Arizona Medicaid, Children’s Rehabilitative Services (CRS) and Division of Developmental Disabilities (DD)

Physician, Health Care Professional, Facility and Ancillary

Provider Manual
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Welcome

UnitedHealthcare Community Plan offers health benefits for people of every age and all walks of life under a variety of programs. In Arizona, we’ve offered Medicaid, Developmentally Disabled (DD), Children’s Rehabilitative Services (CRS) and Medicare Dual Special Needs Plan (SNP) benefits under the UnitedHealthcare Community Plan brand. As of Oct. 1, 2015, UnitedHealthcare Community Plan will also offer behavioral health services for members 18 years of age and older, who are enrolled in the Arizona Health Care Cost Containment System (AHCCCS) for both their Medicare A/B and Medicaid benefit coverage. Please see Chapter 8, section 3 for additional information.

UnitedHealthcare covers medical services for a growing number of Arizona’s population. Quality care providers are the key to delivering quality health care to members. In order to better assist care providers, UnitedHealthcare Community Plan has provided this manual as a resource to answer questions regarding care for enrolled members.

Background of UnitedHealthcare Community Plan

UnitedHealthcare has been serving the needs of Arizona’s medically underserved populations since the Arizona Health Care Cost Containment System (AHCCCS) program began in 1982. Since its inception, UnitedHealthcare has serviced various AHCCCS populations, including individuals with acute care, developmentally disabled, premium share, and Medicaid benefits in the Public Schools.

UnitedHealthcare is dedicated to providing high-quality services to medically and financially vulnerable individuals. In an effort to better assist care providers, UnitedHealthcare Community Plan has provided this manual as a resource to answer questions regarding care for enrolled members. UnitedHealthcare Community Plan’s membership results from contracts with AHCCCS and the Department of Economic Security, Division of Developmental Disabilities (DES/DDD). UnitedHealthcare is responsible for providing covered medical services for more than 300,000 eligible members throughout Arizona.

Effective April 1, 2014, UnitedHealthcare Community Plan transitioned to a new enrollment and claims system. This has affected the AHCCCS, Developmentally Disabled (DD), Children’s Rehabilitative Service (CRS), UnitedHealthcare Dual Complete and Dual Complete One programs. Our website, UHCCommunityPlan.com will still be available for all Prior Authorization Lists, Provider Forms, Bulletins, Reimbursement Policies and much more. However, all electronic functionality such as member eligibility and claims status, claims submissions and electronic remits will be available on UnitedHealthcareOnline.com for all electronic information and transactions such as patient eligibility and benefits, claims and payments. If you are not already registered on UnitedHealthcareOnline.com, you may do so directly on the website. Physicians and other health care professionals should continue to use UHCCommunityPlan.com for online administration for dates of service prior to April 1, 2014 enrollment and claims system transition. This provider manual has been updated with information as it was available and will continue to be updated through our transition.

The claims mailing address for paper claims will remain the same as will our payer ID number for electronic claim submissions.

UnitedHealthcare Community Plan
P.O. Box 5290
Kingston, NY 12402
Payer ID #: 03432

During and after the transition, for questions, please call Provider Services at 800-445-1638.

In 2015, UnitedHealthcare has implemented a second Medicare Advantage Special Needs Plan called UnitedHealthcare Dual Complete One (HMO SNP). This change will split the Dual Special Needs Plan into two plans. UnitedHealthcare Dual Complete will include those Qualified Medicare Beneficiaries (QMB) and dual-eligible members with both Medicare A & B with Medicaid benefits. UnitedHealthcare Dual Complete One includes QMB and dual-eligible members with both Medicare A & B with Long Term Care benefits under Medicaid.
UnitedHealthcare Community Plan Disclaimer

Care providers are contractually obligated to adhere to and comply with all terms of the plan and provider contract, including all requirements described in this manual in addition to all federal and state regulations governing the plan and the provider. While this manual contains basic information about Arizona Health Care Cost Containment System (AHCCCS), care providers are required to fully understand and apply AHCCCS requirements when administering covered services.

How to Join the UnitedHealthcare Community Plan Provider Network

If you are interested in joining the UnitedHealthcare Community Plan provider network, please note the following steps:

You must first register with AHCCCS before the credentialing process can begin. Please be sure to register with the same specialty and demographic information that you will provide when starting the credentialing process with UnitedHealthcare Community Plan. Please be aware that you are not reimbursed for any AHCCCS-covered services unless you are an AHCCCS-registered care provider.

For information on becoming an AHCCCS provider, please visit azahcccs.gov>Plans>Providers> NewProviders>& registration.html and choose Plan and Providers to register.

Once you have started the registration process with AHCCCS, you can start the credentialing process with UnitedHealthcare Community Plan by completing one of the following actions:

Credentialing with UnitedHealthcare Community Plan

UnitedHealthcare Community Plan is a participant of the Arizona Association of Health Plans (AzAHP), which utilizes the council for Affordable Quality Healthcare (CAQH) Universal Provider DataSource for all practitioner credentialing and re-credentialing applications.

Care providers need to complete the appropriate Data form (Practitioner or Organizational) found on our website at UHCComunityPlan.com under the Provider Forms section. Send the completed form and necessary attachments to UnitedHealthcare Community Plan via fax: 612-234-0211. New care providers and existing care providers are re-credentialed with the AzAHP credentialing process.

National Credentialing Line

You can also initiate the credentialing process by calling our National Credentialing line at 877-842-3210.

Note: Hospital-based physicians (radiologists, anesthesiologists, pathologists, emergency physicians, hospitalists, critical care physicians, and neonatologists) do not require credentialing so you must notify UnitedHealthcare via fax at 855-314-6844 of the new hospital-based physicians joining your group and provide the appropriate physician profile information. Once received, the process to add the physician to your group agreement will be started. Please wait for the notification of the contract effective date for your physician prior to him/her providing services to our members.

Note: Prior to contracting and credentialing, there needs to be established policies and procedures process in place that meet AHCCCS requirements; and the process by which the provider’s office reports incidences of Healthcare Acquired Conditions, abuse, neglect, exploitations, injuries and unexpected death to UnitedHealthcare Community Plan per the AHCCCS Medical Policy Manual (AMP). Note: All Allied Healthcare providers now require credentialing to be added to the Community Plan agreements as contracted.

If you provide services to any UnitedHealthcare member before the credentialing and contracting process is complete, prior authorization for these services is REQUIRED. If you do not request prior authorization before providing services to the UnitedHealthcare Community Plan member, your claim will be denied.

Once the physician has completed the credentialing process, our Physician Contract Support and Network Depiction Team (PCND) will initiate the contracting process to add the physician to your group agreement. Upon successful completion of the contracting process, a welcome letter with an effective date will be mailed.

Note: If you need to speak to a live person at any time for assistance with status or contracting, please feel free to call our Network Management Phone Team at 866-574-6088.

If any of the items listed below change during your time as a contracted provider with UnitedHealthcare Community Plan, please contact your contractor or the Network Management Phone Team for assistance and steps to be taken.

- Tax ID change*
  - Please ask for your assigned Network Manager’s contact information.
  - Terminate a provider from a contract
  - Terminations must be sent on letterhead paper.
  - Terminate an existing contract
  - Terminations must be sent on letterhead paper.

*Note: Tax ID changes may require a new contract or amendment. Please call your assigned Network Account Manager for contract assistance.

A Physician/Provider Demographic Fax Form is also available on our website at UHCComunityPlan.com under the Provider Forms section. The completed form can be faxed to 877-265-4877. All other maintenance (examples listed below) updates or changes can be directed to 866-523-6028.

- Address/location change or addition
- Phone number/fax number updates
**UnitedHealthcare Managed Care Philosophy**

UnitedHealthcare Community Plan’s managed care philosophy is to administer efficient, effective, and high-quality health care to our members through a network of independent, credentialed health professionals. **Primary Care Physicians** (PCPs) are the basis of care philosophy. UnitedHealthcare works with contracted PCPs who manage the health care needs of members as outlined in the UnitedHealthcare Managed Care Program. Understanding and adhering to these procedures is essential for successful participation as a UnitedHealthcare provider. UnitedHealthcare Community Plan’s Network Management Team will provide additional information if necessary. Training and education are also available to providers regarding the behavioral health referral and consultation process.

Contracted health care professionals are required to coordinate member care within the UnitedHealthcare provider network. If possible, all UnitedHealthcare member referrals should be directed to UnitedHealthcare contracted providers. Referrals outside of the network are permitted, but only with prior authorization from UnitedHealthcare. The referral and prior authorization procedure (Chapter 5) are particularly important to the UnitedHealthcare Managed Care Program. Understanding and adhering to these procedures is essential for successful participation as a UnitedHealthcare provider. UnitedHealthcare Community Plan’s Network Management Team will provide additional information if necessary. Training and education are also available to providers regarding the behavioral health referral and consultation process.

UnitedHealthcare offers additional services that are structured to support PCPs in providing appropriate provision of covered services to our members. These services include pre-admission education, prior authorization, concurrent review, discharge planning, case management, disease management, and prevention and wellness.

**Provider Resources**

UnitedHealthcare Community Plan manages a comprehensive provider network of independent practitioners and facilities across Arizona. The network includes health care professionals such as primary care physicians, specialist physicians, medical facilities, allied health professionals, and ancillary service providers. UnitedHealthcare Community Plan offers several options to support providers who require assistance.

**LINK**

LINK replaced the Optum Cloud Dashboard in 2015. LINK is your digital health information connection and includes a new interface that can assist providers and make online interactions and resources easier to use. You need an Optum ID to access LINK. Sign-in screens are available to help guide you through the process of obtaining an Optum ID.

LINK offers:

- Claims Management
- Claim Reconsideration
- Eligibility & Benefit Center
- Cost Share Information/Amounts
- Access to UnitedHealthcareOnline.com, UHCWest.com, UHCCommunityPlan.com and more

LINK training and additional information can be located on UnitedHealthcareOnline.com.

**UnitedHealthcareOnline.com Online Resources**

All online remits for UnitedHealthcare Community Plan members enrolled in Acute Medicaid, DD, CRS, UnitedHealthcare Dual Complete One will be accessible through UnitedHealthcareOnline.com. UnitedHealthcareOnline.com offers an innovative suite of online health care management tools. Use of this website is intended for approved Community Plan Providers, facilities and medical administrative staff and offers the convenience of online support 24-hours-a-day, 7-days-a-week and offers these electronic functions:

**UnitedHealthcareOnline.com:**

- Patient Eligibility and Benefits
- Claim Status
- Claim Reconsiderations
- Single EOB Search
- Claim Submissions
Chapter 1 Introduction

- Notifications/Prior Authorization Submission & Status
- Cardiology Notification Submission & Status
- Radiology Notification & Authorization Submission Status
- Reports
  1. PCP Panel Report
  2. Capitation (CAP) Report
  3. Claim Trends
  4. Provider Profile
  5. EPSDT (PDF)
  6. Preventative Health Measures
  7. Emergency Department (ED) Report
- Provider Directory
- Medical Policies

**UHCCommunityPlan.com**

- Provider Information
- Claims and Member Information
- Pharmacy Program
- Reimbursement Policy
- Newsletters
- Bulletins
- Medicare Part D Education Materials
- Provider Forms
- Billing and Reference Guides
- Cultural Practice Guidelines
- Clinical Practice Guidelines
- Electronic Data Interchange (EDI)
- Radiology (CPT Code List, Crosswalk Table, Prior Authorization List)

**UHCCommunityPlan.com Online Resources**

**UHCCommunityPlan.com** offers many online resources as well for our complex provider community. Providers can access Prior Authorization Lists, Referral Forms, Reimbursement Policies as well as Bulletins, Electronic Data Interchange Forms, companion guides and Pharmacy information online.

**Provider Service Center**

This is the primary point of contact for providers who require assistance. The Provider Service Center is staffed with Provider Service Representatives trained specifically for UnitedHealthcare. The Provider Service Center can assist you with questions on Medicaid benefits, eligibility, claims resolution, forms required to report specific services, billing questions, etc. and can be reached at 800-445-1638. The Provider Service Center works closely with all departments in UnitedHealthcare.

**Network Management Department**

Within UnitedHealthcare Community Plan, the Network Management Department is the point of contact for providers who require assistance with their contract, credentialing and in–services. The Network Management Department is staffed with Network Account Managers who are available for visits, contracting, credentialing, and specific issues in working with UnitedHealthcare.

**Cultural Competency Resources**

In order to assist our providers to better meet membership needs, UnitedHealthcare has developed a Cultural Competency Program. Linguistic and cultural barriers can negatively impact access to participation on health care. UnitedHealthcare offers the following support services:

- Language Interpretation Line – Use this service in your office free of charge for translation needs. You can access the language interpretation line by calling UnitedHealthcare Provider Services at 800-445-1638 or Member Services at 800-348-4058.
- Sign Language Interpreter in Tucson/Community Outreach Program for The Deaf (COPD). Please complete the service request form at [copolaz.org](http://copolaz.org).
- Valley Center of the Deaf (VCD) 602-267-1921 located in Phoenix and provides interpretation services for the rest of the state (outside of Tucson).
- Cultural competency in-service through a scheduled office training
- Pocket guide to culturally competent care
- Valley Center of the Deaf (VCD) is located in Phoenix and provides interpretation services for the rest of the state (outside of Tucson) 602-267-1921
- Culturally competent member materials – Materials designed to meet the needs of our members including simplified materials for members with limited English proficiency, additional languages for members who speak language other than English or Spanish, or alternative formats including materials for visually impaired members
- Member service language capacity

Care providers shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, national original or disability.

All care providers shall comply with Federal Regulations and State Executive Order (AAC R9-22-513 and No. 99-4), which mandates that all persons, regardless of race, color, religion, sex, nationals original or political affiliation, shall have equal access to employment opportunities, and all other applicable federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI.
The Division acts in accordance with contractual obligations, state and federal codes and laws, including the Civil Rights Act of 1964 Public Law § 88-352 which prohibits discrimination in government agencies.
Chapter 2 Provider Responsibilities

UnitedHealthcare Community Plan does not prohibit or otherwise restrict a health care professional from advising or advocating on behalf of a member who is his or her patient for the following:

• The members health status, medical care, or treatment options, including any alternative treatment that may be self administered.
• Any information the member needs in order to decide among all relevant treatment options.
• The risks, benefits, and consequences of treatment or non-treatment.

The member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

General Provider Responsibilities

UnitedHealthcare Community Plan’s contracted providers are responsible for:

• Verifying the enrollment and assignment of the member via UnitedHealthcare Community Plan roster, by going to AHCCCS Online, using the Interactive Voice Response (IVR), UnitedHealthcareOnline.com, MediFAX, or contacting Member Services prior to the provision of covered services. Failure to verify member enrollment and assignment may result in claim denial.
• Rendering covered services to UnitedHealthcare Community Plan members in an appropriate, timely, and cost-effective manner and in accordance with their specific contract and AHCCCS program requirements. See the Appointment Availability section.
• Maintaining all licenses, certifications, permits, or other prerequisites required by law to provide covered services, and submitting evidence that each is current and in good standing upon the request of UnitedHealthcare.
• Complete the required re-enrollment process in compliance AHCCCS guidelines as stated in 42 CFR 455, Subpart E.
• Rendering services to members who are diagnosed as being infected with the Human Immunodeficiency Virus (HIV) or having Acquired Immune Deficiency Syndrome (AIDS) in the same manner and to the same extent as other members, and under the compensation terms set forth in their contract.
• Informing all assigned AHCCCS pregnant women of voluntary prenatal HIV testing and the availability of medical counseling. Provide information as to where the member can go for testing.
• Meeting all applicable Americans with Disabilities Act (ADA) requirements when providing services to members with disabilities who may request special accommodations such as interpreters, alternative formats, or assistance with physical accessibility.
• Making a concerted effort to educate and instruct members about the proper use of the practitioner’s office in lieu of hospital emergency rooms. The practitioner shall not refer to direct members to hospital emergency rooms for non-emergent medical services at any time. If hospital emergency room utilization exceeds UnitedHealthcare determined standards of acceptance, UnitedHealthcare may deduct or recoup payments from the practitioner.
• Abiding by the UnitedHealthcare Community Plan referral and prior authorization guidelines found in Chapter 5 of this manual.
• Admitting members in need of hospitalization only to contracted hospitals unless: (1) prior authorization for admission to some other facility has been obtained from UnitedHealthcare; or, (2) the member’s condition is emergent and use of a contracted hospital is not feasible for medical reasons. The practitioner agrees to provide covered services to members while in a hospital as determined medically necessary by the practitioner or a medical director.
• Using contracted hospitals, specialists, and ancillary providers. A member may be referred to a non-contracted practitioner or provider only if the medical services required are not available through a contracted practitioner or provider and if prior authorization is obtained.
• Maintaining staff membership and admission privileges in good standing at one of the hospitals with which UnitedHealthcare has contracted or which UnitedHealthcare has identified as accepting UnitedHealthcare members for non-emergency admissions as long as prior authorization is obtained.
• Complying with UnitedHealthcare Quality Management and Health Services policies and procedures.
• Complying with federal regulations of the Occupational Safety and Health Administration (OSHA) including, without limitation, the regulations concerning Blood-Borne Pathogens Standards at 29 C.F.R. Part 1910.1030.
• Obtaining authorization from UHCCP for all hospital admissions.
• Providing culturally competent care and services. All providers must have a cultural competency program designed to educate and train its staff on addressing cultural and linguistic barriers to the delivery of health care services to members of all cultures.
Chapter 2 Provider Responsibilities

- Compliance with Health Insurance Portability and Accountability Act (HIPAA) provisions.
- Adhering to Advance Directives (Patient Self-Determination Act) The Federal Patient Self-Determination Act requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult members (age 21 and older) written information about their right to have an advance directive. Advance directives are oral or written statements either outlining a member’s choice for medical treatment or naming a person who should make choices if the member loses the ability to make decisions. Information about advance directives is included in the UnitedHealthcare Community Plan Member Handbook.

- Participating in monitoring processes. UnitedHealthcare Community Plan is required to monitor compliance with AHCCCS standards. Monitoring will be coordinated by the Quality Management, Health Services, Network Management, and Member Service departments. The results of the monitoring activities will be directed to the Chief Medical Officer or a designated medical director, the Credentialing Committee, and the Quality Provider Advisory Committee as appropriate.

- Report incidences of healthcare acquired conditions (HCAC), abuse, neglect, exploitation, injuries and unexpected death to UnitedHealthcare. Providers contracted with UHCCP must have established policies and procedures on site that meet AHCCCS requirements, and the process by which the provider, and their staff, report incidences listed above. Reports can be made to UHCCP with supporting documentation via the contact below:
  - Mail Supporting documentation to alleged fraud and abuse to:
    UnitedHealthcare Community Plan
    ATTN: Compliance/Fraud and Abuse
    1 East Washington, Suite 900
    Phoenix, AZ 85004

- For non-Community Plan members, complete the form on the AHCCCS-OIG website at [azahcccs.gov>Fraud>ReportFraud](https://azahcccs.gov/Fraud/ReportFraud) within one business day and submit all documentation that would assist AHCCCS in its investigation.

- As a registered provider with the AHCCCS Administration, you are obligated under 42 C.F.R. §1001.1901(b), to screen all employees, contractors, and/or subcontractors to determine whether any of them have been excluded from participation in federal health care programs. You can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE, and can be accessed at [oig.hhs.gov/fraud/exclusions.asp](https://oig.hhs.gov/fraud/exclusions.asp).

- Providers are responsible for coordinating member behavioral health care and services with Regional Behavioral Health Authority (RBHA) system as needed.

Provider Privileges

In order to help our members get access to appropriate care and to help minimize out-of-pocket costs, providers must have privileges at applicable participating facilities or arrangements with a participating practitioner to admit and provide facility services. This includes, but is not limited to, full admitting privileges, ambulatory surgery center privileges, and/or dialysis center privileges.

Primary Care Physicians (PCPs) and Primary Care Obstetricians (PCOs) Responsibilities

Female members shall have direct access to contracted GYN providers, including physicians, physician assistants, nurse practitioners and midwives within the scope of their practice, without a referral.

If a member’s pregnancy is confirmed by a PCO, the PCO is required to notify UnitedHealthcare Community Plan Health First Steps at 800-599-5985 to initiate a PCO reassignment. The ACOG form needs to be faxed to Healthy First Steps at 877-353-6913 immediately after the initial OB visit. The member’s PCO effective date will be the date the completed ACOG form is received. A PCO’s
failure to notify UnitedHealthcare Community Plan (UHCCP) of this reassignment may result in delay or denial of reimbursement. The date of the PCO assignment is the effective date of the transfer of care from the PCP to the PCO. PCOs are responsible for coordinating a member’s care until the first day of the first month following the 60th day after delivery or termination of pregnancy.

EPSDT services for pregnant members younger than 21 should be performed by the assigned PCO or Perinatologist. UnitedHealthcare Community Plan’s contracted Primary Care Physicians (PCP) and Primary Care Obstetricians (PCO) are responsible for:

- Physicians and practitioners must follow the American College of Obstetricians and Gynecologists standards of care, including the use of a standardized medical risk assessment tool and ongoing risk assessment.
- Providing or arranging for covered services as defined in their contract with UnitedHealthcare, including emergency medical services to members on a 24-hour per-day basis, 7-days per week.
- Providing to members:
  - Office visits during regular office hours
  - Office visits or home visits during non-office hours as determined medically necessary
- Scheduling time-specific appointments for routine medically necessary care within 21 days of a member’s request, within two days for urgent care and on the same day for emergency care.
- Ensuring that members’ waiting time at the PCP’s or PCO’s office does not exceed 45 minutes for scheduled appointment, unless the PCP or PCO is unavailable due to an emergency.
- Initiating and following through on appropriate referrals to Children’s Rehabilitation Services (CRS) for all members up to age 21 who have been diagnosed with medically eligible CRS conditions.
  - Additional information related to CRS conditions and treatment can be located in Chapter 7.
- Coordinating the provision of covered services to members by:
  - Counseling members and their families regarding members’ medical care needs, and advance directives
  - Monitoring progress, care, and managing utilization of specialty services to facilitate the return of care to the PCP as soon as medically appropriate
- Providing preventive health services in accordance with AHCCCS Medical Policy Manual (AMPM). The preventive health services shall include, but not be limited to, periodic health assessments, immunization, and tuberculosis screening (but not immunizations solely for travel), and other measure for the prevention and detection of disease, including instruction in personal healthcare measures and information on proper and timely use of appropriate medical resources provided by or through UHCCP.
- Compensating any physician, who upon the request of the PCP, provides covered services that are included under the PCP capitation payment from UHCCP
- Participating in the Individual Service Planning (ISP) process with the DES/DDD representative, particularly for medically involved DD/ALTCS members
- Participating in UHCCP quality studies
- Participating in and enrolling annually in the Vaccine for Children (VFC) program unless the member panel includes only members 19-years-of-age or older

Note: The AHCCCS Maternity Care Risk Screening Guidelines can be located at in Chapter 400 of the AHCCCS Medical Policy Manual, Exhibit 410-2

Additional PCO Responsibilities

- Scheduling medically necessary care appointments for enrolled pregnant members to obtain initial and ongoing prenatal care within the time frames as stated in this manual under Appointment Standards, Chapter 2
- Coordinating covered services for members
- Counseling members and their families regarding members’ medical care needs, including family planning and advance directives
- Initiating medically necessary referrals for specific covered services to contracted health care practitioners or providers
- Monitoring progress, care and managing utilization of services to facilitate the return of care to the PCP within 60 days after delivery.
- Scheduling time-specific office visits during an uncomplicated pregnancy based upon the recommended standards from the American College of Obstetrics and Gynecology (ACOG).
- Maintaining responsibility for care until the first day of the first month following the 60th day after delivery with a minimum of one postpartum visit at approximately six weeks postpartum. Patients at high risk shall have a return visit scheduled appropriate to their individual need.
Chapter 2 Provider Responsibilities

• Adhering to reproductive health and wellness guidelines contained within UHCCP Policies and Procedure, such as screening members for perinatal and postpartum depression at least once during the pregnancy and then repeated at the postpartum visit. If a positive screening is obtained, referring the member to the appropriate behavioral health provider for services. The PCO will share health information about lifestyle habits that promote healthy pregnancies, including spacing of births and smoking cessation.

