rewarded for issuing denials of coverage or care. Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

UnitedHealthcare will make routine prior approval decisions and give notice within three calendar days and/or two business days. Emergency prior approval decisions will be given within 24 hours after receiving the emergency prior approval request.

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 Identification

The Health Risk Assessment (HRA) and our predictive modeling and stratification system are the primary tools for identifying members for DM 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 questions, 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, multiple conditions issues across multiple domains of care of DM.
- Level 3: High-risk members who are medically fragile, have multiple co-morbidities and need complex care management.

Outreach and Other Identification Processes

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

DM Interventions

After a member has been identified, the Care Manager contacts the member or 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 or member’s parent or caregiver on how to use the DM services, how the member became eligible to participate in the program 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 or 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 reassess risk and needs;
- Access to program website;
- Episodic educational interventions, as needed;
- Post-hospitalization and emergency room assessment;
- Educational materials are sent to member;
- Letter is sent to the care provider identifying the member’s involvement, intervention and point of contact for the DM program; and
- 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, care providers, and community-based organizations. The goal is to employ practical solutions to improve members’ health and keep them in their communities with the resources they need to maintain the highest possible functional status.

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 (e.g., 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 care providers involved in the member’s care; and

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 care 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; and
- Appropriate health care utilization.

**Pharmacy**

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

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

UnitedHealthcare integrates pharmacy disease management for asthma into our regular asthma disease management program.

Our DM program is supported by UnitedHealthcare’s integrated clinical system, which includes basic and comprehensive supplemental assessments, facilitates the development of integrated care plans, and includes ongoing monitoring and evaluation tools.

**Drug Utilization Review Programs**

UnitedHealthcare offers the following Drug Utilization Review (DUR) programs, including:

- Narcotic Drug Utilization Review Program.
- Drug Interaction Alert Program.
- Polypharmacy Program.
- Geriatric RxMonitor Program.
- Dose-Duration Program
- Drug-Age Program
- Asthma Program
- Poly Drug-Disease Program
Coordination of Care With Care Providers

Each member must select a PCP 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 care 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 care 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 helps ensure the plan of care supports care 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:

- Works to identify and understand the member's barriers to success.
- Problem solves for alternative solutions with the member.
- Reports non-compliance to the treating care provider/specialist, offer potential solutions and integrate care provider feedback.
- Facilitates 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 care 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 care 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 care provider's request and provide training for care providers and their staff on how best to integrate practice guidelines into everyday physician practice. When a care provider demonstrates a pattern of non-compliance with clinical practice guidelines, the medical director may contact the care provider by phone or in person to review the guideline and identify any barriers that can be resolved.

Case Management

We use retrospective and prospective methods to 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 care 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 disease management 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 (e.g., insulin or inhalers).
- Emergency room utilization 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 each health plan and state program, we determine the specific threshold for each case and disease management level. As previously mentioned, members are stratified into one of three levels and are assigned to the appropriately qualified staff.

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

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

UnitedHealthcare adopts clinical practice guidelines as the clinical basis for the DM Programs. Clinical guidelines are systematically developed, evidence-based statements that help care providers make decisions about appropriate health care for specific clinical circumstances. We adopt clinical guidelines from recognized sources. These guidelines can be found at UHCCommunityPlan.com/health-professionals/MS/clinical-practice-guidelines.

Concurrent Review

eQHealth
866-740-2221
ms.eqhs.org/Home.aspx

Preventive Health Care Standards

UnitedHealthcare’s goal is to partner with care providers to help 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 on the website. Education is provided to both members and
care 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 Quick Reference Guide:**
cdc.gov/vaccines/schedules/index.html

Source: CDC and Advisory Committee on Immunization Practices

**Cardiology Notification/Prior Authorization Protocol**

The UnitedHealthcare Cardiology Notification/ Prior Authorization protocol is for UnitedHealthcare Community Plans. It applies to all participating care providers, facilities and other health care professionals who perform diagnostic catheterizations electrophysiology implant procedures, echocardiograms, and stress echocardiograms (herein referred to as “cardiac procedures”) on UnitedHealthcare customers. Notification/Prior Authorization for diagnostic catheterizations, echocardiograms and stress echocardiograms is required for outpatient and office-based services only. Notification/Prior Authorization for electrophysiology implants is required for outpatient, office-based and inpatient services. Cardiac procedures rendered in and appropriately billed with any of the following places of service do not require notification/prior authorization: emergency room, urgent care center or inpatient setting (except for electrophysiology implants).

Once notification of a cardiac procedure is received and if the customer’s benefit plan requires health services to be medically necessary in order to be covered, we conduct a clinical coverage review to determine whether the service is medically necessary. You do not need to determine whether a clinical coverage review is required in a given case or for a given customer because once we receive notification, we let you know whether a clinical coverage review is required pursuant to our prior authorization process.

Compliance with this protocol is required. If the entire process described below is not completed before the cardiac procedure is rendered, an administrative claim reimbursement reduction, in part or in whole, occurs.

To see the most current listing of CPT codes for cardiac procedures, please refer to:

UHCCommunityPlan.com

**Process for Care Provider**

To receive payment for services rendered, prior to performing the stated cardiac procedure, the ordering care provider must provide notification by contacting us:

- Online: UHCCommunityPlan.com (select Cardiology tab)
- By phone: 866-889-8054

The information listed below may be requested at the time notification is provided:

**Customer/procedure information**

- Customer’s name and customer’s health care ID number
- Customer’s address and phone number
- Customer’s group number
- Customer’s date of birth.
- The examination(s) or type of service(s) being requested, with the CPT code(s).
- The primary diagnosis or “rule out” with the ICD-10-CM (or its successor) code(s).
Care Provider information

- Ordering provider’s name, TIN/NPI, specialty, address, and phone number.
- Care provider to whom the customer is being referred, if specified, address and phone number.
- Rendering provider’s name and TIN/NPI.

Clinical information

- The member’s clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.
- Dates of prior imaging studies performed.
- Any other information the ordering provider believes would be useful in evaluating whether the service ordered meets current evidence-based clinical guidelines, such as prior diagnostic tests and consultation reports.

Once notification of a planned cardiac procedure is received, if the customer’s benefit plan requires health services to be medically necessary in order to be covered, we conduct a clinical coverage review to determine whether the service is medically necessary pursuant to our prior authorization process. A prior authorization number is issued to the ordering provider, if the service is medically necessary. A clinical denial is issued, and a prior authorization number is not issued, if it is determined during the prior authorization process or the retrospective review process that the service is not medically necessary.

Once notification of a planned cardiac procedure is received, if the customer’s benefit plan does not require health services to be medically necessary in order to be covered, and if the service is consistent with evidence-based clinical guidelines, a notification number is issued to the ordering provider. If the service is not consistent with evidence-based clinical guidelines, or if additional information is needed to assess the request, we let the ordering provider know whether he or she must engage in a physician-to-physician discussion to explain the request, to provide additional clinical information, and to discuss alternative approaches. Upon completion of the discussion, the care provider confirms the procedure ordered and a notification number is issued. If a physician-to-physician is required, that process must be completed in order to ensure payment.

You do not need to determine whether a clinical coverage review is required in a given case or for a given member because once we are notified of a planned cardiac procedure we let you know whether a clinical coverage review will be conducted pursuant to the prior authorization process.

The purpose of the physician-to-physician discussion is to facilitate the provision of evidence-based health care through an open dialogue based on evidence-based clinical guidelines.

A notification number is issued to the ordering provider when the process is completed. The notification number is communicated by fax, phone, or online, consistent with how the request was initiated. To help promote proper payment, the notification number must be communicated by the ordering provider to the rendering provider scheduled to perform the cardiac procedure.

Subject to state regulation, receipt of a notification number or prior authorization number does not guarantee or authorize payment. Payment for covered services is contingent upon coverage within an individual customer’s benefit plan, the care provider being eligible for payment, any claim processing requirements, and the care provider’s participation agreement with UnitedHealthcare.
Standard authorization decisions are communicated within three calendar days and/or two business days following receipt of all clinical information for medically needed services. The standard authorization may be extended up to 14 additional calendar days upon request of the member or the care provider, or if UnitedHealthcare justifies to Medicaid a need for additional information and how the extension is in the member’s best interest.

**Urgent requests during regular business hours**
You may request a notification number or prior authorization number on an “urgent” basis if you determine it to be medically required. Urgent requests should be requested via telephone by calling 866-889-8054. You must state that the case is clinically urgent and explain the clinical urgency. We respond to urgent requests within three hours of our receipt of all required information. If you feel you cannot wait for a decision in three hours, a notification number or prior authorization number must be requested retrospectively following the retrospective review process.

**Urgent requests outside of regular business hours**
If you determine that care is medically required on an urgent basis and a notification number or prior authorization number cannot be requested because it is outside of UnitedHealthcare’s normal business hours, the service may be performed and a notification number or prior authorization number must be requested retrospectively following the retrospective review process described below. You may also call 866-889-8054 and follow the phone prompts provided.