• Educate members regarding potential complications and adverse outcomes related to cesarean sections and elective inductions prior to 39 weeks gestation.

• Referring members for support services to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), as well as other community-based resources, to support healthy pregnancy outcomes. If a member loses eligibility, the member must be notified where they may obtain low-cost or no-cost maternity services.

• Educate members regarding potential complications and adverse outcomes related to cesarean sections and elective inductions prior to 39 weeks gestation.

• Referring members for support services to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), as well as other community-based resources, to support healthy pregnancy outcomes. If a member loses eligibility, the member must be notified where they may obtain low-cost or no-cost maternity services.

• Cooperating with Healthy First Steps, the Maternity Program and/or other perinatal support programs that may be authorized by UnitedHealthcare Community Plan.

• Upon the member’s first prenatal office visit, fax the OB clinical record as a referral to UnitedHealthcare Community Plan Healthy First Steps program. Referrals can be made by faxing any of the following forms to the Healthy First Steps fax number: 877-353-6913.
  • ACOG prenatal forms pages 1 and 2
  • Other prenatal forms that sufficiently document past and present medical, psychosocial and obstetrical history
  • Any other OB Risk Assessment or OB Notification form to Healthy First Steps Referral Fax Number 877-353-6913

• Follow UnitedHealthcare Global Billing Guidelines for Obstetrical services, which may be found on the UnitedHealthcare website, UHCCommunityPlan.com under the Health Professionals tab in Reimbursement Policies section. You may find a detailed guideline in the Bulletins section, or request a copy from your provider advocate.

Perinatology Referrals

A PCO or PCP may refer a member to a contracted Perinatologist when identifying a high risk need.

The PCO or PCP may transfer the member's care to a Perinatologist by calling Provider Customer Service for reassignment.

Once the transfer of care is completed, the Perinatologist becomes the member’s PCO and is responsible for the member's care for the duration of the pregnancy and 60 days postpartum.

PCP and PCO Checklist

PCPs and PCOs should follow the following steps when providing services to UnitedHealthcare members:

• Check PCP/PCO/PCPN member roster, IVR, MediFAX, Provider Portal, AHCCCS Online or call the UnitedHealthcare Community Plan Provider Service Center 800-445-2638 to verify eligibility.

• Call Healthy First Steps 800-599-5985 if the member is not on your member eligibility roster. If needed, the member may be directly assigned to your panel.

• Verify member identity with photo identification

• Collect a co-payment from the member for services rendered in the PCP office if a co-payment is appropriate per Chapter 3 of this manual. (DD/ALTCS members do not pay co-payments for services as indicated on their ID card unless they have primary insurance.)

• Obtain prior authorization from UnitedHealthcare, if required, refer to Chapter 5. Initiation of maternity care does not require Prior Authorization for UHCCP contracted PCO.

• Refer to UHCCP contracted specialists unless otherwise authorized by UnitedHealthcare.

• Identify and appropriately bill other insurance carriers, including Medicare.

• Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 paper claim form. Refer to Chapter 13 of this manual for billing procedures.

• Document immunization services in the Arizona State Immunization Information System (ASIIS).

• Follow UnitedHealthcare Global Billing Guidelines for Obstetrical services, which may be found on the UnitedHealthcare Website, UHCCommunityPlan.com under the Health Professionals tab in Reimbursement Policies section, a detailed Guideline is also available in the Bulletins section or you may request a copy.
Licensed Midwife Services

UnitedHealthcare Community Plan covers maternity care and coordination services provided by contracted licensed midwives. The members must have an uncomplicated prenatal course and an expected low-risk labor and delivery. Members who choose to receive maternity services from this provider type must meet eligibility and medical criteria specified in the AHCCCS Medical Policy Manual, Chapter 400, Policy 410.

Risk status must initially be determined during the first visit, and evaluated at each trimester thereafter using the current standardized assessment criteria and protocols for high risk pregnancies outlined by the American College of Obstetrics and Gynecology or Mutual Insurance Company of Arizona. A new risk assessment must be completed if a new complication or concern is identified, and a referral will be made to a qualified physician if necessary.

Labor and delivery services provided by a licensed midwife cannot be provided in a hospital or other licensed health care institution. Licensed midwives must have a plan of action in case of complications, including the name and address of an AHCCCS registered physician and nearby acute care hospital. The licensed midwife must notify UnitedHealthcare Community Plan or the AHCCCS Newborn Reporting Line of the birth no later than three days after the birth.

Specialists Responsibilities

UnitedHealthcare Community Plan contracted Specialist Physicians (PSP) are responsible for:

• Providing covered specialty care services to member in accordance with accepted community standards of care and practice.
• Verifying the member’s enrollment prior to initiating covered services, unless otherwise authorized.
• Providing services as applicable and within the scope of his/her specialty practice to UnitedHealthcare members, including but not limited to, inpatient consultations.
• Complying with the AHCCCS guidelines for scheduling a consultation or services following a request from the PCP of UHCCP. Appointment Standards are covered in Chapter 2 of this manual.

Specialists Checklist

Specialists should take the following steps when providing services to UnitedHealthcare Community Plan members.

• Verify the member’s enrollment prior to initiating services and before rendering subsequent services by using the IVR, MediFAX, Provider Portal, AHCCCS Online or calling UnitedHealthcare Community plan Provider Service Center 800-445-1638.
• Check the member’s ID card each time the member present for service and verify against photo identification.
• Verify the prior authorization is approved prior to providing services. See Chapter 5 for prior authorization requirements.
• Identify and appropriately bill other insurance carriers when appropriate, including Medicare.

Ancillary Provider Responsibilities

Ancillary providers include pharmacy, home health, durable medical equipment, infusion care, vision, dental, transportation, therapy, home and community-based service providers, and other non-physician providers. PCPs, PCOs, PCPNS, and specialist physicians are required to utilize the UnitedHealthcare Ancillary network. UnitedHealthcare contracted Ancillary providers are responsible for maintaining sufficient facilities, equipment, and personnel to provide timely access to medically necessary covered services.

Ancillary Provider Checklist

Ancillary providers should take the following steps when providing services to UnitedHealthcare members:

• Verify the member’s enrollment prior to initiating services and before rendering subsequent services by using the IVR, MediFAX, Provider Portal, AHCCCS Online or calling UnitedHealthcare Community plan Provider Service Center 800-445-1638.
• Check the member’s ID card each time the member present for service and verify against photo ID.
• Verify prior authorization was received prior to providing services. See Chapter 5 for prior authorization requirements.
• Identify and appropriately bill other insurance carriers, when appropriate, including Medicare.

Appointment Standards

UnitedHealthcare Community Plan actively monitors the adequacy of appointment processes and ensures that a member’s waiting time for a scheduled appointment at the PCP’s, PCO’s or specialist’s office is no more than 45 minutes, except when the provider is unavailable due to an emergency. For the purposes of this section, ‘urgent’ is defined as an acute, but not necessarily life threatening disorder; which, if not attended to, could endanger the patients’ health.
Chapter 2 Provider Responsibilities

- Care providers must ensure that the following appointment standards are met:
  - Emergency PCP appointments – same day of request or within 24 hours of the member’s phone call or other notification
  - Urgent care PCP appointments – within two days of request.
  - Routine care PCP appointments – within 21 days of request.
- For specialty referrals, the following standards must be met:
  - Emergency appointments – within 24 days of referral.
  - Urgent care appointments – within three days of referral.
  - Routine care appointments – within 45 days of referral.
- For dental appointments, the following standards must be met:
  - Emergency appointments – within 24 days of request.
  - Urgent care appointments – within three days of request.
  - Routine care appointments – within 45 days of request.
- For maternity care, the following initial prenatal care appointments for enrolled pregnant members must be met as follows:
  - First Trimester – within 14 days of request.
  - Second Trimester – within seven days of request.
  - Third Trimester – within three days of request.
  - High Risk Pregnancies – within three days of identification of high risk by UHCCP or maternity care provider, or immediately if an emergency exists.
- For behavioral health, the following standards must be met:
  - Emergency appointments the same day or within 24 hours of the referral or request.
  - Urgent care appointments – for CMDP enrolled members no later than 72 hours after notification by DES/CPS that a child has been or will be removed from their home.
  - Appointment for initial services within seven days of referral.
  - Appointment for ongoing services within 23 days of initial appointment.
  - The monitoring results as specified in Attachment B2, CRS Program Contractor’s Chart of Deliverables.
Chapter 3 Physician Office Procedures

Member Eligibility

UnitedHealthcare Community Plan serves members enrolled in AHCCCS, which is Arizona’s Medicaid program. Eligibility for the AHCCCS program is determined by AHCCCS-designated eligibility workers. An individual who becomes eligible for the AHCCCS program either chooses or is assigned to one of the AHCCCS-contracted health plans.

Verifying Member Enrollment

All providers should verify member eligibility prior to providing services. Eligibility can be determined in the following ways:

• Patient Eligibility & Benefits - access enrollment and benefit information online at UnitedHealthcareOnline.com
• Monthly Rosters (sent to PCPs only).
• AHCCCS Online (azweb.statemedicaid.us/).
• UnitedHealthcare Provider Service Center (available 24/7) 800-445-1638.

If the member is not enrolled with UnitedHealthcare, the care provider should call the stat AHCCCS Verification Unit at 602-417-7200 or 800-331-5090 to verify eligibility and correct plan enrollment or check AHCCCS Online at azweb.statemedicaid.us. If the member is enrolled with ALTCS under the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) and the member does not appear on the roster, the care provider should call DES/DDD Member Services at 800-624-4964 to verify eligibility and correct plan enrollment.

AHCCCS Rate Codes

The rate codes found on member rosters refer to the member’s eligibility category. Each member is determined eligible for a rate code that indicates his/her eligibility type, benefits and whether he/she is eligible for Medicare, Part A (hospital insurance). The rate codes do not indicate if the member may have Medicare Part B (voluntary supplemental medical insurance) or some other insurance. Prior period coverage is indicated by a rate code ending in an alpha character. If you are a capitated primary care physician, the rate codes are important as they determine your per-member capitation payment. Updated AHCCCS rate codes can be found at azahcccs.gov.

Rate Codes/Other Insurance

Additionally, on each roster is a Medicare benefit indicator. The definitions of the codes are:

BLANK – Member has no Medicare benefit
A – Member has Medicare Part A (Hospital Insurance)
B – Member has Medicare Part B (Supplemental Health Benefit Coverage)
C – Member has both Medicare Part A and B

UnitedHealthcare Community Plan is the payer of last resort.

UnitedHealthcare is required by law not to duplicate benefits available from other sources. Practitioners and care providers must pay close attention to the Medicare benefits indicator when serving a UnitedHealthcare member.

• Medicare must be billed first before billing UnitedHealthcare.
• UnitedHealthcare members may also have some type of other insurance.

Providers are responsible for identifying any other insurance and for billing the other insurance carrier before billing UnitedHealthcare. If a member has both Medicaid and Medicare coverage through UnitedHealthcare, the provider shall bill applicable benefits through Medicare first.

Member Assignment

Assignment to UnitedHealthcare Community Plan

UnitedHealthcare is assigned AHCCCS-eligible members on a daily basis. UnitedHealthcare is responsible for managing the member’s care on the date that the member is enrolled with the plan and until the member is disenrolled from UnitedHealthcare. UnitedHealthcare is also responsible during Prior Period Coverage (PPC) to pay for any medically necessary covered services for which a member may be eligible. Prior Quarter Coverage is provided by the Arizona Health Care Cost Containment System (AHCCCS), not UHCCP. Disenrollment decisions are made by AHCCCS and
are not the responsibility of UnitedHealthcare. Disenrollment usually takes effect at month’s end, but at times may occur in the middle of the month. At the time of assignment to UnitedHealthcare, each member receives a welcome packet that includes a copy of the UnitedHealthcare Member Handbook. The Member Handbook explains the member’s rights and responsibilities in obtaining health care through UnitedHealthcare. Providers may obtain copies of the Member Handbook online at UHCCommunityPlan.com or contacting the UnitedHealthcare Provider Service Center.

Choosing a Primary Care Physician

Each enrolled UHCCP member either chooses or is automatically assigned to a primary care physician (PCP). The assignment takes into consideration the distance to the PCP, the PCP’s capacity, and if the PCP is accepting new patients. UnitedHealthcare’s Member Services department will assign members to the closest available and appropriate PCP.

Depending upon the age, medical condition and location of the member, the choice of PCP may cover a variety of practice areas, such as family practice, general practice, internal medicine, pediatrics and obstetrics. If the member elects to change the initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare to change his/her PCP at any other time the change will be made effective on the date of the request. Members may change their PCP up to three times per year. In addition to a primary care physician, CRS eligible members may receive services from subspecialist who manage care related to their CRS condition(s).

Assignment to PCP Roster

Once a member has been assigned to a PCP, UnitedHealthcare documents the assignment and provides each PCP a roster indicating the members that have been assigned. Rosters can be viewed electronically on UnitedHealthcareOnline.com. PCPs should use their rosters in conjunction with UnitedHealthcare Community Plan’s IVE, and AHCCCS’ web-based eligibility verification system to determine if they are responsible for providing primary care to a particular member.

Removing Members From a Roster

Should a provider wish to have an assigned member removed from the roster due to the member’s non-compliance or disruptive behavior in the office, the care provider can request the member’s removal. Inform the member in writing of their removal from the panel and forward a copy of the member’s notice along with a written request for removal to UnitedHealthcare. Care providers must remain available to assist with the provision of medical care for 30 days from the date of the letter. The request must be mailed to:

UnitedHealthcare Community Plan
Member Service Department
1 East Washington, Suite 900
Phoenix, AZ 85004

It is recommended that you attempt to resolve member issues prior to requesting an assigned member removal. We have case management, disease management, care coordination and behavioral health programs that might be able to assist you in treating difficult members prior to requesting their removal from your roster. Please call UnitedHealthcare Community Plan’s Provider Service Center at 800-445-1638 and request a referral to one of the aforementioned departments.

Member ID Cards

Care providers are also encouraged to take the precaution of verifying the identity of the person presenting the ID card against some form of photo ID, such as a driver’s license. AHCCCS has added MVD photos to its on-line verification tool that providers can use to verify a member’s eligibility. This type of verification not only deters fraudulent use of the AHCCCS program, but also protects the provider against performing a service for which he/ she was not capitated or for which payment may be denied.

If any potential fraud and abuse situation, events or circumstances (provider or member) come to your attention, please notify UHCCP in writing per instructions regard fraud and abuse addressed in Chapter 15 of this manual, or you can call the AHCCCS administration at 602-417-4193 or 888-487-6686.

UnitedHealthcare Community Plan ID cards will reflect the members Group ID number. The members ID cards will also reflect the members PCP assignment on the front of the card. Some CRS member’s might show 2 PCP assignments with one being the Multi-Specialty Interdisciplinary Clinic (MSIC) and one being the Primary Care Provider (PCP). Providers may view a copy of the members ID card image online at UnitedHealthcareOnline.com while verifying member eligibility.
Fraud, Waste and Abuse Training

Providers must agree to provide training to their staff on the following policies and procedures as well as establish written policies for their employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act; (b) cite administrative remedies for false claims and statements and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs, include as part of such written policies, detailed provisions regarding care provider’s policies and procedure for detecting and preventing fraud, waste and abuse.

UnitedHealthcare Community Plan

Group IDs

On April 1, 2014, UnitedHealthcare Community Plan switched to four new Group ID’s for the following programs. Group Numbers are not required upon submission of a claim (excluding Long Term Care claim submissions with dates of service prior to April 1, 2016). However, if submitting the member Group ID number, please enter in Box 11 of the 1500 claim form or box 62 on the UB04 claim form.

<table>
<thead>
<tr>
<th>Group</th>
<th>Program Name</th>
<th>Program Identified on Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>AZHCCCS</td>
<td>TANF</td>
<td>Medicaid</td>
</tr>
<tr>
<td>AZHCCCS</td>
<td>SSI</td>
<td>Medicaid</td>
</tr>
<tr>
<td>AZHCCCS</td>
<td>BCCTP</td>
<td>Medicaid</td>
</tr>
<tr>
<td>AZHCCCS</td>
<td>SOBRA</td>
<td>Medicaid</td>
</tr>
<tr>
<td>AZHCCCS</td>
<td>KidsCare</td>
<td>Medicaid</td>
</tr>
<tr>
<td>AZHCCCS</td>
<td>Title XIX Waiver Group</td>
<td>Medicaid</td>
</tr>
<tr>
<td>AZDDD</td>
<td>DD</td>
<td>DD</td>
</tr>
<tr>
<td>AZMCARE</td>
<td>Medicare</td>
<td>Medicare</td>
</tr>
<tr>
<td>AZCRS</td>
<td>CRS Fully Integrated</td>
<td>CRS Fully Integrated</td>
</tr>
<tr>
<td>AZCRS</td>
<td>CRS Partially Integrated-BH</td>
<td>CRS Partially Integrated-BH</td>
</tr>
<tr>
<td>AZCRS</td>
<td>CRS Partially Integrated-Acute</td>
<td>CRS Partially Integrated-Acute</td>
</tr>
<tr>
<td>AZCRS</td>
<td>CRS Only</td>
<td>CRS Only</td>
</tr>
</tbody>
</table>

Co-payments

Some people who get AHCCCS Medicaid benefits are asked to pay co-payments for some of the AHCCCS medical services that they receive. Copays can be mandatory (required) or optional (nominal) as explained in the additional paragraphs below. Some people and certain services do not require copays which means there are no mandatory or optional copays charged as shown below.

- Copayments are not charged to the following persons:
  - Children under age 19.
  - People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services.
  - Individuals up through age 20 eligible to receive services from the Children’s Rehabilitative Services (CRS) program.
  - People who are acute care members and who are placed in nursing homes, residential facilities such as an Assisted Living Home when such placement is made as an alternative to hospitalization. The exemption from copayments for acute care members is limited to 90 days in a contract year.
  - People who are enrolled in the Arizona Long Term Care System (ALTCS).
  - People who are eligible for Medicare Savings Programs only.
  - People who receive hospice care.
  - Members in the Breast and Cervical Cancer Treatment Program (BCCTP) eff. 01/01/14.
  - American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under Public Law 93-638, or urban Indian health programs.
  - An adult eligible under A.A.C. R9-22-1427 (E).
  - An individual with respect to whom child welfare services are made available under Part B of Title IV of the Social Security Act on the basis of being a child in foster care, without regard to age.
  - An individual with respect to whom adoption or foster care assistance is made available under Part E of Title IV of the Social Security Act, without regard to age.
  - An individual who is pregnant and through the postpartum period following the pregnancy.

*Note: Co-payments referenced in this section means co-payments charged under Medicaid (AHCCCS). It does not mean a person is exempt from Medicare co-payments.
Chapter 3 Physician Office Procedures

- In addition, co-payments are never charged for the following services for anyone:
  - Hospitalizations
  - Emergency services
  - Family Planning services and supplies
  - Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women
  - Well visits
  - Preventative services
  - Provider preventable services
  - Services paid on a fee-for-service basis

**Nominal (low) Co-Pays for Some AHCCCS Programs**

Most people who get AHCCCS benefits are asked to pay the following nominal co-payments for medical services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$ 2.30</td>
</tr>
<tr>
<td>Out-patient services for physical, occupational and speech therapy</td>
<td>$ 2.30</td>
</tr>
<tr>
<td>Doctor or other provider outpatient office visits for evaluation and management of your care</td>
<td>$ 3.40</td>
</tr>
</tbody>
</table>

Missed appointment fees are allowed to be charged to AHCCCS members if the member lives outside of Maricopa or Pima County. Services are not allowed to be refused if copayments are not paid. This excludes CRS or DD members.

**People With Required Copayments**

- **Families with children that are no longer eligible due to earnings**
  Members eligible for AHCCCS through the Transitional Medical Assistance (TMA) program are subject to mandatory copayments for the services listed below:

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$ 2.30</td>
</tr>
<tr>
<td>Doctor or other provider outpatient office visits for evaluation and management of your care</td>
<td>$ 4.00</td>
</tr>
<tr>
<td>Physical, Occupations and Speech Therapies</td>
<td>$ 3.00</td>
</tr>
<tr>
<td>Outpatient non-emergency or voluntary surgical procedures</td>
<td>$ 3.00</td>
</tr>
</tbody>
</table>

The members are not eligible to be charged a missed appointment fee. Pharmacists and medical care providers can refuse services if the copayments are not made.

Members subject to copays will not be required to pay additional copayments once the total amount of the copays the family has made is more than 5% of the family’s gross family income (before taxes and deductions) during a calendar quarter (January through March, April through June, July through September, and October through December).

The AHCCCS administration will track each member’s specific copayment levels by service type to identify those members who have reached the 5% copayment limit.

- With the exception of prescription drugs (where a copay is charged for each drug received), only one copay may be assessed for services received during a visit. If the coding for the visit falls within more than one copayment category, the member is responsible for the highest copayment amount.

**Copayment Collection**

Care providers are responsible for billing members for the copayment amount at the time of service. This applies to members with optional copayments as well as members with mandatory copays.

- Mandatory copayments permit providers to deny services to members who do not pay the copayment regardless of whether or not the provider successfully collects the mandatory copayment.

- Optional copayments apply to AHCCCS members who are not required to make the mandatory copayments. When a member has an optional copayment, care providers are prohibited from denying the service when the member is unable to pay the copayments. The care provider’s reimbursement cannot be reduced by the amount of the copayment for members with optional copayments if the member is unable to pay.
* **Other Adults** – AHCCCS Care Program (Childless Adults). An adult may get AHCCCS benefits through the AHCCCS Care Program (when available). An adult is on AHCCCS Care because the adult:
  - Does not have an eligible deprived child living with them (See Arizona Administrative Code R9-22-1427),
  - Is not pregnant,
  - Is not aged 65 or over, or
  - Is not disabled.

People on AHCCCS Care have to pay higher copays for some medical services and will need to pay the copays in order to get the following services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Prescriptions and Brand Name Prescriptions when there is no generic</td>
<td>$4.00</td>
</tr>
<tr>
<td>Brand Name Prescriptions when there is a generic that can be used</td>
<td>$10.00</td>
</tr>
<tr>
<td>Non-emergency use of an emergency room</td>
<td>$30.00</td>
</tr>
<tr>
<td>Doctor office visits</td>
<td>$5.00</td>
</tr>
<tr>
<td>Taxi ride to obtain medical services (for adults in Maricopa and Pima counties only)</td>
<td>$2.00 each way</td>
</tr>
</tbody>
</table>

Pharmacists, medical providers, and taxi companies can refuse services if the copayments are not made.

Adult Group (includes adults in the AHCCCS Care Program). An adult is on the new Adult Group because the adult:
  - has incomes between 100-133% of the federal poverty guidelines
  - is not pregnant
  - does not have Medicare
  - is between the ages of 19-64

* Copayment amounts and exceptions for other groups may also change in spring of 2014. More information regarding copayments will be provided as available.

Please check our website at [UHCCommunityPlan.com](http://UHCCommunityPlan.com) and contact Provider Services at 800-445-1638 if you have any questions regarding copays.

*Note: Prescriptions will only be covered at contracted pharmacies. A list of contracted pharmacies is available online at [UHCCommunityPlan.com](http://UHCCommunityPlan.com) or by calling the Provider Service Center at 800-445-1638
Chapter 4 Acute Care Covered Services

As an AHCCCS contractor, UnitedHealthcare Community Plan (UHCCP) is required to make available a specific list of covered services to our members. The services listed below are available to UHCCP members. The remaining sections in this chapter discuss modification to the covered services for specific member groups.

These services are covered only when medically necessary. Excluding Children’s Rehabilitative Services (CRS), all covered services must be provide by or arranged by the member’s PCP. Some services must be prior authorized by UHCCP.

The following lists should not be considered exhaustive. The specific services to be delivered to Community Plan members are described in detail in the AHCCCS Medical Policy Manual (AMPM). Contact the Provider Service Center with questions as to whether a service is covered.

Covered Services for UnitedHealthcare Members

- Doctor’s visits
- Immunizations (shots)
- Prescriptions (not covered if the member has Medicare)
- Lab and X-ray
- UnitedHealthcare covers medically necessary laboratory services ordered by a primary care provider. Medically necessary diagnostic testing and screening are covered services.
- Early and Periodic Screening Diagnosis and Treatment (EPSDT) Services for Medicaid eligible children under age 21 – see Chapter 6 for additional information.
- Specialist care
- Hospital services
- Transportation to doctor
- Emergency care
- Urgent care
- Incontinence briefs (diapers) – See Chapter 6 for members 20 years of age and younger. See incontinence brief section in Chapter 4 for members 21 years of age and older
- Pregnancy care
- Surgery services
- Preventive examinations in the absence of any known disease or symptom (not covered benefit for anyone older than 21 years old)
- Physical exams
- Behavioral health – see Chapter 8 for additional information
- Family planning services
- Maternity care (prenatal, labor and delivery, postpartum)
- Dialysis
- Glasses (for children under age 21)
- Vision exams (for children under age 21)
- Dental treatment and screening (for children under age 21) - see Chapter 9 for additional information
- Hearing exams (for children under age 21)
- Hearing aids (for children under age 21)

Non-Covered Benefit for Members Over 21-Years-of-Age

UnitedHealthcare Community Plan, under the direction of the AHCCCS Administration, will no longer pay for certain medical care for anyone who is 21-years-old or older.

The medical services that will no longer be covered are:

- Emergency dental care
- Vision exam/prescriptive lenses
- Bone-anchored hearing aids and cochlear implants
- Hearing aids
- Insulin pumps
- Percussive vests
- Any transplant deemed not medically necessary
- Any transplant that does not meet the coverage criteria outlines in the AHCCCS Medical Policy Manual (AMPM) Chapter 300
- Occupational/speech therapy
- Physical therapy: Benefit limit of 30 visits for restorative therapy and 30 visits for maintenance therapy (15 visits per calendar year for both restorative and maintenance therapy until 09/30/15)
- TMJ treatment (except for reduction of trauma)
- Microprocessor – controlled lower limbs and joints for lower limbs
- Medical marijuana, or an office visit/other service that is primarily for the purpose of determining if a member will benefit from medical marijuana
UnitedHealthcare Community Plan Developmentally Disabled (DD/ALTCS) Members

The covered services that are listed above, regarding Acute Care members, are also available for Developmentally Disabled (DD/ALTCS) members with the following additions:

- Adaptive aids
- Hospice care
- Specific prescriptions and over-the-counter medicines to meet special needs
- Certain specialized DME approved by UHCCP
- Rehabilitative* Therapy (PT, OT, Speech, Feeding) – PT has maximum of 30 visits per benefit year for members over 21 years of age (15 visits per benefit year ending 09/30/15)

DD/ALTCS members have other services available to them outside the Health Plan. If your patient is in need of these services, please refer them to DES/DD at 602-771-8080 for assistance.

Services provided by DDD (non Health Plan related):

- Attendant Care – assists with daily living.
- Day Treatment and Training – services to promote independent living, self-care, communication and social relationships.
- Employment Support Services – provided assistance in a job setting.
- Habilitation* – includes therapies (PT, OT, Speech, Feeding) & behavioral intervention.
- Home Health Aide/Nursing – long term care nursing, after acute benefit have been exhausted.
- Respite Care – certified caregiver to care for member while caregiver is away.
- Group Home or Skilled Nursing Facility – provides long term housing.

Note: Please notice the below definitions of Rehabilitative and Maintenance Therapies to better determine whether covered by UHCCP or DES/DD.

Rehabilitative: To improve or restore function which has been impaired/lost by a recent surgery, illness, or injury. This therapy is for an ACUTE need.

Maintenance: To assist the member to acquire, retain and/or improve chronic skilled deficits in order to reside successfully in the community as well as work on strengthening, independence, socialization and communication.

Qualified Medicare Beneficiary Members (QMB)

The covered services that are listed above for all UHCCP members are also available for Qualified Medicare Beneficiary (QMB) members with the following additions:

- Respite services
- Chiropractic services
- Outpatient occupational therapy
- Any service covered by Medicare but not by AHCCCS

Immunizations

UnitedHealthcare covers immunizations as appropriate for age, history and health risk for adults and children per the AHCCCS Medical Policy Manual (AMP) and follows recommendations as established by the Centers for Disease Control and Prevention (CDC). Immunizations for passport or via clearance are not covered by UHCCP.

Pharmacy – Preferred Drug List (PDL)

The UnitedHealthcare Medicaid Preferred Drug List (PDL) was developed to assist providers in selecting medically appropriate, high-quality and cost-effective drugs for members. The PDL applies only to prescription medications dispensed by contracted pharmacies to outpatient members; it does not apply to inpatient medications. The PDL is organized by therapeutic class. Care providers are required to prescribe and encourage the substitution of generic drugs included in the preferred drug list 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 800-305-0023, or fax a Pharmacy Prior Notifications Request form to 866-940-7328 to make the request. A medical director will promptly consider the request and the provider will be notified of the decision. Care providers may also initiate requests to add a drug to the UnitedHealthcare PDL. To submit a PDL addition request for consideration, the prescriber should complete the PDL Change Request Form, sign it, and mail or fax it to the UnitedHealthcare Pharmacy Director, or the office of the Chief Medical Officer. The requests will be considered at the Pharmacy and Therapeutic Committee meeting. Results of the review will be sent to the requesting care provider.

Note: Please notice the below definitions of Rehabilitative and Maintenance Therapies to better determine whether covered by UHCCP or DES/DD.

Rehabilitative: To improve or restore function which has been impaired/lost by a recent surgery, illness, or injury. This therapy is for an ACUTE need.

Maintenance: To assist the member to acquire, retain and/or improve chronic skilled deficits in order to reside successfully in the community as well as work on strengthening, independence, socialization and communication.
PDL information, including updates when changes occur, will be provided in advance to providers and a summary of changes posted to the UnitedHealthcare website. The PDL, Pharmacy Prior Notification Request form, and PDL Change Request Form can all be found on UHCCP’s website at UHCCommunityPlan.com and can be printed or saved. To obtain a print copy of the UnitedHealthcare PDL, contact the Provider Service Center.

Laboratory and X-rays

UHCCP requires providers to utilize our contracted laboratory when referring members for lab services not covered in the office Laboratory Corporation of America (LabCorp) is the exclusive provider for all lines of business. Medically necessary laboratory services ordered by a primary care provider (PCP), other practitioner or dentist in one of our in-network, contracted laboratories do not require prior authorization except as noted on our Prior Authorization list. Referrals to noncontracted or hospital laboratories require prior authorization from UHCCP Prior Authorization Intake Unit. Care providers who refer to out of network for laboratory and diagnostic services without prior approval shall be responsible for the charges per your agreement with UnitedHealthcare Community Plan.

Members are to be referred to a contracted laboratory provider unless a practitioner’s contract allows on-site laboratory testing. Providers are required to list either the ordering or referring providers when billing on a HCFA 1500 claim form. Please see Ch. 13 for additional information.

Medically necessary diagnostic testing and screening are covered services.

Genetic Testing Provisions

Genetic testing is only covered when the results of such testing are necessary to differentiate between treatment options. Genetic testing is not covered to determine specific diagnosis or syndromes when such diagnoses would not definitively alter the medical treatments of the member. Genetic testing is not covered to determine the likelihood of associated medical conditions occurring in the future. Testing for other medical conditions (e.g. renal disease, hepatic disease, etc.) that may be associated with an underlying genetic condition is covered when medically necessary. Genetic testing is not covered for the purposes of determining current or future family planning, or to determine whether a member carries a hereditary predisposition to cancer or other diseases.

Transportation

Transportation is covered for AHCCCS-eligible members as indicated below. Transportation provided by UHCCP is a resource of last resort. Members should use their own transportation if available.

<table>
<thead>
<tr>
<th>CRS &amp; DD</th>
<th>CRS</th>
<th>UnitedHealthcare Dual Complete/ Dual Complete One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab Corp: labcorp.com</td>
<td>Lab Corp: labcorp.com</td>
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</table>

<table>
<thead>
<tr>
<th>Medicaid AHCCCS &amp; DD</th>
<th>CRS</th>
<th>UnitedHealthcare Dual Complete/ Dual Complete One</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTBA is contracted to provide non-emergency transportation excluding ambulance service for all acute services. MTBA is responsible for the first Behavioral Health appointment only. Thereafter the RBHA provider is responsible for transportation to all subsequent appointments.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MTBA is contracted to provide non-emergency transportation excluding ambulance service for all acute and CRS services. MTBA is responsible for all Behavioral Health services since this coverage includes the Acute, CRS and BH benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MTBA is contracted to provide non-emergency transportation excluding ambulance service for all acute and CRS services. MTBA is responsible for the first Behavioral Health appointment only. Thereafter the RBHA provider is responsible for transportation to all subsequent appointments.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MTBA contracted to provide non-emergency transportation excluding ambulance services for all CRS and Behavioral Health Services. CMDP and DD members’ primary plan of enrollment provide non-emergency transportation for acute services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MTBA is contracted to provide non-emergency transportation excluding ambulance services for all CRS services. Transportation for acute and BH services are the responsibility of the respective plans covering the member.</td>
<td></td>
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</tr>
</tbody>
</table>
Emergency Services

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

For a list of Urgent Care Centers, call Member Services at 800-348-4058.

Incontinence Briefs (Diapers)

UHCCP will provide incontinence briefs to disabled children when they are requested for purposes of prevention of adverse health conditions. Please see chapter 6/EPSDT for eligibility requirements and guidelines for members 3-20 years of age. For ALTCS members 21 years of age and older, incontinence briefs are covered when medically necessary to treat a medical condition. Medical necessity is met in order to prevent skin breakdown when all the following are met:

- The member is incontinent due to a documented medical condition that causes incontinence of bowel and/or bladder,
- The PCP or attending physician has issued a prescription ordering the incontinence briefs,
- Incontinence briefs do not exceed 180 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 180 briefs per month,
- The member obtains incontinence briefs from vendors within the UHCCP network such as Preferred Homecare.

Durable Medical Equipment (DME)

UnitedHealthcare Community Plan’s DME provider is Preferred Home Care. Care providers who refer for DME services can request authorization for incontinence briefs by calling Preferred Home Care directly at 800-636-2123. The following information should be included with the authorization requests:

- Member’s age
- Number of briefs to be provided in a 30-day period
- Diagnosis
- Any other pertinent information

Preferred Home Care will review with UnitedHealthcare and provide generic brand disposable incontinence briefs when a care provider’s request has been received.

Annual Well-Woman Visit

An annual well-woman preventative care visit is a covered benefit for women for the identification of risk factors for disease, identification of existing medical/mental health problems, and promotion of healthy lifestyle habits. The well-woman preventative visit should include:

a. A physical exam (well exam) that assesses overall health
b. Clinical breast exam
c. Pelvic exam (as necessary, according to current recommendations and best standard of practice)
d. Review and administration of immunizations, screenings and testing as appropriate for age and risk factors. NOTE: Genetic screening and testing is not covered, except as described in AHCCCS Medical Policy Manual Chapter 300, Medical Policy for Covered Services
e. Screening and counseling is included as part of the well-woman preventive care visit and should address:
   i. Proper nutrition
   ii. Physical activity
   iii. Elevated BMI indicative of obesity
   iv. Tobacco/substance use, abuse, and/or dependency
   v. Depression screening
   vi. Interpersonal and domestic violence screening that includes counseling involving elicitation of information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems
   vii. Sexually transmitted infections
   viii. Human Immunodeficiency Virus (HIV)
   ix. Family planning counseling
   x. Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
Chapter 4 Acute Care Covered Services

a) Reproductive history and sexual practices
b) Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake
c) Physical activity or exercise
d) Oral health care
e) Chronic disease management
f) Emotional wellness
g) Tobacco and substance use (caffeine, alcohol, marijuana and other drugs), including prescription drug use
h) Recommended intervals between pregnancies

NOTE: Preconception counseling does not include genetic testing.

f. Initiation of necessary referrals when the need for further evaluation, diagnosis and/or treatment is identified

Important DME Vendor Changes for CRS Members – Effective June 1, 2016

Effective June 1, 2016, please use the following vendors to order durable medical equipment (DME) for UnitedHealthcare Community Plan Children’s Rehabilitative Services (CRS) members:

- Preferred Homecare: For enteral services and DME supplies
- United Seating and Mobility dba Numotion: For wheelchair services

Claims for DME supplies obtained from other vendors for UnitedHealthcare Community Plan CRS members will be denied for dates of service on or after June 1.

Preferred Homecare

DME and medical supplies provided by Preferred Homecare include:

- Covered medical supplies
- Oxygen and respiratory equipment
- Hospital beds
- Continuous positive airway pressure and bi-level positive airway pressure units
- Small volume nebulizers
- Enteral services

To request services from Preferred Homecare, please do one of the following:

- Call Preferred Homecare at 800-636-2123 or 480-446-9010 or fax your order to Preferred Homecare at 866-265-0455.

To find a nearby Preferred Homecare location, please go to preferredhomecare.com.

United Seating and Mobility dba Numotion

To request wheelchair services from United Seating and Mobility dba Numotion, please call one of the following locations:

- Phoenix, AZ: 602-452-4320
- Tucson, AZ: 520-323-4496

If you have questions, please call Provider Services at 800-445-1638. Thank you.

Family Planning

Family planning services are covered when provided by physicians or practitioners to members who voluntarily choose to delay or prevent pregnancy. Family planning services include specified covered medical, surgical, pharmacological and laboratory benefits. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specified family planning methods available. Physicians and other practitioners with members of reproductive age must document in the medical record that they have notified the member, either verbally or in writing, of the family planning services available.

Members (male and female) who are eligible to receive full health care coverage and are enrolled with UnitedHealthcare may elect to receive family planning services in addition to other covered services. Family planning services for members eligible to receive full health care coverage may receive the following medical, surgical, pharmacological and laboratory services:

- Contraceptive counseling, medication, supplies, including, but not limited to: oral and injectable contraceptives, intrauterine devices, diaphragms, condoms, foams and suppositories.
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- Associated medical and laboratory examinations including ultrasound studies related to family planning.
- Treatment of complications resulting from contraceptive use, including emergency treatment.
- Natural family planning education or referral to qualified health professionals, and Postcoital emergency oral contraception within 72 hours after unprotected sexual intercourse (RU 486 is not postcoital emergency oral contraception). Hysteroscopic Tubal Sterilization (Essure) is a covered service under the UnitedHealthcare Community Plan. The procedure does not render a woman immediately sterile and another form of birth control will be required minimally for three months. Care providers should only report sterilization of SOBRA members who have undergone this procedure for at least three months and only after confirmatory hysterosalpingogram produces satisfactory results. The hysterosalpingogram must be billed on the same claim as the Hysteroscopic Tubal Sterilization to help ensure both services were rendered. If the Hysteroscopic Tubal Sterilization (Essure, procedure code 58565) is billed without the hysterosalpingogram (procedure code 58340), the service will be denied for a lack of documentation. The following are not covered for the purpose of family planning services:
  - Infertility services including diagnostic testing, treatment services or reversal of surgically induced infertility.
  - Pregnancy termination counseling.

Pregnancy Termination Services

UnitedHealthcare Community Plan covers pregnancy termination if one of the following conditions is present:

- The pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated.
- The pregnancy is a result of rape or incest.
- The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:
  - Creating a serious physical or mental health problem for the pregnant member or seriously impairing a bodily function of the pregnant member.
  - Causing dysfunction of a bodily organ or part of the pregnant member or exacerbating a health problem of the pregnant member, or
  - Preventing the pregnant member from obtaining treatment for a health problem. The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination. The certificate can be obtained online at azahcccs.gov from the AHCCCS Medical Policy Manual, Chapter 400, Exhibit 410-4. The certificate must be submitted via prior authorization to the UnitedHealthcare Medical Director or designee and must certify that, in the physician’s professional judgment, one or more of the above criteria have been met. Additional required documentation includes:
    - A written informed consent must be obtained by the care provider and kept in the member’s chart for all pregnancy terminations. If the pregnant member is under 18 years-of-age, or is 18-years-of-age or older and considered an incapacitated adult (as defined in A.R.S. § 14-5101), a dated signature of the pregnant member’s parent or legal guardian indicating approval of the pregnancy termination procedure is required.
    - When the pregnancy is the result of rape or incest, documentation must be obtained that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number if available, and the date the report was filed.

Except in cases of medical emergencies, the care provider must obtain prior authorization for all covered pregnancy terminations from the UnitedHealthcare Medical Director or designee. A completed Certificate of Necessity for Pregnancy Termination and Verification of Diagnosis by Contractor for Pregnancy Termination Request must be submitted with the request for prior authorization. The certificates can be obtained online at azahcccs.gov from the AHCCCS Medical Policy Manual, Chapter 400, Exhibit 410-4 and 410-5. In cases of medical emergencies, the care provider must submit all documentation of medical necessity to UnitedHealthcare within two working days of the date on which the pregnancy termination procedure was performed.
Sterilization

Care providers must comply with the requirements listed below before performing a sterilization procedure. Prior authorization is not required unless the member is under 21 years of age. Sterilization of a member under 21 years of age must be medically necessary. A completed Federal Consent Form must be submitted with claims for all voluntary sterilization procedures.

Federal consent requirements for voluntary sterilization require:

- The recipient to be at least 21 years-of-age at the time of consent is signed.
- The recipient to be mentally competent.
- Consent is to be voluntary and obtained without duress.
- 30 days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery. Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 (thirty) days before the expected date of delivery.
- Copy of the signed Federal Consent Form must be submitted by each care provider involved with the hospitalization and/or the sterilization procedure and with a witness present when the consent is obtained.
- Suitable arrangements must be made to ensure that the information in the consent form is effectively communicated to members with limited English proficiency or reading skills and as well as members with visual and/or auditory limitations. Prior to signing consent form, member must first have been offered factual information including:
  - Answers to questions asked regarding the specific procedure to be performed.
  - Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits.
  - A description of available alternative methods.
  - A full description of the discomforts and risks that may accompany or follow the performing of the procedure including an explanation of the type and possible effects of any anesthetic to be used.
- A full description of the advantages or disadvantages that may be expected as a result of the sterilization.
- Notification that sterilization cannot be performed for at least thirty (30) days after consent.
- That sterilization consents may not be obtained when an eligible member:
  - Is in labor or childbirth.
  - Is seeking to obtain or obtaining an abortion.
  - Is under the influence of alcohol or other substances which affect the member’s state of awareness.

The Sterilization Consent Form is available online at [azahcccs.gov](http://azahcccs.gov), in the AHCCCS Medical Policy Manual, Chapter 400, exhibit 420-1

Hysterectomy Claims

Claims for hysterectomy procedures are reimbursable if:

- Documentation is provided to show the patient gave voluntary consent for the hysterectomy. The physician must certify the procedure was medically necessary by submitting one of the following:
  - AHCCCS Certificate of Medical Necessity.
  - Documentation of medical reason for the hysterectomy, type and direction of all medical treatment attempted to avoid surgery, intensity and duration of the symptoms.
  - Pathology Report from the surgery showing the procedure met hysterectomy criteria
  - Operative report.

The physician must also submit documentation of one of the following:

- Request for Hysterectomy form signed by the patient showing she understands the sterilization will be permanent. You may obtain a copy of the Hysterectomy Consent form from the AHCCCS website at [azahcccs.gov](http://azahcccs.gov), Chapter 800 of the Medical Policy Manual, Exhibit 820-1
  - Documentation of previous sterility, if applicable. If the patient is sterile at the time of the hysterectomy, no consent is required; however, it must be confirmed by a record of the exam on the history and physical, the pathology report, or other documentation.
Chapter 4 Acute Care Covered Services

Prior to signing consent form, member must first have been offered factual information including:

- Answers to questions asked regarding the specific procedure to be performed.
- Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits.
- A description of available alternative methods.
- A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic used.
- Notification that sterilization cannot be performed for at least thirty days after consent.

- That sterilization consents may not be obtained when an eligible member:
  - Is in labor or childbirth.
  - Is seeking to obtain or obtaining an abortion.
  - Is under the influence of alcohol or other substances which affect the member’s state of awareness.

Excluded Services

- Any non-emergency service that has not been authorized by UnitedHealthcare (if required) and the member’s PCP.
- Routine circumcisions.
- Hearing aids, eye examinations for prescription lenses, and routine dental services for persons 21 and older. Hearing aids are covered for DD/ALTCS members if the hearing loss is due to an accident or injury-related emergent condition.
- Physical therapy prescribed for maintenance only.
- Outpatient speech and occupational therapy for persons 21 and older.
- Services provided in an institution for the treatment of tuberculosis or for the treatment of mental disorders.
- Sex change operations.
- Reversal of voluntarily induced sterilizations.
- Services or items furnished only for cosmetic purposes.
- Services determined by the AHCCCS Chief Medical Office to be experimental or provided primarily for the purpose of research.
- Services not rendered in accordance with AHCCCS rules or contractual requirements.
- Services by Podiatrists – foot and ankle services provided by a podiatrist are no longer covered. Those services may be reimbursed if rendered by another clinician such as a physician, NP, or PA.
- Well visits are a covered benefit beginning 10/01/13. Well exams mean physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination. Pap smears, mammograms, and colonoscopies are also covered.
- Services that are not medically necessary.
Chapter 5 Medical Management

Referrals and Prior Authorization

UnitedHealthcare Community Plan is designed to ensure a comprehensive approach for providing AHCCCS-covered, medically necessary services in a manner that meets or exceeds the standards and requirements of the AHCCCS Medical Policy Manual (AMPM). The goal of the program is to ensure our members receive the right care in the right setting at the right time. The prior authorization process assists in meeting this goal.