**Retrospective Review Process**
- Retrospective notification number and prior authorization number requests must be made within 15 calendar days for diagnostic catheterizations and electrophysiology implants, and two business days for echocardiograms and stress echocardiograms after the cardiac procedure is rendered.
- Documentation must include an explanation as to why the procedure was required on an urgent basis and why a notification number or prior authorization number could not have been requested during UnitedHealthcare’s normal business hours.
- You should follow the same process outlined above for a standard notification or prior authorization number request. If the member’s benefit plan requires health services to be medically necessary in order to be covered, we will conduct a clinical coverage review to determine whether the service is medically necessary. Urgent services rendered without a required prior authorization number are subject to retrospective review for medical necessity, and payment may be withheld if the services are determined not to have been medically necessary. Please note: the member cannot be balance billed for any denied charges under these circumstances. Failure to obtain a notification number or prior authorization number either prospectively or retrospectively will result in administrative denial of the claim(s).

**Rendering Care Provider (if different than the Ordering Care Provider)**
To be eligible to receive payment for covered services rendered, (a) the rendering care provider must validate with us prior to performing a cardiac procedure that a notification number is on file or, (b) if the member’s benefit plan requires that health services be medically necessary in order to be covered, the rendering care provider must validate with us prior to performing a cardiac procedure that the prior authorization process has been completed and a coverage decision has been issued before rendering the service. This must be done by contacting us as follows:
● Online: UHCCommunityPlan.com (select Cardiology tab)

● By phone: 866 889-8054 (select prompt 2 to check status of a notification request).

If the member’s benefit plan does not require that services be medically necessary in order to be covered:

● If a cardiac procedure is rendered and a claim for the service is submitted without a notification number, an administrative claim reimbursement reduction, in part or in whole occurs. The member cannot be billed for the service.

● If the rendering provider determines there is no notification number on file, and the ordering provider participates in UnitedHealthcare’s network, we use reasonable efforts to work with the rendering care provider to obtain the notification number from the participating ordering care provider prior to the rendering of services.

● If the rendering care provider determines there is no notification number on file, and the ordering care provider does not participate in UnitedHealthcare’s network, and is unwilling to obtain a notification number. If the rendering care provider does not obtain a notification number for cardiac procedures ordered by a non-participating provider, the rendering provider’s claim is denied administratively, in part or in whole, for failure to provide notification, and the member cannot be billed for the service.

If the member’s benefit plan does require services to be medically necessary in order to be covered:

● If the rendering care provider determines a coverage determination has not been issued, and the ordering care provider does not participate in UnitedHealthcare’s network, and is unwilling to complete the prior authorization process, the rendering care provider is required to complete the prior authorization process and verify that a coverage decision has been issued prior to rendering the service. If the rendering care provider provides the service before a coverage decision is issued, the rendering care provider’s claim is denied administratively, in part or in whole, and the customer cannot be billed for the service.

Cardiology Crosswalk Table
Under the CPT Code Crosswalk Table, for certain specified CPT code combinations, care providers are not required to follow the Commercial Cardiology Prior Authorization protocol to modify the existing prior authorization record. A complete listing of applicable CPT code combinations is available at UHCCommunityPlan.com (select Cardiology tab). However, for code combinations not listed on the CPT Code Crosswalk Table, care providers must follow the Cardiology Prior Authorization protocol process set forth above for additional procedures.

For information on the Radiology Prior Authorization program, go to: UHCCommunityPlan.com/health-professionals/ms/radiology.html

Outpatient Injectable Chemotherapy Prior Authorization Program
Effective October 1, 2016, UnitedHealthcare Community Plan members in Wisconsin will require prior authorization for injectable outpatient chemotherapy drugs given for a cancer diagnosis.
Appeals and Grievances

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

Compliance With State Requirements

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

Member and Care Provider Notification: Upon enrollment, UnitedHealthcare informs members and care providers of our complaint/grievance and appeals procedures. Information includes:

- The right to file grievances, appeals and claim disputes.
- The requirements and time frames for filing grievances, appeals and claim disputes.
- The availability of assistance for informal/formal grievance filing and process.
- That members may use a personal representative during the grievance process.
- Care providers may request a copy of the clinical criteria from: P.O. Box 5032, Kingston, NY 12402-5032.
- Toll-free numbers to file a grievance or appeal by phone.
- Notice of grievance rights each time a covered service is denied, reduced or terminated.
- Notice of the right to appeal.
- Notification of the member’s right to appeal the decision through a State Fair Hearing
- Administrative Hearing
- The method for obtaining a hearing.
- The rules that govern representation at the hearing.
- Notice that, when timely filed, member-requested benefits continue during appeal/Administrative Hearing
- Notice that, if the final decision is adverse to the member, the member may be liable for the cost of any continued benefits.
- During the appeal/hearing process, the member and his/her representative will have the opportunity to examine the member’s case files, including any medical records and any other records considered during the appeals process.

We inform members of their right to file complaints/grievances via the UnitedHealthcare member Handbook, new member Welcome packet, and online through the UnitedHealthcare website. We inform members of the grievance 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 and Appeal form, if requested, and assistance with filing grievances. Members may file a grievance either verbally or in writing. UnitedHealthcare informs care providers of the grievance and appeal process through the UnitedHealthcare Provider Manual and the UnitedHealthcare Provider Website. Grievance and Appeal Policies are given to care providers at the time of contract. If significant change is warranted in information and policy materials, written notification is provided at least 30 days before the intended effective date.
Notice of Adverse Action:
UnitedHealthcare notifies the requesting care provider and provides written notice to members of adverse actions. An “action” includes: (a) denial or limited authorization of a requested service; (b) reduction, suspension or termination of a previously authorized service; (c) denial in whole or part of payment for a service (except where a care provider’s claim is denied for technical reasons such as prior authorization rules, referral rules, late filing, invalid codes, etc.); (d) failure by UnitedHealthcare to render a decision within required time frames; and (e) denial of a member’s request to exercise his or her rights under federal law to obtain services outside the network. The written notice explains the adverse action taken; the member’s right to file an appeal with UnitedHealthcare and to request a State Fair Hearing procedures for exercising appeal rights; and information about requesting expedited resolutions and continuation of benefits pending resolution of an appeal.

UnitedHealthcare provides the notice of action within the following time frames:
● For termination, suspension or reduction of previously authorized services, at least three calendar or two business days prior to the effective date of the intended adverse action;
● For expedited requests, no later than 72 hours following receipt of the request; and
● For denial of payment, at the time of the action affecting the claim.
● For standard, non-inpatient, hospital service authorizations, no later than three calendar days or two business days following receipt of all requested information. This may be extended up to 14 additional calendar days if formally requested and the extension is the best interest of the member.

If UnitedHealthcare does not make a decision within the applicable time frames (which constitutes a denial), the notice must be issued on the date the time frames expire.

Filing an Appeal With UnitedHealthcare:
The member, member’s representative acting on behalf of the member, or the care provider may appeal an adverse action within 30 calendar days from receipt of the notice of action. UnitedHealthcare accepts appeals in writing or orally. However, oral appeal requests must be confirmed in writing unless the request is for an expedited resolution. The information is routed to the Escalated Tracking System, where a case file is created. An acknowledgement letter is generated in 10 working days for standard appeals.

The member or member’s authorized representative has the opportunity before and during the process to examine the case file, including all medical records and any other material considered during the process. UnitedHealthcare sends a copy of the file, upon request, to the member or authorized representative at no charge.

UnitedHealthcare resolves an appeal and provides written notice of the resolution within 30 days of receipt for a standard appeal. UnitedHealthcare may extend this time frame by up to 14 calendar days upon request or if UnitedHealthcare demonstrates the need for more information and that a delay in rendering the decision is in the member’s or care provider’s best interest. For any extension not requested, UnitedHealthcare provides a written notice of the reason for delay.

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

The resolution notice includes the decision reached, the date of the decision, and, for appeals not resolved wholly in favor of the member or care provider, information on the right to request a hearing and how to do so, the right to receive benefits while a hearing is pending and how to make such a request, and an explanation of why the member may be liable for the cost of any continued benefits a hearing upholds UnitedHealthcare’s decision.

Expedited Review of Appeals.
UnitedHealthcare expedites resolution of an appeal if, according to the information provided by the member...
or the care provider, the standard resolution time frame could seriously jeopardize the member’s life, health or ability to attain, maintain, or regain maximum function. Under these circumstances, UnitedHealthcare resolves the expedited appeal within 72 hours of initial receipt of the appeal. UnitedHealthcare may extend the resolution timeline by up to an additional 14 calendar days upon request or if UnitedHealthcare demonstrates the need for more information and that a delay in rendering the decision is in the member’s or care provider’s best interest. If the member or care provider did not request the delay, UnitedHealthcare provides a written notice of the extension and the reasons for the delay.

UnitedHealthcare makes reasonable efforts to give prompt verbal notice of an expedited appeal not resolved wholly in favor of the member or care provider and follows-up with a written notice of action within two calendar days. The written notice contains the same information as a resolution notice for a standard appeal, as described above (e.g., the right to request an Administrative Hearing if the resolution was not wholly in favor of the member or care provider).