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

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

UHCCP requires practitioners and care providers to obtain prior authorization when making referrals to non-contracted specialist for services. Prior authorization allows the evaluation of services for continuity of care, benefit coverage under applicable program guidelines and policies, and cost efficiency before services are rendered.

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

Unless another department or unit has been specially designated to authorize a service, requests for prior authorization are routed through the Prior Authorization Intake Department where nurses and medical directors are available 8am to 5pm, local time. Requests can be made via telephone, fax or the Provider Portal; see Chapter 5 for listing of UHCCP phone numbers, fax with a UnitedHealthcare Community Plan prior authorization referral form or via the Provider Online Portal, UnitedHealthcare Community Plan’s Online Prior Authorization tool.

General Referral Information

PCPs are generally responsible for initiating and coordinating referrals of members for medically necessary services beyond the scope of their practice. PCPs are to monitor the progress of referred members’ care and see that members are returned to the PCPs care as soon as medically appropriate.

Services which do not require PCP interaction are:
- Contracted vision providers.
- Contracted dentists.
- Contracted radiologists.
- Female members who self-refer for their well-women exam.
- Behavioral health services (refer to Chapter 8).

Referrals should be made to a UnitedHealthcare contracted provider. If a contracted provider is not available, a referral to a non-contracted provider may be requested, but UnitedHealthcare must authorize the referral.

Services that Require Prior Authorization for UHCCP Acute and Dual Complete Programs

All services rendered by a non-contracted provider require authorization and must have supporting documentation to support the out of network requests. All Out of State services require authorization with medical documentation to support the Out of State request and any service which may be considered experimental or investigational is not a covered benefit.

The following directives apply to all Prior Authorizations:
- The member must be eligible at the time the covered service is rendered.
- Only one service may be requested per prior authorization request form.
- Authorization is not a guarantee of payment. Billing guidelines must be met.
- ALL rendering providers/facilities/vendors must be actively registered with AHCCCS.

Important Reminders:
- All services must be a covered benefit as outlined by the AHCCCS Program.
- All authorization requests may be submitted via UHC Portal, Phone, or Fax.
  - Instructions for submitting prior authorization requests are available online at UHCCCommunityPlan.com.
Chapter 5 Medical Management

Important Phone Numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Services</td>
<td>1-800-348-4058</td>
</tr>
<tr>
<td>Available 8 a.m. to 5 p.m.</td>
<td>TTY-Hearing Impaired</td>
</tr>
<tr>
<td>local time, Mon - Fri</td>
<td>1-800-367-8939</td>
</tr>
<tr>
<td>Provider Services</td>
<td>1-800-445-1638</td>
</tr>
<tr>
<td>Available 8 a.m. to 5 p.m.</td>
<td>TTY-Hearing Impaired</td>
</tr>
<tr>
<td>local time, Mon - Fri</td>
<td>1-800-445-1638</td>
</tr>
<tr>
<td>UnitedHealthcare®</td>
<td>1-877-614-0623</td>
</tr>
<tr>
<td>Dual Complete® (HMO SNP) –</td>
<td>TTY-Hearing Impaired</td>
</tr>
<tr>
<td>Medicare Member Services</td>
<td>1-800-842-4681</td>
</tr>
<tr>
<td>Available 8 a.m. to 5 p.m.</td>
<td></td>
</tr>
<tr>
<td>local time, Mon - Fri</td>
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</table>

Requesting Prior Authorization

Care providers and facilities should utilize the following steps to obtain authorization for services:

- Requests for prior authorization are to be directed to UnitedHealthcare Community Plan’s Prior Authorization Intake Department.
  - Call 866-604-3267 or Fax 888-899-1499.
  - On UnitedHealthcareOnline.com website, a prior authorization fax form is available for completion. Submissions can be made on the Provider Portal Online (contact the Provider Service Center at 800-445-1638).

- All requests for prior authorization require:
  - A valid member ID number.
  - Name of referring physician.
  - Name of servicing provider.
  - The current applicable CPT, ICD-10 (ICD-9 prior to 10/01/15) and HCPCS codes for the services being requested.
  - The designated place of service.

- The PCP is responsible for initiating and coordinating requests for prior authorization. However, UnitedHealthcare recognizes that specialists, ancillary providers, and facilities may need to request prior authorization for additional services in their specialty area and will process these requests as necessary.

The Prior Authorization Department, under the direction of licensed nurses and medical directors, documents and evaluates requests for authorization, including:

- Verification that the member is enrolled with the health plan at the time of the request for authorization and on each date of service.
- Verification that the requested service is covered under the benefits of the member.

- Medical necessity and appropriateness using national medical review criteria based on AHCCCS program requirements, applicable policies and procedure, contracts, and law.
- Verification that the service is being provided by a contracted provider and in the appropriate setting.
- Verification of other insurance for coordination of benefits

Responding to Prior Authorization Requests

The UnitedHealthcare Community Plan Pre-Service Review Team will make determinations on authorization request and will notify requesters of approval or denial of authorization within the AHCCCS regulatory requirements:

- **STANDARD Request (aka Elective/Routine/Non-Urgent)** – A decision and notification will be made no later than 14 calendar days following the receipt of the request, with a possible extension of up to 14 days if the member or care provider requests an extension or if there is justification for additional information and the delay is the member’s best interest. 42 C.F.R. 438.210.

- **EXPEDITED Request (aka Urgent/STAT)** – These requests should ONLY be made when the standard timeframe could seriously jeopardize the member’s life, health, or ability to attain, maintain or regain maximum function. A decision and notification will be made no later than three working days following the receipt of the request, with a possible extension of up to 14 days if the member or care provider requests an extension or if there is justification for additional information and the delay is in the member’s best interest. 42 C.F.R. 438.210.

Denial Requests for Prior Authorization

Denial of authorization requests for medical necessity occurs only after a UHCCP medical director has reviewed the request and determines that the service does not meet criteria. A UnitedHealthcare medical director is available to speak to a care provider who requests a peer to peer to discuss the decision.

Prior authorization service requests are frequently denied because they lack supporting medical documentation. If additional information is requested and not received within the designated timeframe, then the request may be denied.

A care provider can submit additional medical records after receiving a denial of a service request. A new case will be entered into the prior authorization system for review with the supporting documentation.
Period of Referral Authorization

Referrals and prior authorizations are valid ONLY if the member is enrolled with the health plan on the date of the service delivery. Paper referrals are generally valid for 60 calendar days beginning with the date the referring physician signed and dated the referral. However, if the referral covers a consultation or procedure that requires prior authorization from the Prior Authorization Unit, you MUST perform the consultation or procedure within three days prior to or after the date(s) of service authorized. If prior authorization from the PA Unit is required, please call to verify the prior authorization number and the date(s) of service authorized.

Exceptions:
* Orthopedic referrals are valid for 120 days of continued care.
* Hematologist/oncologist, radiation oncology, gynecology oncology and allergy referrals are valid for 180 days of continued care.

Specialty Referrals

Primary Care Obstetrician
Female members shall have direct access to in-network GYN providers, including physicians, physician assistants, nurse practitioners and midwives within the scope of their practice, without a referral. If a member’s pregnancy is confirmed by a PCO, the PCO is required to notify UnitedHealthcare Community Plan Health First Steps at 800-599-5985 to initiate a PCO reassignment. The ACOG form needs to be faxed to Healthy First Steps at 877-353-6913 immediately after the initial OB visit. The member’s PCO effective date will be the date the completed ACOG form is received. A PCO’s failure to notify UnitedHealthcare Community Plan of this reassignment may result in delay or denial of reimbursement. The date of the PCO assignment is the effective date of the transfer of care from the PCP to the PCO.

PCOs are responsible for coordinating a member’s care until the first day of the first month following the eleventh (60th) day after delivery or termination of pregnancy (see Additional PCO Responsibilities, Chapter 2)

EPSDT services for pregnant members under the age of 21 are to be performed by the assigned PCO Perinatologist.

Perinatology Referrals
When a PCO or PCP wants to refer a member for a consult to a contracted Perinatologist, a prior authorization by UHCCP is necessary. If a PCO or PCP wants to transfer the entire care of the member while pregnant to a contracted Perinatologist, the transfer of care requires prior authorization. To arrange for this transfer of care, the PCO should call UnitedHealthcare Community Plan’s Healthy First Steps at 800-599-5985. Once complete transfer of care has taken place, the Perinatologist then becomes the member’s PCO and is responsible for the member’s care for the duration of the pregnancy and 60 days postpartum. EPSDT services for pregnant members under the age of 21 are to be performed by the assigned PCO Perinatologist.

Ancillary Referrals
Contracted physicians may make referrals to ancillary service providers as follows:

- **Dental**
  All eligible members through the age of 20 may self-refer to a general dentist from the list of contracted dentists in the member’s provider directory or by calling UnitedHealthcare’s Member Services department. Children through the age of 20 are covered for preventive, therapeutic, and emergency services. Adults ages 21 and older are only covered for emergency palliative treatment.

  Dentists are to ensure that member’s waiting time at the dental office shall not exceed 45 minutes for scheduled appointments, unless the dentist is unavailable due to an emergency.

  Dental providers shall schedule time-specific appointments as stated in the Appointment Standards section in Chapter 2.

- **Durable Medical Equipment**
  Requests for durable medical equipment (DME) are to be sent on a referral from or a prescription directly to the DME provider, Preferred HomeCare. The DME provider is responsible for obtaining prior authorization if it is required. Claims and referrals sent to a non-contracted DME provider will be denied.

  Practitioners will send medically necessary referrals directly to the contracted provider. The contracted provider is responsible for obtaining prior authorization before rendering service if applicable.

- **Laboratory Referrals**
  Members are to be referred to Laboratory Corporation of America (LabCorp) unless a practitioner’s contract allows on-site laboratory providers for medically necessary testing do not require prior authorization. Referrals to non-contracted or hospital laboratories require prior authorization from UnitedHealthcare Community Plan Prior Authorization Intake Unit.
• Orthotics/Prosthetics (O/P)
Requests for orthotics/prosthetics are to be sent on a referral form or a prescription directly to the O/P provider. A prescription must always be included with the request. The O/P provider is responsible for obtaining prior authorization, if it is required.

According to AHCCCS Medical Policy Manual, Chapter 300, Policy 310-P; orthotics are now covered for members who are 21 years of age and older when all of the following apply:

- The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines.
- The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosis condition.
- The orthotic is ordered by a Physician or Primary Care Practitioner.

• Radiology
Members are to be referred to a contracted radiology provider or to a hospital contracted for outpatient radiology services unless the practitioner’s contract allows radiology services to be performed on-site.

Please refer to UHCCommunityPlan.com under the Radiology section for a current listing of radiology CPTs that require prior authorization, a prior authorization crosswalk table as well as the link to the Online Notifications and Prior Authorizations portal.

• Transportation (Member)
The use of transportation by a member does not require authorization. Members are responsible for setting up their own transportation but may be assisted by another person if necessary. If a physician needs to assist a member in obtaining a ride, call 888-700-6822 or 602-889-1777. Members receiving behavioral health services through RBHA are covered to receive transportation services only to their first RBHA appointment. RBHA enrolled members may obtain transportation services through their RBHA provider. Members who are enrolled in Children’s Rehabilitative Services (CRS) are eligible for transportation based on their CRS coverage type.

• Vision
All eligible members under 21-years-of-age may self-refer to a contracted vision care provider for routine vision services. Members can contact Nationwide Vision for vision care providers.

Members under 21-years-of-age are limited to one diagnostic eye exam in a 12-month period without obtaining prior authorization. Additional exams require prior authorization, and should be obtained by the PCP/PCO from Nationwide Vision.

For members age 21 and older, diagnosis and/or treatment of refractive errors are not a covered service unless prescriptive lenses or contacts are the sole prosthetic device.

Reimbursement
Authorization by UnitedHealthcare Community Plan does not ensure reimbursement for all services provided. Care providers should:

- Determine that the member is eligible on the date of service by using the Provider Portal, contacting UnitedHealthcare Community Plan’s Member Services Department, using the IVR system, checking their paper roster, verifying eligibility on AHCCCS Online, or using electronic verification of eligibility.
- Submit appropriate and requested documentation to support the medical necessity of the requested procedure.
- Be aware that the services provided may be outside the scope of what was authorized by UHCCP.
- Determine if the member has other insurance that should be billed first

Even with a valid prior authorization number, care providers will be reimbursed only for covered services as designated by the provider’s contract with UHCCP. In the event of a conflict between the guide and the agreement, the guide controls unless the agreement dictates otherwise.

UnitedHealthcare Community Plan will not reimburse:

- Services not determined by UnitedHealthcare to be medically necessary.
- Non-covered services
- Services provided to members who are not enrolled on the date(s) of service
- Services provided outside of the United States
## Case Management

UnitedHealthcare Community Plan provides case management services to members who require service coordination due to complex medical conditions or serious psychosocial issues that impact their ability to obtain appropriate care. The UnitedHealthcare Community Plan Medical Case Management Department has assessment tools to help identify members who may be at risk for multiple hospital admissions increased medication usage, or would benefit from a multidisciplinary approach to their medical or psychosocial needs.

Care providers may call Provider Services to refer a patient to Case Management at 800-445-1638. Additionally, UnitedHealthcare provides the Healthy First Steps program which proactively manages women with high-risk pregnancies.

Care coordination is also available for the following cases:

- **Special Needs Populations** – Members with special health care needs are those members who have serious and chronic physical, developmental or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally. A member will be considered as having special health care needs who has a medical condition that simultaneously meets the following criteria:
  - Lasts or is expected to last one year or longer, and
  - Requires ongoing care not generally provide by a primary care provider.

The following populations meet the criteria for the designation of Special Needs:

- Members who are enrolled in the Children’s Rehabilitative Services (CRS) program.
- Members who are receiving behavioral health services from a Regional Behavioral Health Authority (RBHA).
- Members diagnosed with HIV/AIDS.
- Members enrolled in the ALTCS program who are developmentally disabled.
- Members diagnosed with end-stage renal disease receiving dialysis.
- Organ transplantation – The transplant case manager works cooperatively with the AHCCCS Office of Medical Management, contracted providers, and internal UnitedHealthcare departments to coordinate the delivery of services included in the transplantation process.
- Members potentially over utilizing the emergency department who may or may not be demonstrating drug seeking behavior(s).
- HIV/AIDS – UnitedHealthcare offers care providers and members assistance in managing the members HIV/AIDS treatment regimen. Any member receiving antiretroviral therapy will be assigned to a UHCP Nurse Care Coordinator. Physicians are to Physicians are to contact UHCCP whenever a member is diagnosed with HIV or AIDS.
- Chronic pain – UnitedHealthcare offers care providers/ members assistance in managing member with chronic pain diagnoses.
- Behavioral Health – UHCCP has a behavioral health coordinator who is available to assist care providers and members having problems accessing and/or receiving services from the RBHA.

Providers may refer candidates for case management by calling the Provider Service Center at 800-445-1638.

### Evidence Based Medicine/Clinical Practice Guidelines

UnitedHealthcare offers disease management programs for adults and children. Outcomes are compared with the standards of care defined in our evidence-based clinical practice guidelines. UnitedHealthcare offers training opportunities for care providers and their staff on how best to integrate practice guidelines. Evidence-based clinical practice guidelines are reviewed and revised on an annual basis and approved through our Quality Management Department. Our clinical practice guidelines are available online at UHCCommunityPlan.com or at guidelines.gov. Care providers may also call the Provider Service at 800-445-1638 to request a hard copy.

### Acute Facility Concurrent Review

Concurrent review nurses evaluate members’ admissions to Acute Care, Skilled Nursing (SNF), extended care (ECF) and other clinical facilities (such as rehabilitation or LTAC facilities). The services provided in these facilities are reviewed for medical necessity and appropriateness of the level of care using nationally recognized concurrent review criteria, Milliman Care Guidelines (MCG). Concurrent Review nurses also monitor for over- and underutilization, screen for quality and/or risk management issues, and coordinate members’ case management and/or ancillary service needs upon discharge.

Initial review of inpatient services are conducted within one (1) business day of notification of an admission. Reviews are conducted during regular business hours either on-site or by telephone as appropriate to the member’s condition and diagnoses, and include:

- Medical necessity and level of care evaluations based on Milliman Care Guidelines (MCG);
• Quality assessment to identify, risk, and utilization management (with referrals to appropriate UnitedHealthcare medical committees); and

• Discharge planning for needs such as home health, durable medical equipment, etc. and coordination of the services with the hospital and physician

Extended Care/Skilled Nursing Facility (ECF/SNF) Concurrent Review
The ECF/SNF concurrent review nurse conducts concurrent review of services provided to members in extended care or skilled nursing facilities. The concurrent review nurse authorizes medically necessary therapies, coordinates members’ postdischarge care management services, and coordinates activities with prior authorization or case management outpatient care managers as needed.

Medical Claims Review
As a State and Federal Contractor, UnitedHealthcare Community Plan is required to ensure state and federal dollars are appropriately utilized on behalf of our members. To meet this obligation UnitedHealthcare performs pre and post payment medical claims review.

Medical claims reviewers (MCR) use medical review criteria to confirm that the services being billed are a covered benefit for the member and were medically necessary. Medical claims review evaluates claims for emergency room, transportation, and inpatient and outpatient medical services.

Proper Documentation and Medical Review
Medical review is performed to determine if services were provided according to policy, particularly related issues of medical necessity and emergency services. Medical review also is performed to audit appropriateness, utilization, and quality of the service provided. Please note the following scenarios where the appropriate documentation is required to process the claim:

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

• Inpatient claims with extraordinary cost per day thresholds may qualify for an outlier reimbursement. For an inpatient claim to be paid the outlier payment the facility must bill a Condition Code 61 in any of the Condition Code fields (24-30) on the UB-04. If the inpatient claims is an interim bill, only the last bill (i.e. Bill type 114) will be considered for outlier reimbursement.

• All hospitals for inpatient claims that may qualify for Outlier Payment please include itemization of charges.

• All care providers when unlisted procedures are being billed, including any documentation, including: the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used that details what service was provided.

• Medicaid services:
  • Behavioral Health/Substance Abuse.
  • ER Notes.
  • Physician orders, MD, RN, and Social Work notes.
  • MARS for each day of hospitalization.
  • Discharge Orders and/or Instructions.
  • Psychiatric Evaluation and Psychiatric Discharge Summary.

  • Cardiology services.
  • Radiological Service Interpretation.
  • Home Health visits.
  • Injectable drugs.
  • Urgent care.
  • Pharmacy supplies.
  • Prosthetics.
  • Surgical Procedures with Modifier 22 indicating unusual procedural service.
  • Itemized bill for claims where member is eligible for part of the date span but not the entire date span.
  • Elective Abortions require a Certificate of Medical Necessity and Operative Report.
Chapter 6 Early, Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT requirements are applicable to CRS Fully Integrated and CRS Partially Integrated Acute enrolled members. AHCCCS is updating the Benefits and EPSDT requirements. Please check the AHCCCS website at [azahcccs.gov](http://azahcccs.gov) for changes.

**EPSDT Background**

The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and “such other necessary health care, diagnostic services, treatment and other measures described in Federal Law Subsection 42 USC 1396d (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) State Plan.” This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the optional and mandatory categories of “Medical Assistance”, as defined in the Medicaid Act. Services covered under EPSDT include all 28 categories of services in the Federal Law, even when they are not listed as covered services in the AHCCCS State Plan, AHCCCS statutes, rules or policies, as long as the services are medically necessary and cost effective.

EPSDT screening services are provided in compliance with the periodicity requirements of Title 42 of the Code of Federal Regulations (CFR) Section 441.58. Clinicians must ensure members receive required health screenings in compliance with the AHCCCS EPSDT Periodicity Schedule which is available online at [UHCCCommunityPlan.com](http://UHCCCommunityPlan.com) under the Provider Forms section. It may also be found in Chapter AHCCS Medical Policy Manual, located on the AHCCCS website at [azahcccs.gov](http://azahcccs.gov). The services determined by a primary care provider to be medically necessary should be provided, regardless of the interval.

A well child visit is synonymous with an EPSDT visit and includes all screening and services described in the EPSDT and Dental Periodicity Schedules. Effective April 1st, 2014; the payment for the EPSDT is intended to cover all elements outlined in the AHCCCS EPSDT Periodicity Schedule. Refer to the AHCCCS Medical Policy Manual policy 430 for exception to the all-inclusive visit for global payment rate. Claims must be submitted on CMS 1500 claim form. Care providers must bill for preventative EPSDT services using the preventative service, office or other outpatient services and preventative medicine CPT codes (99381-99385, 99391-99395) with an EP modifier. EPSDT visits are paid at a global rate for the service specified in AMPM Policy 430. No additional reimbursement is allowed.

AHCCCS EPSDT Tracking Forms which are to be used by care providers to document all age-specific required information related to EPSDT screenings and visits can be found on our website at [UHCCCommunityPlan.com](http://UHCCCommunityPlan.com) in the Provider Forms section or on the AHCCCS website at [azahcccs.gov](http://azahcccs.gov) in Appendix B of the AHCCCS Medical Policy Manual (AMPM).

**EPSDT Definitions**

Early means in the case of a child already enrolled with UnitedHealthcare, as early as possible in the child’s life, or in other cases, as soon after the member’s eligibility for AHCCCS services has been established.

**Periodic** means at intervals established by AHCCCS Administration for screening to assure that a condition illness, or injury is not incipient or present.

**Screening** means regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children and youth, and the identification of those in need of more definitive evaluation. For the purpose of the AHCCCS EPSDT program screening and diagnosis are not synonymous.

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

**Treatment** means any of the 28 mandatory or optional services described in Federal Law 42 USC 1396d(a), even if the service is not covered under the state AHCCCS plan, when necessary to correct or ameliorate defects and physical and mental illnesses and conditions detected by screening or diagnostic procedures.

**EPSDT Screening Requirements**

Comprehensive periodic screenings must be performed by a clinician according to the time frames identified in the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule as well as inter-periodic screenings as appropriate for each member. Additional detailed information is available in the AHCCCS Medical Policy Manual, Chapter 400 which can be located at [azahcccs.gov](http://azahcccs.gov).
The AHCCCS EPSDT Periodicity Schedule is based on recommendations by the Arizona Medical Association and is closely aligned with guidelines of the American Academy of Pediatrics. EPSDT visits are all-inclusive visits and care providers must use the EP modified to designate all services related to the EPSDT well child check-up, including routine vision and hearing screenings. The payment for the EPSDT visit is intended to cover all elements outlined in the AHCCCS EPSDT Periodicity Schedule. By law EPSDT/Well Child visits must include the following:

- A comprehensive health and developmental history including growth and development screening which includes physical, nutritional and behavioral health assessments.
- Nutritional Assessment provided by a PCP

Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. Payment for the assessment of nutritional status provided by the member’s PCP is part of the EPSDT screening. Payment for nutritional assessments are included in the EPSDT visit and are not a separately billable service.

- Behavioral Health Screening and Services provided by a PCP - EPSDT behavioral health services include the services listed in Federal Law 42 USC 1396d(a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services, whether or not the services are covered under the AHCCCS State Plan. PCPs may treat Attention Deficit Hyperactivity Disorder (ADHD), depression and anxiety. All other behavioral health conditions must be referred to the Regional Behavioral Health Authority (RBHA). American Indian members may receive behavioral health services through an Indian Health Service or Tribally operated 638 facility, with the exclusion of ALTCS, Maricopa Integrated RBHA and CRS program. PCPs that elect to prescribe medications to treat ADHD, depression, or anxiety disorders must complete an annual assessment of the member’s behavioral health condition and treatment plan. Payment for behavioral health screenings and assessments are included as part of the EPSDT visit and are not separately billable service.

Note: CPT code 96101 - Psychological Testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology) is not a separately billable service. The code may be billed on the claim to indicate the service was performed, but payment will be included in the fee paid for the EPSDT visit.

- Developmental Screening Tools used by a PCP - AHCCCS approved developmental screening tools should be utilized for developmental screening by all participating PCPs who care for EPSDT-age members. PCPs must be trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics. The developmental screening should be completed for EPSDT members from birth through three years of age during the 9 month, 18 month and 24 month EPSDT visits. PEDS, ASQ, and M-CHAT training resources will be posted on the Department of Health Services website. A copy of the screening tool must be kept in the medical record. Use of AHCCCS approved developmental screening tools may be billed separately using CPT 96110 (Developmental screening, with interpretation and report, per standardized instrumentation) for the 9, 18 and 24 month visit when the developmental screening tool is used. A developmental screening CPT code (with EP modifier) must be listed in addition to the preventative medicine CPT codes.

AHCCCS approved developmental screening tools include:

A. The Parent’s Evaluation of Developmental Status (Peds) tool which may be obtained from pedtest.com or forepath.org.
B. Ages and Stages Questionnaire (ASQ) tool which may be obtained from agesandstages.com.
C. The Modified Checklist for Autism in Toddlers (MCHAT) may be used only as a screening tool by a primary care provider, for members 16 to 30 months, to screen for autism when medically indicated.

Copies of the completed tools must be retained with medical record.

**EPSDT Service Standards**

EPSDT services must be provided according to community standards of practice and the AHCCCS EPSDT and Dental Periodicity Schedules. The AHCCCS EPSDT Tracking forms must be used to document services provided and compliance with AHCCCS standards. The clinician who performs the screening must sign the tracking forms.

EPSDT care providers must adhere to the following specific standards and requirements.
**Immunizations**

EPSDT covers all child and adolescent immunizations as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood immunization schedules. All appropriate immunizations must be provided to establish, maintain, up-to-date immunization status for each EPSDT age member.

Care providers must coordinate with the Arizona Department of Health Services Vaccine for Children Program in the delivery of immunization services. The “SL” modifier is used to indicate vaccines administered under the federal Vaccines for Children’s (VFC) program and should be coded accordingly on the CMS 1500 claim form. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule. Immunizations are usually given in conjunction with a medical service. When an immunization is the only service performed, a minimal service (99211) may be listed in addition to the injection. Immunization procedures include the supply of materials. Primary care providers with members 0-18 years of age assigned to panel must participate in the Vaccines for Children program and meet standardized vaccine management requirements related to ordering, storage/handling, and reporting. Care providers must re-enroll annually in accordance with AHCCCS contract requirements. Contact the Vaccines for Children program at 602-364-3642 for additional information. Arizona law requires that all immunization of children 0-18 years of age be reported to the state immunization registry as mandated by Arizona law A.R.S. § 36-135. Report immunizations given to all children on your panel to the Arizona State Immunization Information system (ASIIS). If you are not enrolled in ASIIS, please visit [azdhs.gov/phs/asiis/](http://azdhs.gov/phs/asiis/). All immunizations administered to children under age 19 must be reported to ASIIS no less than once a month or within thirty (30) days of immunization administration. Care providers are also encouraged to update member demographic information into the ASIIS system.

For information regarding available ASIIS trainings visit: [azdhs.gov/phs/asiis/training-meetings.htm](http://azdhs.gov/phs/asiis/training-meetings.htm). Care providers may also contact the ASIIS hotline with additional questions or concerns at 602-364-3899 or 877-491-5741. For information on Arizona immunizations visit The Arizona Partnership for Immunizations: [whyimmunize.org](http://whyimmunize.org)

**Eye Examinations and Prescriptive Lenses**

EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule and as medically necessary using standardized visual tools. Vision exams provided in a PCP’s office during an EPSDT visit are not separately billable service. Prescriptive lenses are provided to correct or ameliorate defects, physical illness and conditions discovered by EPSDT screenings, subject to medical necessity. Frames for eyeglasses are also covered.

**Blood Lead Testing**

EPSDT covers blood lead screening. Required blood lead screening for children under six year of age is based on the child’s risk as determined by either the member’s residential zip code or presence of other known risk-factors, as specified in the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

Children living in a targeted high-risk zip code: All children living in a high risk zip code as identified by the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning must have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must receive a screening blood lead test, if they have not been previously screened for lead poisoning.

Children living outside of the targeted high-risk zip codes: Children living in Arizona, but not in a targeted high-risk zip code must receive an individual risk assessment according to the AHCCCS periodicity schedule (when the child is 6, 9, 12, 18, and 24 months of age and then annually through age 6 years), with appropriate follow-up action taken for those children who are determined to be at high risk based on criteria included within the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

A listing of the targeted zip codes and individual risk assessment questions as well as additional resources can be found in ADHS Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning, 2014 at [azdhs.gov/phs/oeh/children/lead/index.htm](http://azdhs.gov/phs/oeh/children/lead/index.htm).

A blood lead test result, equal to or greater than 10 micrograms of lead per deciliter of whole blood obtained by capillary specimen or fingerstick, must be confirmed using a venous blood sample. A verbal blood lead screening risk assessment must be completed at each EPSDT visit for children six through 72 months of age (six years of age) to assist in determining risk. Appropriate follow-up must be provided: Care providers must report blood lead levels equal to or greater than ten micrograms of lead per deciliter of whole blood to Arizona Department of Health Services (A.A.C. R9-4-302).
**Organ and Tissue Transplantation Service**

EPSDT covers medically necessary non-experimental/non-investigational organ and tissue transplants approved for reimbursement in accordance with respective transplant policies.

**Tuberculosis (TB) Testing**

EPSDT covers TB testing. Tuberculin skin testing to be completed as appropriate to age and risk. After a Tuberculin Skin Test (TST) has been administered, the patient must be seen within 48 to 72 hours by a trained health professional to document any reaction or non-reaction. Patients should be advised that they must return to a trained health professional and are not qualified to interpret the results themselves. If results cannot be measured within 72 hours by a trained health professional, the test must be repeated.

For more information regarding tuberculosis and tuberculosis testing please visit: azdhs.gov/phs/oids/tuberculosis/orcdc.gov/tb/

**Nutritional Assessment**

Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutrition intervention. UnitedHealthcare covers the assessment of nutritional status provided by the member’s primary care provider (PCP) as a part of the EPSDT screenings specified in the AHCCCS EPSDT Periodicity Schedule, and on an inter-periodic basis as determined necessary by the member’s PCP. UnitedHealthcare also covers nutritional assessments provided by a registered dietitian when ordered by the member’s PCP. To initiate the referral for a nutritional assessment, the PCP must use the UnitedHealthcare referral form in accordance with contractor protocols. Prior authorization (PA) is not required when the PCP orders the assessment.

**Nutritional Therapy**

AHCCCS covers nutritional therapy for EPSDT eligible members on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member’s daily nutritional and caloric intake.

**Enteral Nutritional Therapy**

Enteral Nutrition provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by jejunostomy tube (J-tube), gastrostomy tube (G-tube) or nasogastric (N/G) tube. (PA is not required for enteral nutritional feedings).

Children’s Rehabilitative Services (CRS) members are required to utilize Preferred Homecare for their Enteral Services. Please see chapter 7 for additional information.

**Parenteral Nutritional Therapy:**

Parenteral Nutritional therapy provides nourishment through the venous system to members with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight and strength (PA is not required for parenteral nutritional feedings).

**Commercial Oral Supplemental Nutritional Feedings:**

Provides nourishment and increases caloric intake as a supplement to the member’s intake of other age appropriate foods, or as the sole source of nutrition for the member. Nourishment is taken orally and is generally provided through commercial nutritional supplements available without prescription.

- Prior authorization is required for commercial oral nutritional supplements unless the member is also currently receiving nutrition through enteral or parenteral feedings. Prior authorization is not required for the first thirty (30) days if the member requires commercial oral nutritional supplements on a temporary basis due to an emergent condition.
- Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member’s PCP or attending physician, using at least the criteria specified in this section. The PCP or attending physician must use the AHCCCS approved form, “Certificate of Medical Necessity for Commercial Oral Nutritional Supplements;”
- The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must document that the PCP or attending physician has provided nutritional counseling as a part of the EPSDT services provided to the members. The documentation must specify alternatives that were tried in an effort to boost caloric intake and/or change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements. At least two of the following criteria must be met:

- The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for three months or more.
- The member has reached a plateau in growth and/or nutritional status for more than six months (prepubescent).
- The member has already demonstrated a medically significant decline in weight within the past three months (prior to assessment).
- The members is able to consume/eat no more the 25% of his or her nutritional requirements from age-appropriate food sources.
• Absorption problems are evidenced by emesis, diarrhea, dehydration, and/or weight loss and intolerance to milk or formula products has been ruled out, or
• The member requires nutritional supplements on a temporary basis due to an emergent condition; e.g. post-hospitalization. (prior authorization is not required for the first 30 days).
• The member is at high risk for regression due to chronic disease or condition and there are no alternatives for adequate nutrition.

Oral Health Services
As part of the physical examination, the physician, physician’s assistant or nurse practitioner should perform an oral health screening. A screening is intended to identify gross dental or oral lesions, but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Depending on the results of the oral health screening, referral to a dentist should be made according to the timeframes listed below.

An oral health screening should be part of an EPSDT screening conducted by a PCP; however it does not substitute for examination through direct referral to a dentist. PCPs are expected to refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral should be documented on the EPSDT form. In addition to PCP referrals, EPSDT members are allowed self-referral to a dentist who is included in the UnitedHealthcare provider network.

Although the AHCCCS EPSDT Periodicity Schedule identifies when routine referrals begin, PCPs may refer EPSDT members for a dental assessment at an earlier age if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional.

<table>
<thead>
<tr>
<th>Category</th>
<th>Recommendation for Next Dental Visit</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent</td>
<td>24 hours</td>
<td>Pain, infection, swelling and/or soft tissue ulceration of approximately two weeks duration or longer.</td>
</tr>
<tr>
<td>Early</td>
<td>Within 3 weeks</td>
<td>Decay without pain, spontaneous bleeding of the gums and/or suspicious white or red tissue areas.</td>
</tr>
<tr>
<td>Routine</td>
<td>Next regular checkup</td>
<td>None of the above problems identified</td>
</tr>
</tbody>
</table>

EPSDT covers the following dental services:
- Emergency dental services including:
  - Treatment for pain, infection, swelling and/or injury.
  - Extraction of symptomatic, infected and non-restorable primary and permanent teeth, as well as retained primary teeth.
  - General anesthesia or conscious sedation when local anesthesia is contraindicated or when management of the patient requires it.
- Preventative dental services provided as specified in the AHCCCS Dental Periodicity Schedule, including, but not limited to:
  - Diagnostic services including comprehensive and periodic examination. Two oral examinations and two oral prophylaxis and fluoride treatments per member per year (i.e., one every six months) for members 12 months through 20 years-of-age.
  - Radiology services which are screening in nature for diagnosis of dental abnormalities and/or pathology, including panoramic or full-mouth x-rays, supplemental bitewing x-rays, and occlusal or periapical films as needed.
Chapter 6 Early, Periodic Screening, Diagnosis and Treatment (EPSDT)

- Preventive services which include:
  - Oral prophylaxis performed by a dentist or dental hygienist which includes instruction in self-care hygiene procedures.
  - Fluoride varnish. PCPs who have completed the AHCCCS required training, may be reimbursed for fluoride varnish applications completed at the EPSDT visits for members who are at least six months of age, with at least one tooth eruption. Additional applications occurring every six month during an EPSDT visit, up until member’s second birthday, may be reimbursed according to AHCCCS-approved fee schedules. Effective Jan. 1, 2015, application of fluoride varnish must be billed with CPT code 99188 if provided by provider types 08, 18, 19 and 31. This CPT replaces D1206 which can only be billed by dentist (provider type 07) effective April 1, 2015. Fluoride varnish training resources will be posted on the Department of Health Services website. Application of fluoride varnish may be billed separately from the EPSDT visit, V07.31. The current reimbursement rate is $18.58. On Jan. 1, 2015, CPT Code 99188 (application of fluoride varnish by a physician) was added to PMMIS as covered and available. This code will replace HCPCS Code D1206 (topical application of fluoride varnish), effective April 1, 2015 for provider types 08, 18, 19 and 31. Provider Type 07 (dentists) will continue to utilize HCPCS Code D1206 when billing for the Application of fluoride varnish.
  - Space maintainers when posterior primary teeth are lost permanently.

All therapeutic dental services will be covered when they are considered medically necessary but may be subject to prior authorization by UnitedHealthcare. Services include but not limited to:
  - Periodontal procedures, scaling/root planning, curettage, gingivectomy, osseous surgery.
  - Crowns:
    - Stainless steel crowns may be used for both primary and permanent posterior teeth; composite, plastic or acrylic crowns must be used for anterior primary teeth, or
    - Cast non-precious or semi-precious crowns for members 18-through-20-years-of-age on all functional permanent endodontically treated teeth, except third molars.
  - Endodontic services including pulp therapy for permanent and primary teeth, except third (3) molars unless it is functioning in place of a missing molar.
  - Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the members is 18-through-20-years-of-age and has had endodontic treatment, and
  - Removable dental prosthetics, including complete dentures and removable partial dentures.
  - Orthodontic services and orthognathic surgery are covered only when these services are necessary to treat a handicapping malocclusion. Services must be medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by the PCP and the dentist in consultation with each other. Orthodontic services are not covered when the primary purpose is cosmetic. Examples of conditions that may require orthodontic treatment including the following:
    - Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services, or
    - Trauma requiring surgical treatment in addition to orthodontic services, or
    - Skeletal discrepancy involving maxillary and/or mandibular structures.

Services or items furnished solely for cosmetic purposes are excluded from AHCCCS coverage (9 A.A.C. 22, Article 2).

All qualified medical professionals must provide proof of certification to CAQH in order to be paid for completing these tools/services. The AHCCCS recommended training for fluoride varnish application is located at smilesforlifeoralhealth.org/buildcontent.aspx?tut=584&pagekey=64563&cbreceipt=0

- Dental sealants on all non-caries permanent firs and second molars and second primary molars for members under age 16, and
- Fluoride varnish training resources will be posted on the Department of Health Services website.
**Cochlear and Osseointegrated Implantation**

**Cochlear Implantation:** Cochlear implantation provides an awareness and identification of sounds and facilities communication for persons who have profound, sensorineural hearing loss (nerve deafness). Deafness may be prelingual/perilingual or postlingual. AHCCCS covers medically necessary services for cochlear implantation for EPSDT members.

Candidates for cochlear implants must meet criteria for medical necessity, including but not limited to, the following indications:

- A diagnosis of bilateral profound sensorineural deafness (using age-appropriate standard testing), with little or no benefit from a hearing (or vibrotactile) aid, as established by audiologic and medical evaluation.
- Presence of an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by CT scan or other appropriate radiologic evaluation.
- No known contraindications to surgery.
- Demonstrated age appropriate cognitive ability to use auditory clues, and
- The device must be used in accordance with the FDA-approved labeling.

Cochlear implantation requires prior authorization for medical necessity through UnitedHealthcare.

**Osseointegrated Implants (Bone Anchored Hearing Aid [BAHA]):** Coverage of medically necessary services for osseointegrated implantation is limited to EPSDT members.

Osseointegrated implants are devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformation, chronic disease, severe sensorineural hearing loss or surgery.

**Conscious Sedation**

AHCCCS covers conscious sedation for members receiving EPSDT services. Conscious sedation provides a state of consciousness that allows the member to tolerate an unpleasant procedure while continuously maintaining adequate cardiovascular and respiratory function, as well as the ability to respond purposely to verbal command and/or tactile stimulation.

Coverage is provided for the following procedures except as specified below:

- Bone marrow biopsy with needle or trocar.
- Bone marrow aspiration.
- Intravenous chemotherapy administration, push technique.
- Chemotherapy administration into central nervous system by spinal puncture.
- Diagnostic lumbar spinal puncture, and
- Therapeutic spinal puncture for drainage of cerebrospinal fluid

Additional applications of conscious sedation for members receiving EPSDT services will be considered on a case-by-case basis and require review for medical necessity and prior authorization by UnitedHealthcare for enrolled members.
Behavioral Health Services
AHCCCS covers behavioral health services for members eligible for EPSDT services. EPSDT behavioral health services include the services listed in Federal Law 42 USC 1396d(a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services whether or not the services are covered under the AHCCCS State Plan.

Religious Non-Medical Health Care Institution Services
AHCCCS covers religious non-medical health care institution services for members eligible for EPSDT services.

Case Management Services
AHCCCS covers case management services as appropriate for members eligible for EPSDT services. In EPSDT, case management involves identifying the health needs of a child, ensuring necessary referrals are made, maintaining health history, and initiating further evaluation/diagnosis and treatment when necessary.

Chiropractic Services
AHCCCS covers chiropractic services to members eligible for EPSDT services when ordered by the member’s PCP for services identified during an EPSDT visit in order to ameliorate the member’s medical condition. Chiropractic services are not covered for members 21 years of age and older.

Personal Care Services
AHCCCS covers personal care services, as appropriate, for members eligible for EPSDT services.

Incontinence Briefs
Incontinence briefs, including pull-ups, are covered in order to prevent skin breakdown and to enable participation in social, community, therapeutic and educational activities under the following circumstances:

- The member is over three years and under 21 years old.
- The member is incontinent due to a documented disability that causes incontinence of bowel and/or bladder.
- The PCP or attending physician has issued a prescription ordering the incontinence briefs.
- Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for the member diagnosed with chronic diarrhea or spastic bladder.
- The member obtains incontinence briefs from care providers in the UnitedHealthcare network.
- Prior authorization has been obtained as required by UnitedHealthcare.

Prior authorization will be permitted to ascertain that:
- The member is over age three and under age 21;
- The member has a disability that causes incontinence of bladder and/or bowel;
- A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by UnitedHealthcare; and
- The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.

Medically Necessary Therapies
AHCCCS covers medically necessary therapies including physician therapy, occupational therapy and speech therapy necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. Therapies are covered under both an inpatient and outpatient basis when medically necessary.

Sick Visit Performed in Addition to AN EPSDT Visit
Billing of a ‘sick visit’ (CPT codes 99201-99215) at the same time as an EPSDT is a separately billable service if:

- An abnormality is encountered or a preexisting problem is addressed in the process of performing an EPSDT service and the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service.
- The ‘sick visit’ is documented on a separate note.
- History, Exam, and Medical Decision Making components of a separate ‘sick visit’ already performed during the course of an EPSDT visit are not to be considered when determining the level of the additional service (CPT code 99201-99215).
• The current status (not history) of the abnormality or preexisting condition is the basis of determining medical necessity.

Modifier 25 must be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service (E/M) was provided by the same physician on the same day as the preventive medicine service. Acute diagnosis codes not applicable to the current visit should not be billed. An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service, and which does not require additional work and the performance of the key components of a problem-oriented E/M service is included in the EPSDT visit and should not be reported.

Arizona Early Intervention Program (Az EIP)

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

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

AzEIP Evaluations for At-Risk Members (under three years of age)

To ensure UHCCP members younger than age three who are at risk of developmental delays and/or disabilities receive services appropriate for their specific condition/situation, we are asking care providers to follow the steps below when requesting physical therapy, occupational therapy, or speech/feeding evaluation:

• After completing the evaluation, the servicing care provider (therapist/facility) who conducted the evaluation is required to submit an Evaluation Report to the primary care physician.

• If the evaluation indicates that the member scored two standard deviations below the mean, which generally translates to Arizona Early Intervention Program (AzEIP) eligibility criteria of 50 percent developmental delay, the child will continue to receive all medically necessary Early Periodic Screening Diagnosis and Treatment (EPSDT) covered services through UnitedHealthcare Community Plan. To help ensure the member receives these services, please:

  • Request ongoing therapies through UnitedHealthcare Community Plan’s Prior Authorization Department at 866-604-3267, and
  • If you have not already submitted an online referral, please complete one and submit it via AzEIP at extranet.azdes.gov/azeip/azeipref/Forms/Categories.aspx.

• If the member is in need of non-medically necessary services that are not covered by Medicaid but are covered under Individuals with Disabilities in Education Act (IDEA) Part C, please notify the UnitedHealthcare Community Plan EPSDT Coordinator at 602-255-8196 or 602-255-8108 if you have not previously submitted an AzEIP referral.

Coordination of Therapy Services With CRS Members Enrolled in AzEIP

To ensure follow-up on Early and Periodic Screening Diagnosis and Treatment (EPSDT), and Arizona Early Intervention Program (AzEIP) referrals for CRS enrolled members, UnitedHealthcare Community Plan will coordinate receipt of care with the MSICs as the member’s health home. EPSDT services for Acute members includes coverage for PT, OT, and Speech/Feeding Therapy between ages 0-21. The CRS Coverage Type determined the payor for these services:

<table>
<thead>
<tr>
<th>CRS Coverage Type</th>
<th>EPSDT Payor of Services (including therapy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Integrated</td>
<td>UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Partially Integrated – Acute</td>
<td>UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Partially Integrated – Behavioral Health</td>
<td>DD Plan of enrollment (which could be UnitedHealthcare Community Plan DD, or other DD Plan) or CMDP</td>
</tr>
<tr>
<td>CRS Only</td>
<td>Primary Program of enrollment</td>
</tr>
</tbody>
</table>
UnitedHealthcare Community Plan is required under the AHCCCS AMPM Policy 430, EPSDT Services; Exhibit 430-3, to review and respond to AzEIP referrals within 10 business days. The following process has been developed to meet the AHCCCS requirement:

**UnitedHealthcare Community Plan and MSIC AzEIP Referral Process (0-3 years of age):**
- An AzEIP Service Coordinator submits a therapy (OT/PT/ST) request to UnitedHealthcare Community Plan’s Coordinator for EPSDT and AzEIP services.
- The UnitedHealthcare Community Plan Coordinator forwards the referral to the appropriate CRS Liaison to determine if the MSIC can provide therapy services.
- The CRS Liaison will provide the MSIC with the CRS Clinical Liaison Communication Log explaining the type of referral, along with the referral from AzEIP.
- The MSIC will review the referral and respond to the CRS Clinical Liaison within **seven days** if services will be provided at the MSIC.
- If services will not be provided at the MSIC, the MSIC will respond back to the Clinical Liaison and UnitedHealthcare Community Plan will authorize treatment to be performed by a contracted provider outside the MSIC.
- For the Yuma MSIC AzEIP requests, the UnitedHealthcare Community Plan Coordinator will send referrals directly to the contracted Provider to coordinate therapy care.
- UnitedHealthcare Community Plan’s Coordinator will email a copy of the Authorization for the contracted servicing care provider to the Clinical Liaison to be saved to the member record.