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

Filing an Appeal With DOM/State Fair Hearing Process:
Any adverse action or appeal not resolved wholly in favor of the member may be appealed to DOM for an Administrative Hearing. A member may appeal an action directly to the DOM; after exhausting all appeal rights with UnitedHealthcare. Appeals to DOM must be requested in writing by the member or the member’s representative within 30 calendar days of UnitedHealthcare’s final decision.

Continuation of Benefits:
UnitedHealthcare shall continue the member’s benefits if all of the following are met:

1. Member or the care provider files a timely appeal of UnitedHealthcare’s action (timely filing means within 10 days of UnitedHealthcare’s notice of action) or the member asks for a State Fair Hearing within 30 calendar days from the date on UnitedHealthcare’s notice of action
2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
3. Authorized care provider ordered services
4. The original authorization has not expired
5. Member requests extension of benefits within 10 days of receiving notice of action

UnitedHealthcare shall provide benefits until one of the following occurs:
1. The member withdraws the appeal
2. 10 calendar days have passed since the date of the notice, provided the resolution of the appeal was against the member and the member has not requested an Administrative Hearing or taken any further action
3. The DOM issues an Administrative Hearing decision adverse to the member
4. The service limits of a previously authorized service has expired

If the final appeal resolution is adverse to the member, UnitedHealthcare may recover the cost of member services while the appeal was pending, if services were furnished solely because of the requirements of this section. If UnitedHealthcare or the DOM reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, UnitedHealthcare shall authorize or provide the disputed services promptly and as expeditiously as the member’s health condition requires. If UnitedHealthcare or the DOM reverses a decision to deny, limit or delay services and the member received the disputed services while the appeal was pending, UnitedHealthcare shall pay for these services.
Filing a Grievance:
A “grievance” is an expression of dissatisfaction about any matter other than an “action” (as defined above). A member or his/her authorized representative as designated in writing or a care provider, may file a grievance with UnitedHealthcare by calling the Call Center toll-free or by mailing a grievance to our Regional Mail Operations (RMO). Telephonic/verbal grievances are routed through the online routing system (ORS), technology that identifies call type and routes to other databases according to category. When the ORS identifies the call as a grievance, the information is logged into the system, and forwarded to a triage team who puts the information into the Escalated Tracking System (ETS), where a case file is created and populated. On receipt of a written grievance, appropriate personnel scan them into the ETS and create a case file. The grievance is logged and tracked by various criteria (e.g., member name/identification number, date received, acknowledgement, description, staff assigned, disposition, tentative disposition date, etc.). We acknowledge receipt of each member grievance no later than ten working days from initial receipt, grievances received orally may be acknowledged orally. Acknowledgement letters are generated automatically via the ETS Client Letter Tool.

Expedited Grievance Process
Members or their representatives have the right to request an expedited grievance. The member or representative may receive an expedited grievance orally or in writing. All oral requests for expedited grievances must be documented and maintained in case files. For grievances involving clinical issues, a health care professional reviews and investigates the clinical aspect of the grievance.

Expedited grievance requests must be resolved within 72 hours of receipt.

UnitedHealthcare must inform the member or their representative of the limited time available to present evidence and allegations in fact or law.

Resolving an expedited grievance may be extended by up to 14 calendar days if:
- The member or their representative requests the extension or if UnitedHealthcare demonstrates to the Medicaid division there is a need for additional information
- The extension is in the member’s interest.

For any extension not requested by the member or their representative, UnitedHealthcare shall provide written notice within two business days to the member or representative the reason for the decision to extend the time frame.

Upon resolution of the expedited grievance, UnitedHealthcare shall:
- Make reasonable efforts to provide and document the decision with verbal notice to the member or representative.
- Follow up with a written notice within two calendar days of providing the verbal notification.

If the request does not meet the expedited criteria, UnitedHealthcare shall:
- Transfer the expedited grievance to a standard grievance and follow the standard grievance process for resolution;
- Make reasonable efforts to give the member or their representative:
  - Prompt verbal notice of the decision to deny the expedited request due to failure to meet the expedited grievance request criteria.
  - Inform the member or their representative the request has been transferred to a standard grievance and advise of the time frame for resolution.
  - Follow up with a written notice within two calendar days of providing verbal notification.

No punitive action may be taken against a member who requests an expedited grievance.

Process for Resolving a Grievance:
Our call center receives calls 24 hours a day, seven days a week to address various issues, including grievances. All calls related to grievances are recorded in the ORS. Even though the majority of grievances are resolved during the initial call, we maintain the data. Those not resolved are forwarded to our Grievances and Appeals
Department on priority and set in queue via First-in-First-Out for our resolving analysts to address. We educate our resolving analysts on complaint and grievance procedures, and member and care provider rights. On notification of a grievance, our resolving analysts conduct preliminary research and verify the appropriate grievance path.

We respond to all grievances no later than 30 days from the date of our receipt of the grievance. Grievances received orally may be responded to orally and need not be followed up with a written response unless requested.

The time to resolve a grievance may be extended by up to 14 calendar days if:

The member or representative requests the extension or if UnitedHealthcare demonstrates to the DOM there is a need for additional information and the extension is in the member’s interest.

For any extension not requested by the member or representative, UnitedHealthcare shall provide the member or representative with written notice of the reason for the extension within two working days of the decision.

The grievance response includes the decision reached and a clear explanation of any further rights available to the member or care provider under UnitedHealthcare’s grievance process.

Our review and response times meet HIPAA, federal, state and regulatory compliance.
## Summary of Non-Expedited Member and Care Provider Complaints, Grievances and Appeals

<table>
<thead>
<tr>
<th>Party</th>
<th>Action</th>
<th>Time Frame</th>
<th>Extensions Available</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complaint:</strong> An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one business day of receipt. Any complaint not resolved within one business day shall be treated as a grievance. A complaint includes, but is not limited to inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information.</td>
<td>Member</td>
<td>Submit a complaint</td>
<td>Within 30 calendar days of the date of the event causing the dissatisfaction</td>
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<tr>
<td></td>
<td>UnitedHealthcare</td>
<td>Respond to a complaint</td>
<td>Within one business day</td>
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<td></td>
<td>Community Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Grievance:</strong> An expression of dissatisfaction received orally or in writing about any matter or aspect of the UnitedHealthcare Community Plan or its operation, other than a Contractor Action as defined in UnitedHealthcare’s contract with the state of Mississippi. A grievance includes, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a care provider or an employee, or failure to respect the members rights.</td>
<td>Member or Care Provider</td>
<td>File a grievance</td>
<td>Within 30 calendar days of the date of the event causing the dissatisfaction</td>
</tr>
<tr>
<td></td>
<td>UnitedHealthcare</td>
<td>Confirm receipt of the grievance and expected date of</td>
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<tr>
<td></td>
<td>Community Plan</td>
<td>resolution</td>
<td></td>
</tr>
<tr>
<td></td>
<td>UnitedHealthcare</td>
<td>Resolve a grievance</td>
<td>Within 30 calendar days of the date the contractor receives the grievance or as expeditiously as the member’s health condition requires</td>
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<td></td>
<td>Community Plan</td>
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<tr>
<td>Party</td>
<td>Action</td>
<td>Time Frame</td>
<td>Extensions Available</td>
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<tr>
<td><strong>Appeal:</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Member or Care Provider</td>
<td>File an appeal</td>
<td>Within 30 calendar days of receiving the Contractor’s notice of action</td>
<td></td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan</td>
<td>Confirm receipt of the appeal and expected date of resolution</td>
<td>Within 10 calendar days of receipt of the appeal</td>
<td></td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan</td>
<td>Resolve an appeal</td>
<td>Within 30 calendar days of the date the contractor receives the appeal or as expeditiously as the member’s health condition requires</td>
<td>Contractor may extend time frames by up to 14 calendar days in accordance with 42 C.F.R. § 438.408(c)</td>
</tr>
<tr>
<td><strong>Administrative Hearing:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member or Care Provider</td>
<td>File a request for a hearing</td>
<td>Within 30 calendar days of the final decision by the contractor</td>
<td></td>
</tr>
<tr>
<td>Division of Medicaid</td>
<td>Take final administrative action</td>
<td>Within 90 calendar days from the date the member filed for direct access to an Administrative Hearing</td>
<td>Or as expeditiously as the Member’s health condition requires but no later than three business days after the Division receives from the contractor the case file and information for circumstances that meet criteria for Expedited Resolution as set forth in 42 C.F.R. § 438.410(a) but was not resolved within the time frame for Expedited Resolution or it was resolved within the time frame but reached a decision wholly or partially adverse to the member.</td>
</tr>
</tbody>
</table>
Quality Management

Care Provider Participation in Quality Management

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

- Provider Advisory Committee (PAC) reviews and recommends action on topics concerning credentialing and recredentialing of care providers and facilities, peer review activities, and performance of all participating care providers. Participating care 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.

- Service Quality Improvement Subcommittee reviews timely tracking, trending and resolution of member administrative complaints and grievances. This subcommittee oversees members and practitioner 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 National Quality Oversight Committee (NQOC). A copy of our Quality Improvement Program is available upon request.