**Approved Developmental Screening Tools**
The AHCCCS approved developmental screening tools include:

A. **The Parent’s Evaluation of Developmental Status (PEDS) tool which may be obtained from pedtest.com or forepath.org.**

B. **Ages and Stages Questionnaire (ASQ) tool which may be obtained from agesandstages.com.**

C. **The Modified Checklist for Autism in Toddlers (MCHAT) may be used only as a screening tool by a primary care provider, for members 16 to 30 months, to screen for autism when medically indicated.**

Copies of the completed tools as well as a copy of the EPSDT form must be retained with medical record. To receive the developmental screening tool payment, the modified EP must be added to the 96110. For claims to be eligible for payment of code 96110; the care provider must have satisfied the training requirements, the claim must be a nine, 18, or 24-month EPSDT visit, and an AHCCCS approved developmental screening tool must have been completed. PEDS, ASQ, and M-CHAT training resources will be posted on the Department of Health Services website.

All qualified medical professionals must provide proof of certification to CAQH: CAQH.org in order to be paid for completing these tools/services.

**EPSDT Forms and Periodicity Schedules**
The AHCCCS EPSDT Tracking Forms must be used by care providers to document all age-specific required information related to EPSDT screenings and visits. Only the AHCCCS forms may be used; substitutes are not acceptable. Care providers should submit the completed form to UnitedHealthcare at the address listed below and a copy of the form must be placed in the member’s chart. Send EPSDT forms to:

**UnitedHealthcare Quality Management**
Attn: EPSDT
1 East Washington, Suite 900
Phoenix, AZ 85004

A copy of all EPSDT forms and EPSDT periodicity schedules are provided on our website at UHCCommunityPlan.com under the Provider Forms section and are also available online at azahcccs.gov. The periodicity schedule is updated regularly on the AHCCCS website. Care providers may also call the UnitedHealthcare Provider Service Center at 800-445-1638 to request a copy of the periodicity schedule.

To order EPSDT forms please call Quality Management 888-664-2777 or fax the EPSDT order form to 602-255-8732. Requests are processed within 24-48 hours from receipt.
Chapter 7 Children’s Rehabilitative Services (CRS)

CRS Coverage Types

CRS eligible members will be enrolled under one of the following four CRS coverage types depending upon the primary program in which the member is enrolled for acute care services. Benefits vary between the different coverage types and not all services are covered by all coverage types. CRS members enrolled prior to age 20 are given a one-time option to remain in CRS after turning 21. AHCCCS will send a letter 60 days prior to the member’s 21st birthday with instructions on how to contact AHCCCS to opt in.

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>CRS</th>
<th>Acute</th>
<th>BH</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRS Fully Integrated</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Members receiving all services from UnitedHealthcare Community Plan including acute health, behavioral health and CRS-related services.</td>
</tr>
<tr>
<td>CRS Partially-Integrated-Acute</td>
<td>X</td>
<td></td>
<td></td>
<td>American Indian (AI) members receiving all acute health and CRS-related services from UnitedHealthcare Community Plan and receiving behavioral health services from a Tribal RBHA. <strong>Coverage: CRS and Acute/Primary Care Conditions Only</strong> <em>(contact RBHA/TRBHA for Behavioral Health)</em></td>
</tr>
<tr>
<td>CRS Partially-Integrated-Behavioral Health (BH)</td>
<td>X</td>
<td></td>
<td>X</td>
<td>CMDP or DDD members receiving all behavioral health and CRS-related services from the CRS Contractor and receiving acute health services from the primary program of enrollment <strong>Coverage: CRS and BH Conditions Only</strong> <em>(contact Primary AHCCCS Health Plan for other Medical Services)</em></td>
</tr>
</tbody>
</table>
| CRS Only                            | X   |       |    | Members receiving all CRS-related services from the CRS Contractor, receiving acute health services from the primary program of enrollment, and receiving behavioral health services as follows:  
  • CMDP and DDD AI members from a Tribal RBHA  
  • AIHP members from a T/RBHA CRS Only also include ALTCS/EPD AI Fee for Service members. **Coverage: CRS Conditions Only** *(contact Primary AHCCCS Health Plan for other medical services)* |

This chapter includes a description of Children’s Rehabilitative Services (CRS) covered conditions and medically necessary covered services for CRS enrolled members. The CRS program enrolls members who require treatment for medically disabling or potentially disabling conditions as defined in A.A.C. R9-22-1303. Enrollment is based upon a member’s qualifying condition and the need for active treatment of CRS condition in R9-22-1303 through medical, surgical or therapy modalities.

Multi-Specialty Interdisciplinary Clinic (MSIC)

The MSIC is the CRS member’s health home. Upon enrollment every member is assigned to one of four regionally based MSICs. The MSIC provides accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. Members enrolled in the CRS Fully Integrated and CRS Partially Integrated-Acute coverage types may choose a primary care provider in the community or within the MSIC, if available. UHCCP coordinates with the MSIC and the PCP to ensure there is an integrated approach to care and the decision-making process.

CRS Medical Records

Please see Chapter 11 for UHCCP Medical Record Policy information. The MSIC must have an integrated electronic medical record for each member that is maintained and available for the multi-specialty treatment team and community care providers. An integrated electronic medical record must contain all information necessary to facilitate the coordination and quality of care delivered by multiple care providers in multiple locations at varying times.

All CRS contracted care providers must retain medical records in compliance with A.R.S. §12-2291 and 2297, which requires, among other things, that children’s medical records be retained for at least three years after the child’s 18th birthday or for at least six years after the last date the child received medical or health care services from the provider, whichever date occurs later.
**Telemedicine**

This technology is used to deliver care and services directly to the member and to maximize the provider network. The technology can also be used to enhance communication, increase educational opportunities for members, member’s families, CRS staff, and care providers.

**Services Provided**

Services provided through telemedicine technology may include:

- Outreach clinics
- Physician consultation
- Other professional consultation or services
- Member, family and professional education, and Videoconference meetings or trainings

**Covered and Excluded CRS Services**

AHCCCS determines eligibility for those applicants who require treatment for medical conditions that are conducive to treatment where specialized treatment is necessary, and functional improvement is potentially achievable. Longterm follow-up may be required for maximum achievable results. Care providers need to confirm CRS coverage type and therefore covered benefits prior to providing services.

**Services That Require Prior Authorization for CRS Services**

Any service rendered outside of the MSIC with a condition listed on the CRS Master Diagnosis List (CRS Condition Only*) requires prior authorization. The full prior authorization list as well as the Master Diagnosis List are available online at UHCCCommunityPlan.com. All services rendered by a non-contracted provider require prior authorization and must have supporting documentation to support the out of network request. Any service which may be considered experimental or investigational is not a covered benefit.

The following directives apply to all CRS Prior Authorizations:

- The member must be eligible at the time the covered service is rendered.
- Only one service may be requested per Physicians Services Requisition (PSR) form.
- Authorization is not a guarantee of payment.
- ALL rendering providers/facilities/vendors must be actively registered with AHCCCS.

**Important Reminders:**

- All services must be covered benefits as outlined by the Arizona Health Care Cost Containment System (AHCCCS) program and as defined by AHCCCS for one of the CRS four plan type (see table in beginning of Chapter).
- All prior authorization requests may be submitted via Phone, Fax, or UHC Portal.
- Instructions for submitting prior authorization requests online can be found at UHCCCommunityPlan.com.

**Prior Authorization Fax Number 888-899-1499.**

**Audiology Services**

UHCCP provides covered audiology services to CRS members who are hearing impaired or whose CRS condition poses a risk for hearing impairment. Audiology services include:

- Audiologic Assessments
  - Audiologic assessments shall be consistent with accepted standards of audiologic practice.
  - CRS may provide Brainstem Audiology Evoked Response (BAER) evaluations at the request of the CRS physician.
- Hearing Aid Fittings and Evaluations
  
  The following are covered:

  - Hearing aids are provided for CRS members. The CRS member may have the hearing aid reevaluated annually.
  - A hearing aid may be replaced once every three years, unless the member experiences a change in hearing levels or is determined by a CRS contracted audiologist to require a hearing aid replacement.
  - Implantable bone conduction devices are covered.
  - Cochlear implants are covered.
Exclusions and Limitations:
Accessory items are excluded. Only items necessary for proper functioning and maintenance of the hearing aid are included.

Benefit and coverage guidelines for acute members as stated in previous chapters pertain to those CRS members over the age of 21.

Contractor Requirements:
The Contractor shall:
• A provide an audiology area with the following:
  • An audiometric testing suite containing at least one sound booth (6’ x 6’ minimum):
  • Each sound booth shall be equipped with two sufficient ohm loud speakers that are mounted 6’ apart at 45 or 90 degrees azimuth and
  • On two-channel pure-tone (air and bone conduction) audiometer per sound booth having masking capabilities and speech capabilities (both for recorded and monitored live voice stimuli) and able to generate warble tones and/or narrow band noise stimuli for sound field testing.
  • Dedicated space for a hearing aid laboratory.
• Provide the following audiology equipment/supplies:
  • Speech (recorded and live voice) stimuli test materials;
  • A diagnostic impedance bridge;
  • Materials with capabilities for visual reinforcement and conditioned play;
  • One halogen lamp otoscope with assorted ear tips for each sound booth;
  • One electroacoustic hearing aid analyzer and an assortment of earmold and hearing aid servicing tools, supplies and equipment;
  • Availability of hearing aids from various manufacturers, in order to meet the needs of each member; and
  • A diagnostic Auditory Brainstem Response (ABR) unit for use on site. Appropriately licensed staff shall be provided to administer sedation and monitor members requiring sedation for ABR testing.
  • A bed and a quiet room shall be available for ABR testing.

Dental and Orthodontia Services

Dental
UHCCP provides a full range of dental services only to enrolled members who have one of the following diagnosed conditions or circumstances:
• Cleft lip and/or cleft palate,
• A cerebral spinal fluid diversion shunt where the member is at risk for subacute bacterial endocarditis,
• A cardiac condition where the member is at risk for subacute bacterial endocarditis,
• Dental complications arising as a result of treatment for a CRS condition, or
• Documented significant functional malocclusion where malocclusion is defined as functionally impairing in a CRS member with a craniofacial anomaly (e.g., hemifacial microsomia, Treacher Collins Syndrome) or when one of the following criteria is present:
  • Masticatory and swallowing abnormalities affect the nutritional status of the individual resulting in growth abnormalities,
  • The malocclusion induces clinically significant respiratory problems such as dynamic or static airway obstruction, or
  • Serious verbal communication disturbance as determined by a CRS contracted speech therapist. Report must indicate the malocclusion as the primary etiology for the speech impairment and that speech cannot be further improved by the speech therapy alone.

Orthodontia Services
Orthodontia services are covered for a member with a diagnosis of cleft palate or documented significant functional malocclusion as defined above.

Exclusions and Limitations
Dental and orthodontia services may be provided in CRS clinics. When services are limited or in communities where there is no CRS clinic; the dental and orthodontia services may be provided at the CRS practitioner’s private office. Benefit and coverage guidelines for acute members as stated in previous chapters pertain to those CRS members over the age of 21.
Diagnostic Testing and Laboratory Services

CRS Contractors shall provide member access to the following laboratory and diagnostic testing services:

- A full service laboratory including blood bank, pulmonary function, micro processing, testing with STAT capability, including phlebotomy and blood specimen preparation services, as well as equipment for performing CBC’s and urinalysis.
- A full service general radiographic unit in or adjacent to the outpatient clinic.
- Special diagnostic testing services including: visual evoked response, CT scan, ultrasound, brainstem auditory evoked response (BAER), magnetic resonance imaging (MRI), electroencephalogram (EEG), electrocardiogram (EKG), and echocardiogram.

Exclusions and Limitations

Diagnostic Testing: Diagnostic testing is a covered service as otherwise stated in this manual. For the purposes of the CRS program, the following exclusions stated in this chapter apply. Experimental or investigational testing is not covered, according to AHCCCS guidelines.

Laboratory Services:

Follow-up laboratory evaluations where discovered laboratory abnormalities are unrelated to the CRS condition are excluded. The individual must be referred to his or her primary care physician for follow-up care.

For example, an applicant is found to have sickle cell anemia, a CRS condition, but is also human immunodeficiency virus (HIV) positive. Follow-up care for the HIV status must be referred to the individual’s CRS PCP. Depending on the member’s coverage type, the PCP may be part of the CRS network, and follow up care can be provided by CRS.

Genetic Diagnostic Testing Provisions

AHCCCS Medical Policy for Genetic Testing Provisions: Prior authorization requests must include documentation regarding how the genetic testing is consistent with the genetic testing coverage limitations. Genetic testing is only covered when the results of such testing are necessary to differentiate between treatment options. Genetic testing is not covered to determine specific diagnoses or syndromes when such diagnoses would not definitively alter the medical treatments of the member. Genetic testing is not covered to determine the likelihood of associated medical conditions occurring in the future. Routine, non-genetic testing for other medical conditions (e.g., renal disease, hepatic disease, etc.) that may be associated with an underlying genetic condition is covered when medically necessary. Genetic testing is not covered as a substitute for ongoing monitoring or testing of potential complications or sequelae of a suspected genetic anomaly. Genetic testing is not a covered service for purposes of determining current or future family planning. Genetic testing is not covered to determine whether a member carries a hereditary predisposition to cancer or other diseases. Genetic testing is also not covered for members diagnosed with cancer to determine whether their particular cancer is due to a hereditary genetic mutation known to increase the risks of developing that cancer.

Durable Medical Equipment (DME)

Medically necessary durable medical equipment is provided to the member for the purpose of rehabilitative care that is directly related to treatment for a CRS condition. Please call Preferred Homecare at 800-636-2123. DME does not require prior authorization unless it is provided by a vendor other than Preferred HomeCare and/or if the cost is more than $500.

Equipment repairs are covered when medically necessary. Oxygen therapy is covered when ordered by a CRS physician for the treatment of a CRS condition.

Exclusions and Limitations

Members are eligible for equipment only when they are being followed in a medical or surgical CRS clinic. All equipment shall be directly related to the care of the CRS condition. Equipment is covered only when an authorized CRS provider orders it. Coverage is excluded for equipment used only for school purposes.

Oxygen and related supplies are no longer limited to 30 calendar days of coverage if it is for a CRS-related condition.

Coverage is excluded for the following items:

- Cranial modeling bands, except for members who are 24 months of age or younger who have undergone CRS approved cranial modeling surgery and demonstrate postoperative progressive loss of surgically achieved correction and that without intervention would most likely require additional remodeling surgery,
- Mobilizer walker,
- Motorized caster carts,
- Standers,
- Strollers, except when used as modified seating for positioning and
Equipment Maintenance
CRS does pay for equipment modifications necessary due to the member’s growth or due to changes in the member’s orthopedic or health needs. The CRS physician, the physical therapist, or occupational therapist shall recommend equipment modifications. CRS does not pay for repairs needed because of improper use or neglect.

Equipment Replacement or Repair
• Contractors must have a contract clause with durable medical equipment (DME) providers, providing assurance that if an article furnished under the contract is found to be unsatisfactory due to imperfect or faulty construction within 60 calendar days of delivery, such articles shall be returned to the Contractor’s provider to be corrected, adjusted, or replaced at no additional charge.
• A replacement for lost or stolen equipment shall be requested through the prior authorization process. If the equipment was stolen, a copy of the police report, verifying the incident, must be submitted to the appropriate CRS clinic. Lost equipment can be replaced if it has not been replaced within the previous 12 months due to loss.
• A repair can be made to equipment in lieu of replacement if the equipment was provided by the Contractor or, if not provided by the Contractor, has been determined by a CRS provider to be safe, appropriate and medically necessary.

Prosthetic and Orthotic Devices
Coverage and benefits depend upon the member’s CRS Coverage Type. Some covered services include:
• Prosthetic and orthotic devices are provided to a member to enhance the member’s ability to perform activities of daily living.
• CRS covers prosthetic and orthotic modifications or repairs which are medically necessary because of the individual’s growth or due to changes in the individual’s orthopedic or health needs or when equipment is no longer safe.
• CRS covers ocular prostheses and replacements when related to a CRS condition. CRS also provides and replaces ocular prostheses for CRS members when medically necessary.
• A replacement for lost or stolen prosthetic and orthotic devices shall be requested in writing for prior authorization. If the device was stolen, a copy of the police report, verifying the incident, must be submitted to the appropriate CRS clinic. A lost device can be replaced if it has not been replaced within the previous 12 months due to loss.

• CRS shall provide or fabricate orthotic/prosthetic devices that assist CRS members in performing normal living activities and skills, such as:
  • all orthotic/prosthetic devices shall be constructed or fabricated using high quality products;
  • all orthotics shall be completed, modified or repaired and delivered to the CRS member within 15 working days of the provider’s order;
  • all prostheses shall be completed, modified or repaired and delivered to the CRS member within 20 working days following the member’s provider order;
  • orthotic/prosthetic repairs ordered by physician as “urgent” shall be delivered within five working days; and
  • Same day service shall be provided for emergency adjustments for members unable to undertake their normal daily activities without the repairs and/or modifications.

• CRS will assure there will be no additional charge for modifications and/or repairs during the normal life expectancy of the device except as required to accommodate a documented change in the member’s physical size, functional level, or medical condition.

Exclusions and Limitations
• Myoelectric prostheses are excluded.
• Microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs are not a covered benefit.
• Shoes for prosthesis are excluded.
• Repair or replacement required due to misuse by the member is excluded.

Prosthetic and Orthotic devices may be part of the member’s acute care benefit under the CRS Integrated Program. See AHCCCS Policy Manual, Attachment 300-3 for additional listed exceptions.

Wheelchairs and Ambulation Devices
• UnitedHealthcare Community Plan’s contracted, in network supplier for wheelchairs and ambulation devices is NuMotion/United Seating and Mobility. Please contact NuMotion at 866-248-4839.
• CRS will provide and modify wheelchairs for CRS members, as well as provide ambulation assistive devices (crutches, canes, walkers).
• CRS will provide wheelchair fittings modifications and repairs within 60 working days from the date ordered by the member’s provider.
• CRS will provide final fittings for ambulation assistive/adaptive devices from the date ordered within:
  • 20 working days for routine fittings.
  • Five working days for repairs ordered by a physician as ‘urgent’.
  • Same day service shall be provided for emergency adjustments or repairs for members unable to undertake their normal daily activities safely without the repair/adjustments.
• CRS covers medically necessary equipment modifications due to member’s growth or changes in the member’s orthopedic or health needs.
• Wheelchairs and ambulation devices are covered when:
  • There is a change in the member’s medical condition,
  • The equipment is no longer safe to operate, or
  • The member has outgrown the equipment.
• Custom fit stander and parapodiums with clich-clacks are covered for braced-walking potential for spinal cord defect patients.
• Trays for wheelchairs will be provided when documentation indicates that the need is directly related to improvement in functional skill level.

Exclusions and Limitations
• Replacement of wheelchairs and ambulation devices is not covered service when the equipment is functional and can be repaired such that the equipment is safe to operate.
• CRS does not pay for physical or structural modifications to a home.
• The CRS member’s family or guardian shall be responsible for the care of and transportation of equipment.
• The CRS member and/or his or her family shall demonstrate that they can safely use all equipment provided to the member. Practical and functional use of equipment shall be documented in the member’s CRS medical record.
• Wheelchairs and ambulation devices used solely for school purposes are excluded.
• CRS may repair or provide maintenance of equipment that, although not provided to the member by CRS, a CRS provider has determined to be safe and appropriate.
• Wheelchair and ambulation device needs shall be met through recycled items, i.e., wheelchairs, if the item meets needed specifications
• Short-term rental wheelchairs and ambulation devices are limited to 30 calendar days. A prior authorization request may be submitted for an extension.

High Frequency Chest Wall Oscillation (HFCWO) Therapy
Criteria for medical necessity include, but are not limited to, all of the following:
• Diagnosis of cystic fibrosis
• Documentation of excessive sputum production combined with the member’s inability to clear the sputum without assistance;
• Copy of chest x-ray report and pulmonary function tests showing findings consistent with moderate or severe chronic obstructive pulmonary disease (COPD);
• Prescription signed by M.D. or D.O. with a specialty in pulmonary disease, indicating the need for at least daily (or more frequent) chest physiotherapy;
• Age two years or older or 20 inch chest size, whichever comes first
• Specific documentation supporting why HFCWO therapy for the member is superior to other more cost-effective therapy methods, including at least one of the following:
  • Promotes independent self-care for the individual;
  • Allows independent living or university or college attendance for the individual
  • Provides stabilization in single adults or emancipated individuals without able partners to assist with CPT, or
  • Sever end-stage lung disease requiring complex or frequent chest physiotherapy.
• Evidence that the member can use the vest effectively, including continuing compliance with all forms of prescribed therapy and treatment and member and family acceptance of HFCWO therapy; and
• Coordination between the provider’s office or clinic and Arizona Health Care Cost Containment System (AHCCCS) or other payer source, such as UHCCP, prior to implementation of HFCWO therapy for long-term use.

Discontinuation Criteria for HFCWO
• Patient and/or prescribing physician request; or
• Patient treatment compliance at a rate of less than 50% usage as prescribed in the medical treatment plan, to be checked at two and six months of usage.

HFCWO percussive vest requires prior authorization. All cases will be reviewed on a case-by-case basis. Requests for prior authorization must be accompanied by specific documentation in the individual’s personal medical record that supports the medical necessity for HFCWO percussive vest. Criteria for medical necessity include, but are not limited to, that listed above.
Home Health Care Services

Home health care services include professional nurse visits, therapies, social work services, equipment, and medications for the CRS member.

Pre-hospitalization

Home health care services are limited to pre-hospitalization for a procedure or surgery in lieu of hospitalization to provide total parenteral nutrition.

Post-hospitalization

Home health care services may be provided under the CRS Integrated Program, for acute care services and are limited to the post-hospitalization rehabilitative or recovery period or are provided in lieu of hospitalization. Services must be ordered by the CRS Provider.

Home health care services provided in a member’s place of residence includes:
- Assessment of home health needs,
- IV therapies,
- Wound evaluation,
- Administration of medications,
- Monitoring vital signs,
- Monitoring oxygen administration,
- Monitoring and assessing patient physical signs,
- Teaching and evaluating of therapies,
- Enterostomal therapy and teaching,
- Catheter insertion, care, and teaching, and
- Instruction regarding home health care to member or member’s caregivers.

Exclusions and limitations

Home health care services must be ordered by the physician who is supervising the CRS care for the member.

Inpatient Services

CRS covers inpatient hospitalizations for CRS members at contracted facilities. The hospitalization is covered for a member when it is specifically for the treatment of a CRS condition however, inpatient services may also be provided under the CRS Integrated Program for those with acute care needs. Inpatient admissions are limited to 25 days per fiscal year for members over the age of 21 who are discharged prior to October 1st, 2014. Observation services do not require prior authorization. Observation stays that are greater than 24 hours will be counted as 1 bed day and will be included in the 25 bed days per year benefit for members over 21 years of age. There will no longer be a 25 bed day limit per fiscal year for members who are discharged on or after October 1st, 2014 per the AHCCCS implementation of APR-DRG based payment methodology.

Requirements for Admission and CRS Reimbursement for an Inpatient Acute Care Stay

- Only CRS physicians can admit and treat CRS members for CRS conditions. Physicians must have a contract with a UHCCP or be appropriately credentialed with a UHCCP to admit and treat CRS members.
- The admitting physician shall obtain prior authorization from the CRS Contractor for all non-emergency hospital CRS related admissions.
- Prior authorization is not required for an emergency admission that is related to a CRS condition under the member’s specialty care coverage.
- The primary reason for hospitalization shall be related to the CRS condition.
- CRS does not provide hospitalization for the sole purpose of maintaining the member, i.e., long-term ventilator support, nutritional support.
- See AHCCCS Medical Policy Manual (AMPM) Chapter 300, for Discharge Planning. CRS will pay for the initial diagnostic evaluation by a CRS provider to rule out a ventricular infection or ventricular shunt failure at a CRS contractor hospital. The period of time covered for the rule out is from the time of admission until the results of the CT scan, MRI, CFS culture, or measurements of ICP are available to the physician. If the member does not have a shunt infection or failure as described above, he or she must be decertified from CRS payer liability from the point of the neurosurgeon’s diagnosis forward. The acute illness and reason for hospitalization, then falls under the acute benefits, if applicable.

Growth Hormone Therapy

CRS covers growth hormone therapy only for members with panhypopituitarism.

Nursing Services

Nursing services include:
- Direct nursing care to members during specialty clinics and supervision of subordinate nursing staff during specialty clinics;
- Documented nursing care assessments, interventions, implementation, and revisions of care following evaluation;
Education of members, families, caregivers, and other staff in treatment and testing procedures, health promotion, self-care skills, and anticipatory guidance; and

- Discharge planning and care coordination services.

Nutrition Services

Covered Services

- Nutrition services include screening, assessment, intervention, and monitoring. CRS providers shall cover nutrition services for CRS members with special nutritional needs when the nutritional need is related to a CRS condition.

Exclusions and Limitations

- Preferred Homecare is the exclusive in-network provider for Enteral Services for UHCCP CRS members. To request these services from Preferred Homecare:
  - Call Preferred Homecare at 800-636-2123 or 480-446-9010
  - Fax an order to Preferred Homecare at 866-265-0455
  - Provide written order on a prescription form and allow the member to directly request the order from Preferred Homecare
- A registered dietitian must provide nutrition services.
- CRS covers nutritional supplements upon referral from CRS physicians with consultation by a registered dietitian in accordance with the following guidelines:
  - Metabolic Disorders
  - Formulas for metabolic disorders such as PKU, MSUD, HCU, and isovaleric acidemia that are treated by a special diet are covered based on the CRS Contractor’s formulary or CRS Medical Director approval and in accordance with the following guidelines:
    1. PRODUCTS: Specified formulas for treatment of metabolic disorders such as Lofenalac, Phenyl-Free, Analog X, Maxamaid X, MSUD Diet Powder, and formula component products such as Mead Johnson Product 80056.
    2. QUANTITY: As needed, based upon demands for growth and maintenance, to be determined by the registered dietitian.
      - DURATION: As long as treatment through dietary modification continues.
  - NOT COVERED: Lactose-free formulas for galactosemia; infant formulas or milk products used in conjunction with modified amino acid formulas; low protein food products such as pasta, breads, and cookies for amino acid disorders.

3. TUBE FEEDINGS

Tube feedings and medically necessary tube feeding equipment are available for CRS members when the need is related to a CRS condition.

- PRODUCTS: Commercially available tube feeding formulas such as Compleat, Isocal, Osmolite, and formula component products such as Polycose.
- QUANTITY: As needed, based upon demands for growth and maintenance, to be determined by the physician or registered dietitian.
- EQUIPMENT: Tube feeding equipment, such as feeding pumps, will be provided by CRS when deemed medically necessary to provide adequate nutrition.
- NOT COVERED: Foods and beverages recommended for blenderized recipes.

4. CYSTIC FIBROSIS

Nutrition services are available for CRS members with cystic fibrosis when appropriate growth and maintenance requires a supplemental product and no other resources or community nutrition support programs are available.

- PRODUCTS: Commercially available nutrition supplements for additional calories and other nutrients. Examples include Ensure, Enrich, Sustacal, and formula component products such as MCT oil. (Consult manufacturers’ product handbooks for nutritional content.)
- QUANTITY: Limited to approximately 50 percent of daily caloric needs for infants, individuals, and adults as a supplement to a regular diet unless the cystic fibrosis individual is also being tube fed (see 2 above).
- DURATION: Limited to 30 calendar days of coverage. The CRS Medical Director or designee must approve extension for coverage.
- NOT COVERED: Foods and beverages that constitute the member’s regular diet.
Outpatient Services

Acute outpatient services may also be available depending on the members CRS coverage type.

Refer to the Prior Authorization list available online at UHCCommunityPlan.com

Covered Services:

• Covered outpatient services include:
  • Ambulatory surgery,
  • Outpatient diagnostic and laboratory services,
  • Ancillary services, and
  • Clinic Services.

• Multi-specialty, Interdisciplinary Clinics
  1. CRS members require multi-specialty, interdisciplinary care.
  2. CRS Specialty Clinics may include but are not limited to:
     a. Amputee,
     b. Arthritis/rheumatology,
     c. Cardiac,
     d. Cystic fibrosis
     e. ENT,
     f. Endocrine,
     g. Eye,
     h. Feeding
     i. General Surgery
     j. Genetics,
     k. Hand,
     l. Metabolic
     m. Myelomeningocele,
     n. Neurofibromatosis
     o. Neurology,
     p. Neurosurgery,
     q. Nutrition,
     r. Orthodontia,
     s. Orthopedics
     t. Cerebral palsy,
     u. Plastic surgery,
     v. Pulmonary,
     w. Rhizotomy,
     x. Scoliosis,
     y. Sickle cell anemia,
     z. Urology,
     a1. Wheelchair

• Community-Based Field Clinics
  1. CRS develops field clinics where the demand exists and resources are available. Community-based field clinics are specialty clinics that are held periodically in locations other than the CRS MSIC, rural communities in Arizona, or on Indian Reservations.
  2. Outreach clinics may include:
     a. Cardiac,
     b. Orthopedic,
     c. Neurology,
     d. Plastic Surgery, and
     e. Ear, Nose, and Throat (ENT).

Limitations

Depending on the CRS Coverage Type, routine and acute medical care that is not related to the CRS condition, such as periodic visits for scheduled immunizations and periodic physical examinations may be covered by the CRS Integrated Program.

Pharmaceuticals

CRS has implemented an Integrated Patient Drug List (PDL) or formulary. The PDL covers CRS, Acute care and behavioral health drugs, depending on the member’s CRS coverage type.

Covered Services:

• Pharmaceuticals are covered when appropriate, when ordered by the CRS physician and when provided through a contracted pharmacy. Covered services also include special formulation nutrition needs for metabolic patients.

Exclusions and Limitations

The following exclusions and limitations are dependent upon the member’s CRS coverage type.

• Pharmaceuticals or supplies that would normally be ordered by the primary care physician for the overall health maintenance of the individual are not covered (i.e., multiple vitamins, antibiotics, insulin, asthma drugs, etc.), or drugs used for the treatment of a non-CRS condition.

• Medications covered under Medicare Part D for CRS members who are dual eligible (AHCCCS/Medicare) enrollees are not covered by CRS.

• Exceptions to the formulary may be made under special circumstances when approved through prior authorization. The Pharmacy Prior Authorization Request and Formulary is available online at UHCCommunityPlan.com.
Physical and Occupational Therapy Services

Physical and occupational therapy services must be related to the member’s CRS condition. Coverage depends on the member’s CRS Coverage Type. Physical Therapy has a limit of 30 visits per fiscal year for members over 21 years of age. Occupational therapy is not a covered outpatient service for members over 21 years of age.

Covered services:
- Physical therapy and occupational therapy are provided when the member is unable to obtain physical therapy or occupational therapy through a source other than CRS, and
- The member has a strong potential for rehabilitation as determined by a CRS provider.
- AHCCCS age limits and benefit limits apply.

Speech Therapy Services

Speech therapy services must be related to the member’s CRS condition. Speech therapy is not a covered outpatient service for members over 21 years of age.

Covered Services
- Speech therapy is provided when the member is unable to obtain speech therapy through a source other than CRS, and
- The member has a strong potential for rehabilitation as determined by a CRS provider.
- AHCCCS age limits and benefits apply.

Physician Services

Physician services shall be furnished by a licensed physician and shall be covered for members when rendered within the physician’s scope of practice under A.R.S Title 32. A CRS contracted physician shall be appropriately credentialed. UnitedHealthcare Community Plan contracts statewide with pediatric specialists to provide CRS services.

Medically necessary physician services may be provided in an inpatient or outpatient setting, and includes:
- Medical evaluations, consultation, and diagnostic workups,
- Medically necessary treatment for the CRS condition,
- Prescriptions for medications, supplies and equipment,
- Referrals to other specialists or health care professionals when necessary, and
- Patient education.

Psychology and Psychiatry Services

Please refer to Chapter 8 for CRS related Behavioral Health Coverage and Limitations.

Second Opinions

Covered Services
- CRS covers second opinions by other CRS contracted physicians when available. If not available, CRS will provide a second opinion by a non CRS contracted physician.

Exclusions and Limitations
- Only one-second opinion is allowed per episode or specialty.
- Second opinion visits will be provided at the first available appointment.
- Office visits for second opinions may be arranged on an urgent basis at the discretion of the CRS Medical Director.

Transplants

Covered services depend on the member’s CRS coverage type
- CRS covers transplant services for corneal transplants and incidental bone grafting transplants related to the CRS condition.

Exclusions and Limitations
Depending on the member’s coverage type, some services may also be part of the acute care benefit under the CRS Integrated Program.
Chapter 7 Children’s Rehabilitative Services (CRS)

Vision Services

Covered services depend on the member’s CRS coverage type. Covered Services

- Vision services include examinations, eyeglasses, and contact lenses for the treatment of a CRS condition.

Exclusions and Limitations

- Replacements for broken or lost glasses or contact lenses are limited to one replacement per prescription per calendar year.
- Lens enhancements such as ultra violet (UV) tinting and safety glass shall be provided as medically necessary and ordered by a CRS physician.

Renal Hemodialysis

CRS does not cover renal hemodialysis services. Depending on the member’s CRS coverage type, routine vision services may be available for members under 21 years of age in accordance with their acute benefits.

Family-Centered and Culturally Competent Services

Member Advocacy Program
The Ombudsman/Member Advocate is responsible for overseeing the Member Advocacy program and works closely with member and provider services to ensure the CRS program provides accessible, effective, person-and-family-centered, culturally and linguistically appropriate care, delivered in a manner consistent with evidence based best practice guidelines. This position is responsible for the coordination and dissemination of communication regarding advocacy; providing assistance and support for members and families to advocate within the systems of care; working closely with community and family advocacy organizations to share program updates; developing family friendly materials; and acting as a liaison for families and members to work with providers to prevent or resolve issues or concerns.

The Member Advocacy program produces and disseminates information that supports families and providers in navigating the multitude of health and social service systems that provide care for children with special needs. The program is responsible for working with state agencies, community service and advocacy organizations to identify barriers on an individual member basis and to identify systemic issues that may keep a member from accessing services.

Care Coordination Services

Care coordination services include:

- CRS Integrated Care
- Coordination of CRS health care through multispecialty, interdisciplinary approach to care
- Coordination of member health care needs through a Service Plan (see AHCCCS Medical Policy Manual (AMPM) Chapter 300, Exhibit 330-1)
- Collaboration with providers, communities, agencies, service systems, members, and families
- Sharing information with other appropriate professionals, with the member’s or family’s consent
- Coordination, communication, and support services designed to manage the transition of care for a member
- Other activities as described in the AHCCCS Medical Policy Manual (AMPM), Case Management/Care Coordination

Child Life Services

CRS provides child life services at each of the four MSICs. Child life services include organization of individual, family, or group activities designed to reduce the member’s and family’s fear of the nature of the illness, medical care, and procedures. Child Life activities may include:

- Group activities of expressive play
- Pre-operative teaching and medical play designed to decrease fears while increasing understanding and confidence
- Explanations comprehensible to the member of sequence, nature, and reasons for procedures and routines
- Support and coping strategies for the member during painful procedures

Education Services

CRS provides education services including:

- Education of and assistance to members and their families. Provide information about care, services, support systems, and advocacy.
- Education of members and their families about the history and prognosis of the CRS condition, treatment options even if the medical services are not covered by CRS, treatment planning, health risks, growth and development, transition planning, and offering of genetic counseling, when appropriate, regarding the condition.
- Coordination with the schools, physicians, parents, and clinic staff regarding accommodation of a member’s special educational needs.
• Coordination with the educational system regarding the educational needs of CRS members for the purpose of establishing goals for an inpatient stay or homebound program.

• Public education for community groups and organizations, public health personnel, school personnel, health care providers, insurers, regional and national health organizations.

• Education to physicians, health care professionals, and other individuals regarding the unique needs and concerns related to the care and treatment of

• Support for teaching and research initiatives.

**Family-Centered Culturally Competent Care**

UHCCP provides family-centered care in all aspects of its service delivery system. Responsibilities of CRS support of family-centered care include:

• Recognize the family as the primary source of support for the members’ health care decision-making process. Service systems and personnel are available to support the family’s role as decision makers.

• Facilitate collaboration among members, families, health care providers, and policymakers at all levels for the:
  • Care of the member,
  • Development, implementation, and evaluation of programs, and
  • Policy development.

• Promote complete exchange of unbiased information between members, families, and health care professionals in a supportive manner at all times.

• Recognize cultural, racial, ethnic, geographic, social, spiritual, and economic diversity and individuality within and across all families.

• Implement practices and policies that support the needs of members and families, including medical, developmental, educational, emotional, cultural, environmental, and financial needs.

• Participate in Family-Centered Cultural Competence Trainings.

• Facilitate family-to-family support and networking.

• Promote available, accessible, and comprehensive community, home, and hospital support systems to meet diverse, unique needs of the family.

• Acknowledge that families are essential to the members’ health and well-being and are crucial allies for quality within the service delivery system.

• Appreciate and recognize the unique nature of each member and their family.

**Culturally and Linguistically Appropriate Services (CLAS)**

UHCCP has developed a Cultural Competency Program. Linguistic and cultural barriers can negatively impact access to participation on health care.

**Providers Organizational Supports for Culturally Competent Care**

• Ensure the member and family receives effective, understandable, respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

• Implement strategies to recruit, retain and promote a diverse staff and leadership that are representative of the demographic characteristics of the service area.

• Ensure that all staff receives ongoing education and training in culturally and linguistically appropriate services.

• Develop, implement, and promote goals and policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

• Conduct initial and ongoing organizational self-assessments of CLAS related activities and integrate cultural and linguistic competence-related measures into internal audits, performance improvement programs, member satisfaction assessments, and outcome-based evaluations.

• Ensure data on member’s race, ethnicity, and preferred language is collected in the member’s medical record, integrated into management information systems, and periodically updated.

• Maintain a current demographic profile of the service area as well as communicate existing needs in order to accurately plan for and implement services that respond to the cultural and linguistic characteristic of the service area.

• Develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate member, family, and community involvement in designing and implementing CLAS related activities.
• Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts, or complaints by member and family.

• Regularly make available information about the progress and successful innovations in implementing culturally and linguistically appropriate services to the public.

**Language Interpretation Line:**
UHCCP provides free translation and interpreter services to ensure that all CRS members and their families understand the member’s diagnosis and course of recommended treatment in a culturally sensitive manner. Care providers may use this service in their office free of charge for translation needs. Care providers can access the language interpretation line by contacting UnitedHealthcare Member Services at 800-348-4058, TTY 711.

**Member and Family Rights and Responsibilities**

• **Access to Care**
  • The member and family can expect impartial access to information, treatment, and accommodations that are available or medically indicated, regardless of race, color, creed, ethnicity, sex, age, religion, national origin, ancestry, marital status, sexual preference, genetic information, physical or cognitive disability, diagnosis, prognosis, or sources of payment for care.
  • The member and family can expect services that are provided in a culturally competent manner with consideration for members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds, visual and/or auditory limitations.
  • The member and family can request to be seen in any CRS Clinic or by another CRS physician.
  • The member and family can request a second opinion at no cost to the family member.
  • Members and families can be informed of medical alternatives and other types of care and how to access that care.
  • Members and families can expect to be informed in writing of changes in services.
  • Members and families can ask and be informed about how CRS pays their care providers and how CRS bills for services.
  • Members and families can request results of the CRS Family Satisfaction Survey.

• **Respect, Dignity, and Emotional Support**
  The member and family have the right to receive considerate, respectful care with recognition of personal dignity and impartial access to emotional and spiritual support at all times and under all circumstances regardless of race, ethnicity, sex, national origin, diagnosis, prognosis, or sources of payment for care.

• **Privacy and Confidentiality**
  • The member and family have a right to expect every consideration of adequate personal and informational privacy.
  • CRS Contractors must implement procedures to ensure the confidentiality of health and medical records and of other member information. Procedures need to:
    • Be in compliance with all federal, state, and local requirements; and
    • Include process for monitoring and ensuring compliance.

• **Identity**
  • Members have the right to know the identity of physicians, nurses, and others involved in their care. This includes students, residents, or other trainees providing care to CRS members.

• **Communication**
  • The member and family have a right to obtain complete and current information about diagnosis, treatment, and expectations for outcome from health care providers.
  • The member and family have a right to formulate advance directives. Advance directives must be:
    • In compliance with federal and state statutes and
    • Be documented in writing in the member’s medical record.
  • UHCCP makes every effort to ensure that all information prepared for distribution to members is written in an easily understood language and format. Regardless of the format chosen, CRS information is printed in a type, style and size that can be easily read by recipients with varying degrees of visual impairment. Members must be notified that alternative formats are available and how to access them.
  • The member and family have a right to receive translation/signer services free of charge and know about care providers who speak languages other than English and how to get a free directory of CRS care providers.
• Growth and Development
  The member has the right to developmentally appropriate care and information with respect to the manner in which personnel speak and interact with them, choices of activities, and inclusion in decisions made about their care.

• Grievance and Appeal Procedure
  • The member and family have the right to voice dissatisfaction they have with the treatment or care the member receives and be free from any form of punishment, restraint, or seclusion for decisions and filing a complaint.
  • Applicants, members, parents, and legal representatives are provided with information regarding how to voice complaints, file grievances, or appeals and request administrative hearings.
  • Applicants, members, parents, and legal representatives are provided with information regarding expedited reviews.
  • Members, parents, and legal representatives will be provided with information regarding continuation of reduced or denied services within thirty (30) days of enrollment or changes to the information (See Chapter 14 for Grievance/Appeal process).

Member Action Council (MAC)

• The Member Action Council is a partnership between UHCCP, its members and member families that includes representatives from the CRS Program.

• MAC members will meet quarterly to provide input about service delivery, member communication including member materials, website, and family centered, people first resources.

• The MAC requires a representative from the CRS program. UnitedHealthcare Community Plan will work with the four statewide CRS clinics and encourage them to recruit and identify CRS member families, members, or graduates to participate on the MAC.

The MAC provides the opportunity for CRS members or their families to meet with other UHCCP members and staff to share and discuss ideas and information about how they are experiencing care as a CRS member.

Transportation Coordination
Transportation services are provided as indicated below based on the members Coverage Type.

<table>
<thead>
<tr>
<th>CRS Fully Integrated</th>
<th>MTBA is contracted to provide non-emergency transportation excluding ambulance service for all acute and CRS services. MTBA is responsible for all Behavioral Health services since this coverage includes the Acute, CRS and BH benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRS Partially Integrated-Acute</td>
<td>MTBA is contracted to provide non-emergency transportation excluding ambulance service for all acute and CRS services. MTBA is responsible for the first Behavioral Health appointment. Thereafter the RBHA provider is responsible for transportation to all subsequent appointments</td>
</tr>
<tr>
<td>CRS Partially Integrated-Behavioral Health</td>
<td>MTBA contracted to provide non-emergency transportation excluding ambulance services for all CRS and Behavioral Health Services. CMDP and DD members’ primary plan of enrollment provide non-emergency transportation for acute services.</td>
</tr>
<tr>
<td>CRS Only</td>
<td>MTBA is contracted to provide non-emergency transportation excluding ambulance services for all CRS services. Transportation for acute and BH services are the responsibility of the respective plans covering the member.</td>
</tr>
</tbody>
</table>

For members with private insurance, the non-emergency transportation should be coordinated through the insurance carrier if the transportation is a covered benefit.
Chapter 8 Behavioral Health

This chapter includes information related to behavioral health services for our integrated CRS program as well as those Medicaid members with Medicare coverage. Please refer below for general information pertaining to our behavioral health provider network. There are additional sections within this chapter to provide further information for the CRS Fully Integrated/CRS Partially Integrated Behavioral Health program (section 1), CRS Fully Integrated/CRS Fully Integrated Behavioral Health program (section 2) and Medicaid Members with Medicare Behavioral Health program (section 3).

AHCCCS covers behavioral health services (mental health and/or substance abuse service) for all members. The following outlines the service delivery system for behavioral health services.

- **Acute Medicaid** – Members 18 years of age and over, without Medicare A and/or B, are eligible to receive medically necessary behavioral health services. Services are provided through the Regional Behavioral Health Authorities (RBHA) and Tribal Regional Behavioral Health Authorities (T/RBHA). American Indian members may receive behavioral health services from an IHS/638 Facility, a T/RBHA, or be referred to a RBHA. Services are listed in the amount, duration and scope section of this policy and are described with limitations in the Behavioral Health Services Guide.

- **Acute Medicaid/DD** – Members 18 years of age and over, with Medicare A and/or B, are eligible to receive medically necessary behavioral health services throughout UnitedHealthcare Community Plan. This is an integrated program providing all physical and behavioral health services. The member may obtain contracted care provider information by looking on line at uhccommunityplan.com website or contacting the Member Customer Service department for assistance. No referral is needed by the primary care physician. SMI members assigned to the CRS program will receive their behavioral health services thorough the CRS program network.

- **Seriously Mental Illness (SMI) program** – Members evaluated and enrolled in the SMI program will be transitioned to one of the Regional Behavioral Health Authority (RBHA) programs for all services. This is an integrated program providing all physical and behavioral health services.

- **Children Rehabilitative Services (CRS)** – Members, all ages, are eligible for behavioral health services provided by the CRS program. This is an integrated program providing all physical and behavioral health services. The member may obtain contracted care provider information by looking on line at uhccommunityplan.com website or contacting the Member Customer Service department for assistance. No referral is needed by the primary care physician.