The Quality Improvement Program consists of the following components:

- Quality Improvement measures and studies.
- Clinical practice guidelines.
- Health promotion activities.
- Service measures and monitoring.
- Ongoing monitoring of key indicators (e.g., over and underutilization, continuity of care).
- Health plan performance information analysis and auditing (e.g., HEDIS®).
- Care Coordination.
- 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 Quality Improvement Committees 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 Coordination 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.
Care Provider Satisfaction

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

- Annual Care Provider Satisfaction Surveys and Targeted Improvement Plans.
- Regular visits to care providers.
- Care provider townhall meetings.

Objectivity is our utmost concern in the survey process. To this end, UnitedHealthcare works with Survey Research Solutions and the Center for Study Services (CSS) to conduct our annual care provider satisfaction survey(s). Our surveys are targeted to primary care physicians (PCPs) and high-volume specialists. CSS draws the survey samples of eligible physicians working within UnitedHealthcare’s networks.

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

Care Provider Responsibilities

You shall immediately notify UnitedHealthcare, in writing, if your ability to practice medicine is restricted or impaired in any way, if any adverse action is taken, 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 nationally recognized applicable accreditation agencies, including primary verification of training/experience, office site visits, etc. Each care provider is recredentialed at least every three years or such other time period as established by the NCQA or applicable law. UnitedHealthcare and Affiliates National Credentialing Committee (NCC) reviews credentialing information and recommends appointment to the panel. It is the applicant’s responsibility to supply all requested documentation in a form that is satisfactory to the Credentialing Committee. Applications that are lacking supporting documentation will not be considered by the committee. UnitedHealthcare processes the initial application and presents for committee review 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, the NCC and its agents make every effort to obtain such information as soon as possible.
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 is not disclosed to any person not directly involved in the credentialing process.

HIPAA Compliance

Care Provider Responsibilities

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is aimed at improving the efficiency and effectiveness of the health care system in the United States. While the portability and continuity of insurance coverage for workers and greater ability to fight health care fraud and abuse were the core goals of the Act, the Administrative Simplification provisions of HIPAA have had the greatest impact on the operations of the health care industry. UnitedHealthcare 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 care 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 medical information. The regulations protect medical records and other individually identifiable health information, whether it is electronic, paper or oral.

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

4. Security

The Security Regulations require covered entities to meet basic security objectives:

1. Ensure the confidentiality, integrity and availability of all electronic protected health information (PHI) the covered entity creates, receives, maintains and transmits;

2. Protect against any reasonably anticipated threats or hazards to the security or integrity of such information;

3. Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the Privacy Regulations; and
4. Ensure compliance with the Security Regulations by the covered entity’s workforce.

UnitedHealthcare expects all participating care 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**

**Member Rights**

MississippiCAN members have the following rights:

- Get information about UnitedHealthcare Community Plan, its services, the doctors giving care, and member rights and responsibilities
- Be told by the doctor what is wrong, what can be done, and what the result may be in language understood by the member
- Learn about options for treatment, regardless of cost or coverage, in a way that members can understand
- Voice complaints or appeals about UnitedHealthcare and the care received
- Suggest changes to member rights and responsibilities
- Be cared for with respect and dignity and with regard to privacy, without regard for health status, physical or mental handicap, sex, race, color, religion, national origin, age, marital status or sexual orientation
- Be told where, when and how to get the services needed
- Get a second opinion
- Communicate agreement to any treatment or care plan after it has been explained
- Refuse care and be told what risks may result
- Be free from any restraint or seclusion as a means of coercion, discipline, convenience or retaliation
- Get a copy of the personal medical record, discuss it with the doctor, and ask that it be amended or corrected
- Have medical records kept private, shared only when required by law or contract, or with member approval
- Get respectful care in a clean and safe environment, free of unnecessary restraints
- Get information about doctor incentives
- Exercise member rights with no impact on the way members are treated
- Make an advance directive
- Make a decision on organ donation
- Receive services not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- Access oral interpretation services free of charge.

**Member Responsibilities**

MississippiCAN members have the following responsibilities:

- Give information needed by UnitedHealthcare and the doctor to appropriately provide care
- Listen to the doctor’s advice, follow instructions, and ask questions
- Understand health problems and work with the doctor to set treatment goals
- Work with the doctor to guard and improve your health
- Find out how the health care system works
- Go back to the doctor or ask for a second opinion if health does not improve
- Treat healthcare staff with respect
- Tell UnitedHealthcare of any problems with any health care staff
- Follow the appointment scheduling process
- Keep appointments - call as soon as possible if cancellation is necessary
- Call the doctor when medical care is needed - even after office hours
- Use the emergency room only for real emergencies
Members must pay for unapproved health care received from non-participating care providers, and also have the right to know how to obtain approval for these services.

Inform the plan of changes in family size, address changes, or other health care coverage.

National Provider Identifier (NPI)

NPI is the standard unique identifier (a 10-character number with no imbedded intelligence) for health care providers under 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 care provider with all impacted trading partners such as care providers to whom you refer patients, billing companies, and health plans.

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

There are two entity types for the purposes of enumeration. A Type 1 entity is an individual health care practitioner and a Type 2 entity is an organizational care provider, such as a hospital system, clinic, or DME providers with multiple locations. Type 2 care providers may enumerate based on location, taxonomy or department.

Only care providers who are direct care providers of health care services are eligible to apply for an NPI. This creates a subset of care 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 requires NPI on paper claims also in anticipation of encounter submissions to the state agency.

NPI is 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 nppes.cms.hhs.gov.
- 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, N.D., whereby staff at the NPI Enumerator will enter the application data into NPPES. The form is 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: 800-465-3203 or
  TTY: 800-692-2326
  Mail: NPI Enumerator
  P.O. Box 6059
  Fargo, ND 58108-6059
  
  Phone: 800-465-3203 or
  TTY: 800-692-2326
  Mail: NPI Enumerator
  P.O. Box 6059
  Fargo, ND 58108-6059
How to share your NPI with us

Once you have 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.

Please note that all care providers must provide to UnitedHealthcare the NPI that aligns with their MS Medicaid ID. Failure to do so may impact claims payment.

NPI information can also be faxed to 866-455-4068 or 414-721-9006. 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 care 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 cooperation with evolving policies and initiatives to detect, prevent and combat fraud, waste and abuse, as well as 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

There is no single definition of “fraud” in the health care industry. Generally speaking, fraud as a legal concept involves an intentional misrepresentation of a material fact made to induce detrimental reliance by another. A misrepresentation can entail an affirmative false statement or the omission of a material fact. Moreover, fraud can be both intentional (knowing), reckless, or negligent. Intentional or knowing fraud can include both misrepresentations made to deceive and induce reliance, and those made with the knowledge that they are substantially likely to induce reliance. Federal and state statutes and regulations variously define fraud (e.g., 42 C.F.R. § 455.2 defines fraud as “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person”).

“Waste and abuse” in the context of health care claims are generally broader concepts than fraud. They include over-utilization of services and care provider and member practices inconsistent with sound fiscal, business, or medical practices that cause unnecessary costs or fail to meet professionally recognized health care standards.

Some typical general categorical examples of care provider health care fraud, waste and abuse include:

- Billing for services/goods never provided.
- Billing for services/goods not medically necessary.
- Billing for services/goods not covered (e.g., experimental services) and/or for services to ineligible members.
- Duplicative billing for the same services/goods.
- Billing without adequate supporting documentation.
- Billing for more costly/complex services/goods than those actually provided (“upcoding”).
- Billing separately services/goods required to be billed collectively (“unbundling”).
- Improper modifications of billing codes.
- Billings by fictitious, sanctioned, and/or unqualified care providers.
- Excessive fees charged for services/goods.
- Poor quality services that are tantamount to no services provided.
- Provider/member identity theft.
- Provider waiver of patient copayments.
- Misrepresentations in cost reports.
- Unlawful referrals of patients to related care providers.
Some examples of member/beneficiary health care fraud, waste and abuse include:

- Selling/loaning member identification information.
- Intentional receipt of unnecessary/excessive services/goods.
- Unlawful sales of prescriptions and/or prescription medications.
- Misrepresentations to establish program/plan eligibility (e.g., non-disclosure of income/assets).

**Ethics and Integrity**

**Introduction**

UnitedHealthcare is dedicated to conducting business honestly and ethically with members, care 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; and
- 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 care provider should be reported to a UnitedHealthcare senior manager in the health plan or directly to the corporate compliance department.

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 contracts. When informed of potentially irregular, inappropriate or potentially fraudulent practices within the plan or by our care providers, UnitedHealthcare will conduct an appropriate investigation. Care 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 the Participating Provider Agreement) and access to care provider office staff. If activity in violation of law or regulation is established, appropriate governmental authorities will be advised.

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

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are estimated to reduce program spending by $11 billion over five years. These provisions are aimed at reducing Medicaid fraud.

Under Section 6032 of the DRA, every entity that receives at least $5 million in Medicaid payments annually must establish written policies for all employees of the entity, and for all employees of any health plan or agent of the entity, providing detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a contracted care provider with UnitedHealthcare, you and your staff are subject to this provision. The UnitedHealthcare policy, titled "Integrity of Claims, Reports and Representations to Government Entities" can be found at [UHCCommunityPlan.com](http://UHCCommunityPlan.com). This policy details our commitment to compliance with the federal and state false claims acts, provides a detailed description of these acts and of the mechanisms in place within our organization to detect and prevent fraud, waste and abuse, as well as the rights of employees to be protected as whistleblowers.
Claims Filing & Processing

Claims Billing Procedures

Electronic claims reduce errors and shorten payment cycles.

Electronic Data Interchange (EDI) Claims - 800-842-1109

UnitedHealthcare connects with multiple clearinghouses to allow health care professionals to submit claims electronically via their practice management software. To answer questions regarding your EDI options for electronic claims submission, obtain a list of clearinghouses that submit directly to UnitedHealthcare, or assistance in establishing an EDI connection, call (800) 842-1109. Visit our EDI Education for Electronic Transactions site for valuable information regarding EDI. EDI issues can also be submitted online EDI Issue Submission.

If a claim must be submitted on paper, you should send claims to the following address:

UnitedHealthcare
P.O. Box 5032
Kingston, NY 12402-5032.

Claims Format

All claims for medical or hospital services must be submitted using the standard CMS1500, UB04 (also known as CMS1450), or respective electronic format. We recommend the use of black ink when completing a CMS 1500. Black ink on a red CMS 1500 form allows for optimal scanning into the claims processing system. No matter which format you use to submit the claim, ensure that all appropriate secondary diagnosis codes are captured and indicated for line items. This allows for proper reporting on encounter data.

Claim Processing Time

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

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; and
- Unlisted procedure codes if sufficient information is not sent in the notes field.

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

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.
- We follow CMS NUCC Manual guidelines for placement of data for both CMS 1500 and UB04.

The health plan does not accept span dates for these types of claims.
Payment Policies and Tools

Reimbursement Policies

To align with federal mandates regarding enforcement of CCI and Fraud, Waste and Abuse Prevention tools, the health plan performs coding edit procedures.

These program integrity activities are referred to as reimbursement policies.

Reimbursement policies are based on external sourcing including:

- CMS National CCI.
- CMS National/Local Coverage Determinations (NCDs/LCDs).
- Specialty Societies including, but not limited to:
  - American Society of Anesthesiologists (AMA).
  - American College of Cardiologists (ACC).
  - American College of Obstetrics and Gynecology (ACOG).
  - National Physician Fee Schedule (NPFS)/ Relative Value File.

Reimbursement policies are available online at: [UHCCommunityPlan.com](http://UHCCommunityPlan.com). Reimbursement policies may be referred to in your agreement with UnitedHealthcare as “payment policies.”

UnitedHealthcare may revise/update or add to these policies on occasion. As a participating care provider, you agree to abide by these policies. UnitedHealthcare is committed to notifying care providers who are impacted by policy changes/additions.

Payment of a claim is subject to our payment policies (reimbursement policies) and medical policies, which are available to you online or upon request to your Network Management contact.

NOTE: Policies do not cover all issues related to reimbursement for services rendered to UnitedHealthcare enrollees as legislative mandates, the physician or other care provider contract documents, the enrollee’s benefit coverage documents, and the Physician Manual all may supplement or in some cases supersede these policies.

Physician Claim-Editing Tools

UnitedHealthcare utilizes a customized version of the INGENIX Claim Edit System known as iCES Clearinghouse. iCES-CH is a clinical edit system application that analyzes health care claims based on business rules designed to automate UnitedHealthcare reimbursement policy and industry standard coding practices. Claims are analyzed prior to payment to validate billings in order to minimize inaccurate claim payments.

Facility Claim Editing

UnitedHealthcare utilizes the Ingenix Facility Editor® for claims for outpatient and inpatient services provided to Medicaid beneficiaries. The Facility Editor is a rules-based software application that evaluates claims data for validity and reasonableness. The edits are based on CCI guidelines and other CMS rules established for government programs.

Outpatient Code Edits

These reasonableness tests incorporate the Outpatient Code Edits (OCE) developed by the Centers for Medicare and Medicaid Services (CMS) for hospital outpatient claims. The Facility Editor is used to examine outpatient facility-based claims prior to payment to validate billings in order to minimize inaccurate claim payments.
The CMS OCE edits that are applied by the Facility Editor include:

1. Basic field validity screens for patient demographic and clinical data elements on each claim;

2. Effective-dated ICD-10-CM, CPT-4 and HCPCS Level II code validation, based on service dates and patient clinical data;

3. Facility-specific National CCI edits. The NCCI edits identify pairs of codes that are not separately payable, except under certain circumstances. NCCI edits were developed for use by all health care providers; the Facility Editor incorporates those NCCI edits that are applicable to facility claims. The NCCI edits in the Facility Editor are applied to services billed by the same hospital for the same beneficiary on the same date of service. There are two categories of NCCI edits: (a) Comprehensive code edits, which identify individual codes, known as component codes, which are considered part of another code and are designed to prevent unbundling; and (b) Mutually exclusive code edits, which identify procedures or services that could not reasonably be performed at the same session by the same care provider on the same beneficiary; and

4. Other OCE edits for inappropriate coding, including incorrect coding of bilateral services, evaluation and management services, incorrect use of certain modifiers, and inadequate coding of services in specific revenue centers are also included in the Facility Editor.

**Inpatient Code Edits:**

The inpatient editing rule sets are also developed by the CMS for hospital inpatient claims. As with the outpatient edits, the claims-editing tool reviews claims prior to payment to validate billings to minimize inaccurate claims payments.

The inpatient edits are sourced to:

Medicare Code Editor (MCE), which include (but are not limited to) the following edit rules:

**Data Validation Edits.**

- Age and Gender to Diagnosis/Procedure Edits.
- Coding Convention Edits.
- E-Codes and Manifestations Code Edits.
- Medicare Coding Guideline Edits.
- Medicare Coverage Edits.

UnitedHealthcare updates/enhances these rules on occasion to align with federal and state mandates and notifies providers when changes materially impact reimbursement.

UnitedHealthcare administers professional claims only for MississippiCAN. As a reminder, inpatient facility claims should be filed directly to Medicaid for processing.

**Medicaid ID Edit:**

An enhanced denial edit ensures that no payments are made to care providers without a MS Medicaid ID on file. If your claims have denied due to missing Medicaid ID and you have a current MS Medicaid ID, please contact Provider Services' hotline at 877-743-8734 so that we can facilitate updating your records and adjusting applicable claims.

If you do not have a current MS Medicaid ID, a Provider Enrollment application can be found at:

[msmedicaid.acs-inc.com/msenvision/index.do](msmedicaid.acs-inc.com/msenvision/index.do)

**Tax Identification Numbers/Provider IDs**

Please submit standard transactions using your tax identification number and your NPI. To help 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 our EDI Performance Team at 800-210-8315 or email [AC_EDI_OPS@uhc.com](mailto:AC_EDI_OPS@uhc.com).
Coordination of Benefits

Coordination of Benefits (COB) is designed to avoid duplicate payment for covered services. COB is applied whenever the member covered by the health plan is also eligible for health insurance benefits through another insurance company. The contracting care provider agrees to cooperate with the health plan toward the effective implementation of COB procedures, including identification of services and individuals for which there may be a financially responsible party other than the health plan, and assist in efforts to coordinate payments with those parties.

How to file:

● When the health plan is primary, submit directly to us.
● When the health plan is secondary, submit to primary carrier first, then, submit the EOB with the claim to the health plan for consideration. EOBs can be submitted to the health plan electronically, in the Provider to Payer ANSI COB Model.

Refer to “Claims Submission Rules” in this manual.

● Secondary COB claims may be submitted if the following “required” fields are included on the electronic submission in the Provider to Payer ANSI COB Model.

   – **Professional**: Payer Paid Amount, Line Level Allowed Amount, Patient Responsibility, Line Level Discount Amount (Contractual Discount Amount of Other Payer), Patient Paid Amount (amount that the payer paid to the member not the provider).

   – **Dental**: Payer Paid Amount, Patient Responsibility Amount, Discount Amount (Contractual Discount Amount of Other Payer), Patient Paid Amount (amount that the payer paid to the member not the provider).

Electronic Claims Submission and Billing

All documents, frequently asked questions and other information regarding electronic claims submission can be found at EDI Education for Electronic Transactions site, or you may call 800-842-1109.

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

● Our Payer ID is 87726.
● All claims are set up as “commercial” through the clearinghouse regardless of product, Medicaid, Medicare or commercial.
● Clearinghouse Acknowledgement Reports and Payer specific Acknowledgment Reports identifying claims failing to successfully transmit electronically.

Importance and 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 health plan. Acknowledgement reports show you the status of your electronic claims after each transmission. By analyzing these reports, you know if your claims have reached the health plan for payment or if it has been rejected for an error or additional information.
You MUST review your reports, clearinghouse acknowledgement reports and the health plan’s status reports to eliminate processing delays and timely filing penalties for claims that have not reached the health plan.

**How do I get these reports?**

Your software vendor is responsible for establishing your connectivity to our clearinghouse 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 the health plan according to contract terms because this can differ by contract, the CLAIM WILL BE CONSIDERED LATE BILLED and denied as not allowed for timely filing.

**EDI Companion Documents**

The health 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 Documents are located on our website at UHCCCommunityPlan.com.

The health plan utilizes the companion guides to:

- Clarify data content that meets the needs of the health plan’s business purposes when the IG allows multiple choices.
- Outline which situational elements the health 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 the health plan makes information available on various transactions, we 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 are included in Change Summary located in each section of the Companion Document.

**e-Business Support**

Our interactive voice response (IVR) telephone system is available to members 24 hours a day, seven days a week, as well as our Nurse triage hotline for health-related issues.

- EFT – EFT enrollment forms are located at UHCCCommunityPlan.com. For electronic fund transfer, please contact our e-Business support at: Phone: 800-210-8315
Contacting your software vendor and/or clearinghouse prior to contacting UnitedHealthcare should be considered.

**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 eliminates the need for an itemized bill and allow electronic submission.

**Effective Date/Termination Date**

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

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

**Overpayments**

If an overpayment has been made, please include reference to the claim number or member ID and date of service. The best way to handle a potential overpayment is to call Customer Service. The health plan claim processing system automatically deducts any overpayment made from the next remittance advice. If an overpayment is identified, contact Customer Service. Customer Service will submit an overpayment request. Checks should not be sent to the health plan for overpayment-related issues unless specifically requested.

**Subrogation**

The health plan does not override timely filing denials based on decisions received from third-party carriers on subrogation or workers’ compensation claims. At the time of service, please submit all claims to the health plan for processing.

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

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

**Care Provider/Member Cost Sharing Responsibilities**

No copayments, deductibles or other cost sharing is allowed for MississippiCAN members. Care providers also may not charge members for missed appointments.

**Timely Filing and Late Bill Criteria**

Effective for dates of service on and after 7/1/2014, timely filing limit is 180 days from date of service.

**Claim Reconsideration Requests**

If you believe the claim you submitted to us was not paid correctly, the first step in addressing your concern is to submit a Claim Reconsideration.

- The quickest way to submit a Claim Reconsideration request is online. Go to [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) > Claims & Payments > Claim Reconsideration.
- Please identify the specific claims in “paid” or “denied” status which you believe should be adjusted and give a description of the requested adjustment.
• The Claim Reconsideration Form can also be mailed to the following address:

UnitedHealthcare
P.O. Box 5032
Kingston NY 12402-5032.

• You can view other important information on Claims Reconsiderations on the cover sheet and information sheet that accompanies the form on the website. The information sheet also explains the reasons and definitions for submitting the requested information we need to complete the claim reconsideration request.

• Alternatively, you can call the Customer Care number to request an adjustment for a claim that does not require written documentation.

• If you have a request involving 20 or more paid or denied claims, aggregate these claims on the Claim Project online form and submit the form for research and review. Go to UnitedHealthcareOnline.com > Claims & Payments > Claim Research Project.

Refer to page 36 for a summary of how UnitedHealthcare Community Plan handles complaints, grievances, and appeals. Please call the Provider Services helpline at 877-743-8734 to initiate any requests for resolution of complaints.

Resolving Disputes

Agreement concern or complaint

If you have a concern or complaint about your relationship with us, send a letter containing the details to the address listed in your agreement with us. A representative will look into your complaint and try to resolve it through an informal discussion. If you disagree with the outcome of this discussion, an arbitration proceeding may be filed as described below and in your agreement with us.

If your concern or complaint relates to a matter involving UnitedHealthcare administrative procedures, such as the credentialing, notification, or appeal processes described in this Guide, we follow the dispute procedures set forth to resolve the concern or complaint. After following those procedures, if the care provider remains dissatisfied, an arbitration proceeding may be filed as described below and in our agreement.

If we have a concern or complaint about your agreement with us, we’ll send you a letter containing the details. If we cannot resolve the complaint through informal discussions with you, an arbitration proceeding may be filed as described in your agreement with us.

Arbitration proceedings are held at the location described in your agreement with us or if a location is not specified in your agreement, then at a location as described in the Arbitration counties by location section.

Care Provider Appeals

A care provider may appeal a denial or other adverse determination within 30 calendar days from formal notice.

To expedite the processing of Provider Appeals, please utilize the Provider Appeal Form located at uhccommunityplan.com/assets/MS_Appeal_Form.pdf

Completed Appeal Forms should be submitted to the following address:

P.O. Box 5032
Kingston, NY 12402-5032

UnitedHealthcare will issue a written determination within 30 calendar days of receipt of a written appeal. Upon receipt of notice of an appeal denial from UnitedHealthcare, a care provider may appeal the determination to the Division of Medicaid.
The Correct Coding Initiative

The health plan performs coding edit procedures, based primarily on the CCI and other nationally recognized and validated sources. The health plan continues to develop and apply additional edits as necessary to implement program integrity initiatives in response to current circumstances and requirements.

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 that 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 edit your claims prior to submission. Your CPT and ICD-10 vendor probably offers a version of the CCI manual, and many specialty organizations have comprised their own publications geared to address specific CCI issues within the specialty. CMS’s authorized distributor of CCI information is the U.S. Department of Commerce’s National Technology Information Service, or NTIS. They can be reached at 800-363-2068, or on the web at ntis.gov.

Vaccines For Children (VFC) Billing

UnitedHealthcare provides 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 are provided through the Mississippi State Department of Health, which distributes vaccines to care providers who are willing to participate in the vaccine program.

The cost of the vaccine is not billed to UnitedHealthcare. The only cost associated with
immunizations to be reimbursed under the contract shall be the cost to administer the vaccine. Vaccines may be administered by network care providers, including school-based nurses, by a non-participating care provider to whom UnitedHealthcare has referred the member or by the State Health Department. Care providers administering member vaccines must agree to participate in the State's Immunization Registry. UnitedHealthcare must reimburse these care providers in alignment with Medicaid policy (i.e. Fee-For-Service or Vaccines For Children Program). 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 shall submit a monthly report containing a list of care providers, their contact information, claimant information and corresponding vaccine administrations to the Mississippi State Department of Health.

**Member Identification Cards**

UnitedHealthcare 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.

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**Sample Member ID Card**

![Sample Member ID Card Image]

This card does not guarantee coverage. To verify benefits or to find a provider, visit the website www.uhccommunityplan.com or call.

**For Members:**
- NurseLine 24-7: 877-370-4009
- Medical Claim Address: P.O. Box 5032, Kingston, NY 12402-5032
- For use of non-participating providers, prior authorization is required: 1-866-604-3267

**For Providers:**
- www.uhccommunityplan.com 877-743-8734
- 11/02/2014
- Rights Reserved by UnitedHealthcare 2016
- Printed: 04/23/12
Role of the Primary Care Physician (PCP)

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 coverage 24 hours a day/seven days a week and backup coverage when he or she is not available.

UnitedHealthcare 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.

Women 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 checkups (twice a year), follow-up care if there is a problem and regular care during pregnancy.

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

Responsibilities of the PCP

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

- Offer access to office visits on a timely basis, in conformance with the standards outlined in the Timeliness Standards for Appointment Scheduling section of this Administrative Guide.
- Conduct a baseline examination during the member’s first appointment. This should occur within 90 days of a new member’s enrollment in UnitedHealthcare. The PCP should attempt to schedule this appointment if the new member fails to do so.
- Treat general health care needs of members. Use nationally recognized clinical practice guidelines as a guide for treatment of important medical conditions. Such guidelines are referenced on the UHCCommunityPlan.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, ahcpr.gov/clinic/uspstfix.htm.
- Make use of any member lists supplied by the health 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 877-743-8734.
- Give 30 days’ notice to terminate members.
- Provide all Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services to members up to 21 years.
- EPSDT services include:
  - A comprehensive unclothed physical exam
  - Comprehensive family/medical/developmental history
  - Immunization status, any shots that are needed
  - Lead assessment and testing
  - Necessary blood and urine screening
  - TB skin test
  - Developmental assessment
  - Nutritional assessment/counseling
  - Adolescent counseling
  - Vision testing/screening
  - Hearing testing/screening
  - Dental referral services
For proper reimbursement, PCP must remain current with all documentation required by the Division of Medicaid. Documentation may include, but is not limited to:

- EPSDT/Mississippi Cool Kids program enrollment
- Provider disclosures forms
- Self-attestation for incentive payments

- Screen members for behavioral health problems.
- Coordinate each member’s overall course of care.
- Be available personally to accept UnitedHealthcare members at each office location at least 16 hours a week.
- Be available to members by telephone 24 hours a day, seven days a week, or have arrangements for telephone coverage by another UnitedHealthcare participating PCP or an answering machine directing the member to a live voice.
- Respond to after-hour patient calls within 30-45 minutes for non-emergent symptomatic conditions and within 15 minutes for emergency situations.
- Educate members about appropriate use of emergency services.
- Contact members who are non-compliant with EPSDT services. Report repeated non-compliance to the DOM and UnitedHealthcare's Case Management office at 877-743-8731.
- Discuss available treatment options and alternative courses of care with members.
- Refer services requiring prior authorization to the Prior Authorization Department or pharmacy as appropriate.
- Inform UnitedHealthcare Case Management at 877-743-8731 of any member showing signs of End Stage Renal Disease.
- Admit UnitedHealthcare members to the hospital when necessary and coordinate the medical care of the member while hospitalized.
- Respect the Advance Directives of the patient and document in a prominent place in the medical record whether or not a member has executed an advance directive form.
- Provide covered benefits in a manner consistent with professionally recognized standards of health care and in accordance with standards established by UnitedHealthcare.
- Document procedures for monitoring patients’ missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records to other medical practitioners for the purpose of continuity of care within 10 business days of a request. Copies of members’ medical records must be provided to members upon request at no charge.
- Allow timely access to UnitedHealthcare member medical records as per contract requirements for purposes such as: medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA regulations.
- Maintain staff privileges at a minimum of one UnitedHealthcare participating hospital.
- Report infectious diseases, lead toxicity, and other conditions as required by state and local laws and regulations.
- Offer the same office hours to UnitedHealthcare Community Plan members as those offered to our commercial plan members.
- Members are able to change PCPs through a member-selected or contractor-reassignment process. This can be due to a variety of reasons including, but not limited to: when a care provider terminates relationship with UnitedHealthcare or Medicaid, when a member chooses to seek a new care provider, or a formal grievance or complaint is filed.
- For any reason, including panel size, if the PCP is unable to assume care for assigned member(s), the PCP should notify UnitedHealthcare via regular mail: UnitedHealthcare c/o Medical Director 795 Woodlands Parkway-Suite 301 Ridgeland, MS 39157
Responsibilities of Specialist Physicians

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

- Provide specialty care medical services to UnitedHealthcare members recommended by the member’s PCP.
- Provide the PCP copies of all medical information, reports, and discharge summaries resulting from the specialist’s care.
- Communicate in writing to the PCP all findings and recommendations for continuing patient care and note them in the patient’s medical record.
- Maintain staff privileges at a minimum of one UnitedHealthcare participating hospital.
- Report infectious diseases, lead toxicity, and other conditions as required by state and local laws and regulations.
- Offer the same office hours to UnitedHealthcare Community Plan members as those offered to our commercial plan members.

Member Notification of Termination

At least 15 calendar days prior to the effective date of your termination or your group’s termination from the network, MississippiCAN will send, via regular mail, notification to our affected members/your patients. Your affected patients/our members will include those MississippiCAN members for whom a claim was filed on your behalf or on behalf of your medical group within the six months prior to the effective date of termination or departure.

Medical Residents in Specialty Practice

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

Standards for Appointment Scheduling

<table>
<thead>
<tr>
<th>Type</th>
<th>Appointment Scheduling Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCPs (well care visit)</td>
<td>Not to exceed 30 calendar days</td>
</tr>
<tr>
<td>PCP (routine sick visit)</td>
<td>Not to exceed seven calendar days</td>
</tr>
<tr>
<td>PCP (Urgent Care visit)</td>
<td>Not to exceed 24 hours</td>
</tr>
<tr>
<td>Specialists</td>
<td>Not to exceed 45 calendar days</td>
</tr>
<tr>
<td>Dental Providers (routine visit)</td>
<td>Not to exceed 45 calendar days</td>
</tr>
<tr>
<td>Dental Providers (Urgent Care)</td>
<td>Not to exceed 48 hours</td>
</tr>
<tr>
<td>Behavior Health Providers (routine visit)</td>
<td>Not to exceed 21 calendar days</td>
</tr>
<tr>
<td>Behavior Health Providers (urgent visit)</td>
<td>Not to exceed 24 hours</td>
</tr>
<tr>
<td>Behavior Health Providers (post-discharge from an acute psychiatric hospital when the contractor is aware of the member’s discharge)</td>
<td>Not to exceed seven calendar days</td>
</tr>
<tr>
<td>Urgent Care Providers</td>
<td>Not to exceed 24 hours</td>
</tr>
<tr>
<td>Emergency Providers</td>
<td>Immediately (24 hours a day, seven days a week) and without Prior Authorization</td>
</tr>
</tbody>
</table>
Timeliness Standards for Notifying Members of Test Results

Care providers should notify members of laboratory or radiology test results within 24 hours of receipt of results in urgent or emergent cases. Care 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

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

Care 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 are available to care providers that qualify as small businesses (up to 30 FTE employees or less than $1 million gross revenue). Tax credits are available for "access expenditures" ranging from $250 to $10,250 and tax deductions are available up to $15,000 per year for expenses associated with the removal of barriers. For more information, the Provider Relations Advocate 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 Advocate may perform a site visit before care can be rendered at the new location.

Care providers are expected to provide family-centered care. As such, interpretive and language assistance services may be necessary. If the care provider is unable to provide necessary services, UnitedHealthcare’s Member Services can help at no cost to members. For interpretation assistance, at least 72 hours before a scheduled appointment, please call 877-743-8731, TTY: 711. Sign language services require a two week notice.
Medical Record Charting Standards

All participating UnitedHealthcare providers are required to maintain medical records in a complete and orderly fashion which promotes efficient and quality patient care. As part of this process care providers are required to participate in UnitedHealthcare’s quality review of medical records and meet the following requirements for medical record keeping.

<table>
<thead>
<tr>
<th>Confidentiality</th>
</tr>
</thead>
<tbody>
<tr>
<td>● The office has a policy and procedure in place that addresses the confidentiality of the patient medical record.</td>
</tr>
<tr>
<td>● Office staff receive initial and periodic training in maintaining the confidentiality of patient records.</td>
</tr>
<tr>
<td>● Medical records are released only to the patient and/or entities as designated in accordance with HIPAA regulations.</td>
</tr>
<tr>
<td>● Medical records are stored in a manner that ensures patient confidentiality. Records are kept in a secure area which is only accessible to authorized personnel.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organization</th>
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</thead>
<tbody>
<tr>
<td>● Medical records are filed in a manner in which they are easily retrievable.</td>
</tr>
<tr>
<td>● Medical records are readily available to the treating physician whenever the patient is seen at the site where they generally receive care.</td>
</tr>
<tr>
<td>● Medical records are sent promptly to specialty care providers upon patient request. For urgent issues, records are made available within 48 hrs.</td>
</tr>
<tr>
<td>● There is a policy for medical record retention.</td>
</tr>
<tr>
<td>● The contents of medical records must be organized in such a manner that reports, problem lists, immunization records, etc. are easily retrievable and are located in the same area in each record.</td>
</tr>
<tr>
<td>● There is one medical record per patient.</td>
</tr>
<tr>
<td>● Pages in the medical record are secure.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Record Documentation Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>● The chart is legible.</td>
</tr>
<tr>
<td>● The chart contains at a minimum the following patient identifiers: name, sex, address, phone # and DOB.</td>
</tr>
<tr>
<td>● The patient name/ID # is located on each page of the medical record.</td>
</tr>
<tr>
<td>● Each entry is dated and signed by the treating practitioner(s).</td>
</tr>
<tr>
<td>● An initial history and physical is present.</td>
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<tr>
<td>● Documentation of the presence or absence of allergies or adverse reactions is clearly noted.</td>
</tr>
<tr>
<td>● Screenings for high risk behaviors such as drug, alcohol and tobacco use are present.</td>
</tr>
<tr>
<td>● Screening for behavioral health issues including depression.</td>
</tr>
<tr>
<td>● Documentation of the presence or absence of an executed Advanced Directive.</td>
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<tr>
<td>● An updated Problem List includes medical and psychological conditions.</td>
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<tr>
<td>● A Medication List includes current and past meds.</td>
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<tr>
<td>● Progress notes from each visit that document the reason for the visit, the physical findings, the diagnosis, and treatment plan.</td>
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<tr>
<td>● Documentation of need for follow-up visits.</td>
</tr>
<tr>
<td>● Documentation of member input and/or understanding of the treatment plan.</td>
</tr>
<tr>
<td>● Documentation that reflects compliance with EPSDT standards for all pediatric patients.</td>
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<tr>
<td>● Maintenance of a current immunization record for all pediatric patients.</td>
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<tr>
<td>● Tracking and referral for age appropriate preventive health screenings such as mammography, pap smears, colorectal screen and flu shots are noted.</td>
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<tr>
<td>● Appropriate use of lab testing (HbA1c, LDL, lead screen).</td>
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<tr>
<td>● Results of lab, X-ray, and other tests as ordered by the practitioner including indication of physician review.</td>
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<tr>
<td>● Notation of treating specialists (including behavioral health) as well as copies of consultant reports ordered by the practitioner.</td>
</tr>
<tr>
<td>● Continuity of care demonstrated by evidence of copies of Home Health Nursing reports, Hospital Discharge summaries, Emergency Room visits, and physical or other therapies as ordered by the practitioner.</td>
</tr>
<tr>
<td>● Use of Clinical Practice Guidelines or flowsheets for the management of chronic conditions (diabetes, asthma, etc.).</td>
</tr>
<tr>
<td>● Mechanism for tracking and management of no shows.</td>
</tr>
</tbody>
</table>
Screening and Documentation Tools

Most of these tools were developed by UnitedHealthcare with assistance from the Provider Advisory Committee (PAC) to help you comply with regulatory requirements and practice in accordance with accepted standards.

Medical Record Review

On a routine basis, UnitedHealthcare conducts a review of the medical records you maintain for our members. Physicians are expected to achieve a passing score of 85 percent or better. Medical records should include:

Initial health assessment, including a baseline comprehensive medical history, which should be completed in less than two visits and documented, and ongoing physical assessments documented on each subsequent visit.

- Problem list, includes the following documented data:
  - Biographical data, including family history.
  - Past and present medical and surgical intervention.
  - Significant illnesses and medical conditions with dates of onset and resolution.
  - Documentation of education/counseling regarding HIV pre- and post-test, including results.

- Entries dated and the author identified.
- Legible entries.

- Medication allergies and adverse reactions are prominently noted. Also note if there are no known allergies or adverse reactions.

- Past medical history is easily identified and includes serious illnesses, injuries and operations (for patients seen three or more times). For children and adolescents (18 years or younger), past history relates to prenatal care, birth, operations and childhood illnesses.

- Medication record includes name of medication, dosage, amount dispensed and dispensing instructions.

- Immunization record.

- Document tobacco habits, alcohol use and substance abuse (12 years and older).

- Copy of Advance Directive, or other document as allowed by state law, or a notation that patient does not want one.

- History of physical examination (including subjective and objective findings).

- Unresolved problems from previous visit(s) addressed in subsequent visits.

- Diagnosis and treatment plans consistent with findings.

- Lab and other studies as appropriate.

- 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 initiated by primary physician to indicate review.

- Consultation and abnormal studies including follow-up plans.

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 mental health assessment (CAGE, TWEAK).
Medical Record Documentation Standards Audit Tool

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Provider ID#:</th>
<th>Provider Specialty:</th>
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<tbody>
<tr>
<td>Reviewer Name:</td>
<td>Review Date:</td>
<td>Score</td>
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<table>
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<tr>
<th>Member Initials/DOB:</th>
<th>Member ID#:</th>
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<table>
<thead>
<tr>
<th>Confidentiality and Record Organization and Office Procedures</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tbody>
<tr>
<td>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).</td>
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<td>2. Staff are trained in medical record confidentiality.</td>
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<tr>
<td>3. The office uses a Release of Information form that requires patient signature.</td>
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<td>4. There is a policy for timely transfer of medical records to other locations/providers.</td>
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<td>5. There is an identified order to the chart assembly.</td>
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<td>6. Pages are fastened in the medical record.</td>
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<td>7. Each patient has a separate medical record.</td>
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<td>8. Medical records are stored in an organized fashion for easy retrieval.</td>
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<tr>
<td>9. Medical records are available to the treating practitioner where the member generally receives care.</td>
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<td>10. Medical records are released to entities as designated consistent with federal regulations.</td>
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<tr>
<td>11. Records are stored in a secure location only accessible by authorized personnel.</td>
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<td>12. There is a mechanism to monitor and handle missed appointments</td>
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### Procedural Elements

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The medical record is legible.*</td>
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<td>2. All entries are signed and dated.</td>
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<td>3. Patient name/identification number is located on each page of the record.</td>
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<td>4. Medical records contain patient demographic information.</td>
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<td>5. Medical record identifies primary language spoken and any cultural or religious preferences if applicable.</td>
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<tr>
<td>6. Adults 18 and older, emancipated minors, and minors with children have an executed advance directive in a prominent part of the medical record.</td>
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<tr>
<td>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.</td>
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<td>7. A problem list includes significant illnesses and active medical conditions.</td>
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<tr>
<td>8. A medication list includes prescribed and over-the-counter medications and is reviewed annually.</td>
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<td>9. The presence or absence of allergies or adverse reactions is clearly displayed.</td>
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### History

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>1. Medical and surgical history is present.</td>
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<td>2. The family history includes pertinent history of parents and/or siblings.</td>
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<td>3. The social history minimally includes pertinent information such as occupation, living situation etc.</td>
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<tr>
<td>Preventative Services</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Yes</td>
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<tr>
<td>1. Evidence of current age appropriate immunizations.</td>
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<td>2. Annual comprehensive physical (or more often for newborns).</td>
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<td>3. Documentation of mental and physical development for children and/or cognitive functioning for adults.</td>
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<td>4. Evidence of depression screening.</td>
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<td>5. Evidence of screening for high risk behaviors such as drug, alcohol and tobacco use, sexual activity, exercise and nutrition counseling.</td>
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<td>6. Evidence that Medicare patients are screened for functional status and pain.</td>
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<td>7. Evidence of tracking and referral of age and gender appropriate preventive health services.</td>
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<tr>
<td>8. Use of flow sheets or tools to promote adherence to Clinical Practice Guidelines/Preventative Screenings.</td>
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<tr>
<td>9. A medication list includes prescribed and over-the-counter medications and is reviewed annually.</td>
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<table>
<thead>
<tr>
<th>Problem Evaluation and Management</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Documentation for each visit includes:</td>
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<tr>
<td>1. Appropriate Vital Signs (e.g., Weight, height, BMI measurement annually).</td>
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<td>2. Chief complaint.</td>
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<td>4. Diagnosis.</td>
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<td>5. Treatment plan.</td>
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<tr>
<td>Treatment plans are consistent with evidence-based care and with findings/diagnosis.</td>
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<tr>
<td>6. Appropriate use of referrals/consults, studies, tests.</td>
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<tr>
<td>7. X-rays, labs, consultation reports are included in the medical record with evidence of practitioner review.</td>
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<tr>
<td>Problem Evaluation and Management (cont’d)</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Yes</td>
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<td>8. Timeframe for follow-up visit as appropriate.</td>
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<td>9. Follow-up of all abnormal diagnostic tests, procedures, X-rays, consultation reports.</td>
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<td>10. Unresolved issues from the first visit are followed-up on the subsequent visit.</td>
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<td>11. There is evidence of coordination of care with behavioral health.</td>
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<td>12. Education, including counseling is documented.</td>
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<td>13. Patient input and/or understanding of treatment plan and options is documented.</td>
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<td>14. Copies of hospital discharge summaries, home health care reports, emergency room care physical or other therapies as ordered by the practitioner are documented.</td>
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(Questions) (# N/A) (Adjusted # of Questions) (# Yes) (Adjusted # of Questions) (Score)

Note: For each of the first 3 charts there are a possible total of 34 questions.

If a provider scores less than 85 percent, 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 percent 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 percent the original calculation of that element will remain.

* Items are MUST PASS
Advance Directives

The member has the right to make health care decisions and to execute advance directives. An advance directive is a formal document, written by the member in advance of an incapacitating illness or injury.

There may be several types of advance directives available to a member. If completed, the member’s designee keeps the original. The care provider should be aware of and maintain in the patient’s medical record a copy of the member’s completed directive or health care proxy. The care provider should not send a copy to UnitedHealthcare. Members are not required to initiate an advance directive or proxy and cannot be denied care if they do not have an advance directive. If a member believes that a care provider has not complied with an advance directive, he or she may file a complaint with the UnitedHealthcare Medical Director or Physician Reviewer.

Protect Confidentiality of Member Data

UnitedHealthcare members have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates who need that information to fulfill our obligations and to facilitate improvements to our members’ health care experience. We require our associates and business associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you as the holder of the medical records. You will comply with applicable regulatory requirements, including, but not limited to those relating to confidentiality of member medical information. You agree specifically to comply in all relevant respects with the applicable requirements of HIPAA and associated regulations, in addition to the applicable state laws and regulations. UnitedHealthcare uses member information for treatment, operations and payment. UnitedHealthcare has safeguards to prevent unintentional disclosure of PHI. This includes policies and procedures governing administrative and technical safeguards of protected health information. Training is provided to all personnel on an annual basis and to all new employees within the first 30 days of employment.
The UnitedHealthcare care provider education and training program is built on 27 years of experience with care providers and multi-state Medicaid-managed care programs and includes the following training components:

- Care provider website.
- Care provider forums/town hall meetings.
- Care provider office visits.
- Care provider newsletters and bulletins.
- Care provider manual.

**Care Provider Website**

UnitedHealthcare promotes the use of web-based functionality among its care provider population. UnitedHealthcare’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 has implemented an Internet-based prior authorization system on [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com), which allows care providers who have Internet access the ability to request their medical prior authorizations online rather than telephonically. The UnitedHealthcare website also contains an online version of the Provider Manual, the Provider Directory, the PDL (both searchable and comprehensive listing), clinical practice guidelines, quality and utilization requirements and educational materials such as newsletters, recent fax service bulletins and other care provider information. UnitedHealthcare 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.

**Care Provider Office Visits**

Provider Service Advocates visit PCPs, specialist and ancillary provider offices on a regular basis. Each Provider Service Advocate is assigned to a geographic territory to deliver face-to-face support to our providers across the state. The prioritization and quantity of care 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 produces and distributes a Provider Newsletter to the entire MississippiCAN 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 uses electronic bulletins, posted on the [UHCCommunityPlan.com](http://UHCCommunityPlan.com) website, to rapidly disseminate urgent information that impacts the entire network.

UnitedHealthcare publishes this manual 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 care provider resources and incentives. Care providers without Internet access may request a hard copy of the provider manual by contacting Provider Services.