**Covered Services**

Covered services include:

- Behavioral Health Case Management services
- Behavioral Health therapeutic home care services
- Behavioral Management (behavioral health personal care, family support/home care training, self-help/peer support)
- Care Coordination Services
- Crisis Intervention
- Emergency and Non-Emergency Transportation (transportation services will not be separately reimbursed as transportation if provided by UnitedHealthcare Community Plan via MTBA)
- Evaluation and Assessment
- Individual, Group and Family Therapy and Counseling
- Inpatient Psychiatric Facilities Services
- Residential Treatment Centers (Level 1 and sub-acute facilities)
- Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis.
- Nursing services
- Opioid Agonist Treatment
- Partial Care (supervised day program, therapeutic day program and medical day program)
- Physician services
- Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services)
- Psychotropic Medication, adjustments and monitoring
- Rehabilitative services
- Respite Care (600 hours max benefit)
- Screening, evaluation and diagnosis
- Substance Abuse (drug and alcohol) counseling
- Support services

T1013 (sign language or oral interpretive services, per 15 min) will not be separately reimbursed as Interpretation Services are provided by Language Line on behalf of UnitedHealthcare Community Plan. Please see Chapter 1, under Cultural Competency Resources.

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RBHA Referrals: Initiating a Referral

RBHA referrals are based on the county and zip codes (See RBHA Listing at end of chapter). Although members have been auto enrolled for BH benefits, to activate those benefits members have to contact the RBHA and schedule a first time appointment referred to as an “Intake” appointment. Referrals to the RBHA do not require a prior authorization from the health plan or a doctor’s order. There are several ways that a referral can be made to a RBHA:

- The care provider, parent or legal guardian, or member may contact the RBHA directly by phone.
- Providers may fax a referral using the current ADHS/DBHS Form 3.3.1 Referral for Behavioral Health Services. Referral form is available at: [azdhs.gov/bhs/provider/documents/forms/pm3-3-1.pdf](http://www.azdhs.gov/bhs/provider/documents/forms/pm3-3-1.pdf)
- Schools or State agencies may also refer members.
- Members can call the RBHA directly and schedule their own appointment also known as a self-referral

Referrals: Initiating a Referral for a DD/ALTCS Member

To initiate a referral to the RBHA for a DD/ALTCS member, you may contact the RBHA or you may contact the member’s DD/DES Support Coordinator directly. If the member is unable to give you the coordinator’s name or telephone number, you may call Health Care Services of the Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) at: 602-771-8080 during normal business hours to obtain this information. Please have the member’s name and date of birth available. Referral form is available at: [azdhs.gov/bhs/provider/forms/pm3-3-1.pdf](http://www.azdhs.gov/bhs/provider/forms/pm3-3-1.pdf).

RBHA Referrals: When to Make a RBHA Referral

- Refer to RBHA if member require services outside of the scope of PCPs expertise or comfort level.
- Refer to RBHA if member presents with a diagnosis other than ADHD, anxiety, mild depression.

RBHA Referrals: Referral for Member Not Established on Psych Medication

If a member is not currently established on a BH medication, and you are planning to refer to the RBHA for services, UnitedHealthcare Community Plan suggests you do not start the member on a medication that may have to be changed after member is assessed by a RBHA Prescriber. (If CURRENTLY prescribing medications for anxiety, ADHD, depression, please refer to Section VII. RBHA REFERRALS-TRANSFER OF CARE)

Fill out and fax: a ADHS RBHA referral form for behavioral health services.

For current copy go to link: [azdhs.gov/bhs/provider/documents/forms/pm3-3-1.pdf](http://www.azdhs.gov/bhs/provider/documents/forms/pm3-3-1.pdf)

RBHA Referrals: Transfer of Care to the RBHA

When a PCP has initiated medication-management services for a member to treat a behavioral health disorder, and it is subsequently determined by the servicing provider that the member should be transferred to a T/RBHA prescriber for evaluation and/or continued medication management services, the following steps should be taken:

- Fill out and fax: ADHS/DBHS 3.3.1 Referral Form to the members appropriate RBHA (RBHA assigned by geography)

Current copy of RBHA Referral Form can be obtained by going to the link: [azdhs.gov/bhs/provider/documents/forms/pm3-3-1.pdf](http://www.azdhs.gov/bhs/provider/documents/forms/pm3-3-1.pdf)

- PCP will maintain continuity of care for these members until they can be established with a RBHA provider to receive behavioral health services and/or medication evaluation and management.
- Fill out ADHD/DBHS 3.3.1 Referral for Behavioral Health Services. When transferring care AHCCCS requires the referral include at a minimum:
  - The reason for the referral
  - Medication trials/failures
  - Current diagnosis
  - Date of last PCP visit and/or hospitalization
  - Lab/diagnostic results
  - Other pertinent information
- PCP oversight for continuity of care during transition is a
Chapter 8 Behavioral Health

Transfer of Care From the RBHA/Step Therapy

If, during the process of credentialing or recredentialing, the health plan discovers information that varies substantially from that which was initially provided, the health plan will notify the clinician or facility and offer an opportunity to correct the information. Care provider(s) and facilities are given 10 business days.

Step Therapy

Step Therapy Drugs appearing on the Preferred Drug List (PDL) require a trial and failure of a specific covered drug(s), before a member can receive the Step Therapy Drug. The Step Therapy Drugs are covered automatically if the members’ pharmacy history shows that the required drug(s) have been tried first. If the pharmacy history shows that the required drug had not been tried, the prescriber will need to submit a prior authorization request. UnitedHealthcare Community Plan asks the prescriber to submit information explaining why the member cannot use the required drug(s) first. However, members that have been stabilized on a medication while in service through the RBHA for the treatment of ADHD, anxiety and/or depression, will be maintained on that medication when discharged and seeing PCP for medication management. In the event that the PCP identifies a change in the member’s condition, the PCP may utilize STEP Therapy until the member is stabilized once again.

Transfer of Care

PCPs may continue with medication management of members who have been treated and stabilized by the RBHA for behavioral health disorders of uncomplicated ADHD, anxiety or depression for a period no less than 6 months, under these conditions:

- Physician feels comfortable in managing members’

  psychotropic medications
- Is within the physician’s scope of practice and expertise
- PCP’s may request these medications for continuity of care management by submitting a completed UnitedHealthcare Pharmacy Prior Authorization Form indicating STEP therapy has been completed by the RBHA and the member needs to continue on current medication and dosage for stabilization, unless there is subsequently a change in medical condition of the member. PDL drugs requiring STEP Therapy are routinely covered only after a sufficient trial of an indicated first-line agent has been adequately tried and failed.
- Before faxing the completed Pharmacy Prior Authorization Form with documentation, please indicate on the Pharmacy Prior Authorization Form:
  - “Request for STEP Therapy Medication”.
  - State if the request is “Expedited” or “Routine”.
  - To prevent any lapse in medication coverage, or for assistance with this process, contact UnitedHealthcare Pharmacy at 800-305-0023 or Fax to 800-853-3844

UnitedHealthcare Pharmacy Prior Authorization Form can be obtained at UHCCommunityPlan.com

Behavioral Health Screenings

Members should be screened by their PCP for behavioral health needs during routine or preventative visits. EPSDT and Behavioral Health Screenings for members up to 21 years of age in accordance to the AHCCCS periodicity schedule. Based on the behavioral health screening and assessment, Best Practice Guidelines, and EBM, PCPs are responsible for making a behavioral health referral to the members assigned RBHA. For more information go to: uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/clinicalguidelines/PCA15516-Clinical%20Practice%20Guidelines.pdf or https://integration.samhsa.gov/clinical-practice/screening-tools

PCP Coordination of Care Responsibilities

The Primary Care Physician is responsible for ensuring that a member specific medical record is established when behavioral health documentation is received from the RBHA or behavioral health provider on one of your assigned members. Even if you have not seen the member, a record must be created. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member’s medical record as soon as one is established. PCP shall respond to T/RBHA/ provider information requests pertaining to the behavioral health recipient within 10 business

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days of receiving the request. The response should include all pertinent information including, but not limited to, current diagnoses, medications, laboratory results, last PCP visit, and recent hospitalizations.

The PCP is to document and initial the RBHA documentation received on one of their assigned health plan members. The signature indicates their knowledge that the member is receiving Behavioral Health service.

UnitedHealthcare Community Plan performs random Behavioral Health Record Reviews (BHRR) yearly on providers that have 10 or more members actively receiving BH services from a RBHA, or in which the PCP is prescribing and/or managing member’s medications for the treatment of ADHD, anxiety or depression.

**Medication Management Services**

PCP may provide medication management services (prescriptions, medication monitoring visits, laboratory and other diagnostic tests necessary for diagnosis and treatment of behavioral disorders) to members with diagnoses of ADHD, anxiety, and depression as long as it is within their expertise, scope of practice, and comfort level with UnitedHealthcare formulary medications available to treat these disorders.

- Refer to UnitedHealthcare Formulary to see if prior authorization (PA) is required. To request PA, please call UnitedHealthcare Pharmacy Prior Authorization at 800-305-0023 or fax a completed PA Request Form to 866-940-7328.
- UnitedHealthcare Community Plan Pharmacy Prior Authorization form can be obtained at UHCCommunityPlan.com under the Provider Forms Section.
- After PCP has faxed in Form 3.3.1 ADHS/DBHS Referral for Behavioral Health Services, the transition period to the RBHA should take place within 30 days and no later than 90 days. PCPs will receive a “disposition fax” from the RBHA, informing them of the member’s enrollment status. If you do not receive a disposition fax, contact the T/RBHA and ask to speak to a liaison or Behavioral Health Coordinator.

**Consultations Through the T/RBHAs**

PCPs may contact the RBHAs and request a telephonic consultation with a psychiatrist regarding medication management, transition of care and treatment options for a member with a behavioral health diagnosis with co-morbidities by calling RBHA Member Services, following the prompts for ‘Consultations’, or fax 3.3.1 RBHA Referral for Behavioral Health Services Form. For “type of service requested” indicate “one-time consultation”. Under “reason for referral” section, indicate if you are requesting telephonic consultation for medication management, phone number and best time to be contacted. Member does not have to be RBHA enrolled for PCP to obtain a consultation.

**Behavioral Health Best Practices and Guidelines**

PCP’S may treat UnitedHealthcare members with behavioral health disorders of: ADHD, anxiety and depression that are considered “uncomplicated”. UHCCP defines uncomplicated as an individual who does not have multiple behavioral health diagnoses in which treatment/medication is required simultaneously, receiving services for substance abuse, prior inpatient psychiatric treatment within the last year, history of dangerous or harmful behavior toward self or others (includes overdoses and suicide attempts). AHCCCS has developed a set of clinical “tool kits” that include assessments and algorithms to assist PCPs in assessing the needs of the children/adolescents (ages 8-17), and adults (age 18 and above), the need and type of medication, and if a RBHA referral is indicated.

You can obtain these Guidelines on our website at UHCCommunityPlan.com under the Clinical Practice Guidelines section.

**Diabetic Members Admitted to Arizona State Hospital**

Diabetic members who are admitted to the Arizona State Hospital (AzSH) for behavioral health services will receive training to use a glucometer and testing supplies during their stay at AzSH. Upon discharge from AzSH, the PCP will be provided with the diabetic information to include the brand and model of equipment the member has been trained on.

The PCP must ensure that members are issued the same brand and model of both glucometer and supplies they were trained on during their admission. UnitedHealthcare Community Plan will coordinate with AzSH to ensure that the member has sufficient testing supplies to last until the member is scheduled an office visit with the PCP.

In the event the member’s mental status renders him/her incapable or unwilling to manage their medical condition and that condition requires medically necessary ongoing medical care, UnitedHealthcare Community Plan will coordinate with the RBHA, member guardian, and AzSH to obtain the appropriate discharge placement and follow-up care.
AHCCCS Behavioral Health Tool Kits

AHCCCS Behavioral Health Tool Kits can be accessed online at [UHCCommunityPlan.com](http://UHCCommunityPlan.com) under the Clinical Practice Guidelines section or online [azahcccs.gov](http://azahcccs.gov) in the Medical Policy Manual, Appendix E (Child and Adolescent Behavioral Health Tool Kits) and F (Adult Behavioral Health Tool Kits).

UnitedHealthcare Community Plan Important Phone Numbers

Behavioral Health Coordinator: 877-885-8445 #61053
Member Services: 800-348-4058
Member Transportation: 888-700-6822
Pharmacy Prior Authorization: 800-305-0023
Pharmacy Prior Authorization Fax: 866-940-7328
Prior Authorization Services: 866-604-3267

Important Web Addresses

UnitedHealthcare website [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) & [UHCCommunityPlan.com](http://UHCCommunityPlan.com)
AHCCCS website [azahcccs.gov](http://azahcccs.gov)
Arizona Department of Health Services [azdhs.gov](http://azdhs.gov)
Behavioral Health and T/RBHA listings [azdhs.gov/bhs/aboutbhs.htm](http://azdhs.gov/bhs/aboutbhs.htm)
Arizona DES/DDD [des.az.gov](http://des.az.gov)

Regional Behavioral Health Authorities (RBHA) Listings

Cenpatico Integrated Care (CIC) Cochise, Gila, Graham, Greenlee La Paz Pima, Pinal, Santa Cruz Yuma Counties
Member Services: 866-495-6738
Fax: 800-398-6182
Crisis Line: 866-495-6735

Mercy Care Integrated Care (MMIC) Maricopa County
Member Services: 800-564-5465
Fax: 844-484-3975
Crisis Line: 800-631-1314

Health Choice Integrated Care (HCIC) Apache, Coconino, Mohave, Navajo, Yavapai Counties
Member Services: 800-640-2123
Fax: 855-408-3400
Crisis Line: 877-765-4090

UnitedHealthcare Community Plan CRS Statewide R “BHA”
all counties for enrolled CRS Fully Integrated and Partially Integrated Behavioral Health Members
Members Services: 800-348-4058
Crisis Line: use crisis line listed under appropriate county above

UnitedHealthcare Community Plan Medicaid/Medicare
enrolled members
Members Services: 800-348-4058
Crisis Line: use crisis line listed under appropriate county above

Tribal Regional Behavioral Health Authority (TRBHA)
Apache White Mountain
Member Services: 520-879-6060
Crisis Line 877-336-4811
Gila River
Member Services: 540-562-7140
Crisis Line: 800-259-3449
Navajo Nation
Member Services: 928-729-4349
Crisis Line: 866-841-0277
Pascua Yaqui
Member Services: 520-879-6060
Crisis Line: 877-342-0912
Colorado River Indian
Tribe Member Services: 928-669-3256

How to Join the Optum Behavioral Health Network

If you are interested in joining the CRS behavioral health provider network through Optum1, please note the steps below. Refer to Chapter 1 for joining the UnitedHealthcare Community and State Provider Network.

1. You must first register with AHCCCS before the credentialing process can begin. Please be sure to register with the same specialty and demographic information that you will provide when starting the credentialing process with us. Please be aware that you are not reimbursed for any AHCCCS covered services unless you are an AHCCCS registered provider. For information on becoming an AHCCCS provider, please visit [azahcccs.gov>PlansProviders>NewProviders>registration.html](http://azahcccs.gov>PlansProviders>NewProviders>registration.html) and choose Plan and Providers to register.

2. Once you have started the registration process with
AHCCCS, you can start the credentialing process by going to the “Join Our Network” section of ProviderExpress.com and following the instructions for Arizona providers.

1 United Behavioral Health, operating under the brand Optum

Provider Initiated Unavailable Status
Individual clinicians may request to be made unavailable for new referrals at one or more of your practice locations for up to six months. You are required to notify Network Management within 10 calendar days of your lack of availability for new referrals. You may make this notification through secure “transactions” on Optum’s website, ProviderExpress.com, or by contacting Network Management. You will be sent a letter confirming that your request has been processed. When you have been on unavailable status for five consecutive months, we will send you a letter reminding you that you will be returned to active status within 30 calendar days. You may contact network Management to request an extension of your unavailable status. Should you decide that you want to return to active status sooner than expected, you may update your status on Provider Express or notify Network Management. Some common reasons for requesting unavailable status are: extended illness, vacation or leave plans, lack of available appointments. Please note that while on unavailable status your Agreement remains in effect. Group practices and facilities/agencies that wish to be made unavailable should contact Network Management.

Provider Resources
UnitedHealthcare Community Plan (UHCCP) manages a comprehensive provider network of independent practitioners and facilities across Arizona. UHCCP offers several options to support providers who require assistance.

UnitedHealthcare Online Resources
All online electronic functionality such as member eligibility, claim status, claim submission and electronic remits for UnitedHealthcare Community Plan members enrolled in Acute Medicaid, DD, CRS and, UnitedHealthcare Dual Complete and Dual Complete One will be accessible through UnitedHealthcareOnline.com. If you are not registered on UnitedHealthcareOnline.com, you may do so directly on the website. UnitedHealthcareOnline.com offers an innovative suite of online health care management tools. Use of this website is intended for approved Community Plan providers, facilities and medical administrative staff and offers the convenience of online support 24-hours-a-day, 7-days-a-week and offers these electronic functions:

- Claim Reconsiderations
- Single EOB Search
- Claim Submissions
- Notification/Prior Authorization Submission & Status

UHCCommunityPlan.com:
- Pharmacy Program
- Newsletters
- Bulletins
- Medicare Part D Education Materials
- Provider Forms
- Cultural Practice Guidelines
- Prior Authorization Form
- Clinical Practice Guideline

ProviderExpress.com
- Roster Management
- Provider Demographic Changes

Provider Service Center
This is the primary point of contact for providers who require assistance. The Provider Service Center is staffed with Provider Service Representatives trained specifically for UnitedHealthcare.

The Provider Service Center can assist you with questions on Medicaid benefits, eligibility, claims resolution, forms required to report specific services, billing questions, etc. and can be reached at 800-445-1638. The Provider Service Center works closely with all departments in UnitedHealthcare.

Claims and Customer Service
Providers can access Claims information on UnitedHealthcareOnline.com and Provider Services at 800-445-1638.

To ensure proper processing of claims, it is important to promptly contact Network Management if you change your Tax ID number. You may make changes to your practice address online.

For Further Assistance
For general information and contractual questions, contact Network Management using the Provider Service Line at 877-614-0484.

Written Notification of Status Change
Providers are required to notify us in writing within 10 calendar days of any changes to:
• The status of the practice, including changes in practice location, billing address, or telephone/fax numbers
• Changes in facility, agency, or group ownership
• The status of professional licensure and/or certification such as revocation, suspension, restriction, probation, termination, reprimand, inactive status, voluntary relinquishment, debarment from any government program, monitoring or any other adverse action
• The status of professional liability insurance
• Potential legal standing (any malpractice action or notice of licensing board complaint filing)
• Tax Identification (TIN) used for claims filing
• The programs you offer (services you provide must continue to meet our credentialing criteria)

Registered users of Provider Express, except facilities and agencies, are encouraged to use the “My Practice Info” function to update this information. Otherwise, clinicians and group practices should submit changes in writing, using fax or mail, to your state-specific Network Management Team. Facilities or agencies should submit their changes, in writing, using fax or e-mail, to the Network Manager or Facility Contract Manager.

Termination or Restriction of CRS Behavioral Health Network
A care provider’s participation with Optum can end for a variety of reasons. Both parties have the right to terminate the agreement upon written notice, pursuant to the terms of your agreement. If you need clarification on how to terminate your agreement, you may contact Network Management or your Facility Contract Manager.

Network Clinicians, Group Practices and Agencies
Who withdraw from our network are required to notify us, in writing in accordance with your agreement, 90 calendar days prior to the effective date of termination, unless otherwise stated in your agreement or required by state law. With the exception of terminations due to quality-related issues, suspected fraud, waste or abuse, change in license status or change in ability to participate in federal programs, clinicians are obligated to continue to provide treatment for all members under their care. The timeline for continued treatment is up to 90 calendar days from the effective date of the contract termination, or as outlined in your agreement or until one of the following conditions is met, whichever is shortest:

• The Member is transitioned to another contracted clinician.
• The current episode of care has been completed.
• The member’s CRS benefit is no longer active.

Please note that AHCCCS regulations will be followed for member transition.

To ensure continuity of care, we will notify members affected by the termination of a clinician, group practice or agency at least 30 calendar days prior to the effective date of the termination whenever feasible. We will assist these members in selecting a new clinician, group or agency. You are also expected to clearly inform members of your impending non-participation status upon the earlier of the member’s next appointment or prior to the effective termination date, in compliance with your agreement.

Network facilities
That withdraw from the network are required to notify us, in writing in accordance with your agreement, 120 calendar days prior to the date of termination unless otherwise stated in your agreement or required by Arizona state law.

To ensure there is no disruption in a member’s care, Optum has established a 120 calendar-day transition period for voluntary terminations. In the event that a facility’s participation is terminated due to quality-related issues, fraud or change in license status requiring immediate transfer of a member to another facility, UnitedHealthcare and the facility will coordinate to ensure a safe and effective transition of care. Members may not be balance billed.

Communication with Primary Physicians and Other Health Care Professionals
We expect our provider community to coordinate and manage care between behavioral health and medical professionals and/or other behavioral health clinicians (e.g., psychiatrists, therapists). Coordination and communication should take place at: the time of intake, during treatment, the time of discharge or termination of care, between levels of care and at any other point in treatment that may be appropriate. Please ensure coordination with CRS clinical liaisons for the member’s assigned Multi Specialty Interdisciplinary Clinics (MSIC). Coordination of services improves the quality of care to members in several ways:

• It allows behavioral health and medical providers to create a comprehensive care plan.
• It allows a primary care physician to know that his or her patient followed through on a behavioral health referral.
• It minimizes potential adverse medication interactions for members who are being treated with psychotropic and onpsychotropic medication.
• It allows for better management of treatment and followup for members with coexisting behavioral and medical disorders.
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- It promotes a safe and effective transition from one level of care to another.
- It can reduce the risk of relapse.
- The following guidelines are intended to facilitate effective communication among all treatment professionals involved in a member’s care:
- During the diagnostic assessment session, request the member’s written consent to exchange information with all appropriate treatment professionals.
- After the initial assessment, provide other treating professionals with the following information within two weeks:
  - Summary of member’s evaluation.
  - Diagnosis.
  - Treatment plan summary (including any medications prescribed).
  - Primary clinician treating the Member.
  - Update other behavioral health and/or medical clinicians when there is a change in the Member’s condition or medication(s).
  - Update other health care professionals when serious medical conditions warrant closer coordination.
  - At the completion of treatment, send a copy of the discharge summary to the other treating professionals.
  - Attempt to obtain all relevant clinical information that other treating professionals may have pertaining to the Member’s mental health or substance use problems.

Some Members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. We, as well as accrediting organizations, expect you to make a “good faith” effort at communicating with other behavioral health clinicians or facilities and any medical care professionals who are treating the Member as part of an overall approach to coordinating care.

Treatment Record Documentation Requirements

In accordance with your Agreement, you are required to maintain high quality medical, financial and administrative records (including appointment or scheduling books) related to the behavioral health services you provide. These records must be maintained in a manner consistent with the standards of the community, and conform to all applicable laws and regulations including, but not limited to, state licensing, Centers for Medicare and Medicaid Services (CMS) and/or national certification board standards.

In order to perform required utilization management, practice management and quality improvement activities, we may request access to such records, including, but not limited to, claims records and treatment record documentation. You are permitted under HIPAA Treatment, Payment or Healthcare Operations to provide requested records as contractually required. In accordance with HIPAA and the definition of Treatment, Payment or Healthcare Operations, you must provide such records upon request. Federal, state and local government or accrediting agencies may also request such information as necessary to comply with accreditation standards, laws or regulations applicable to Optum and its Payors, customers, clinicians, and facilities.

We may review your records during a scheduled On-Site Audit or may ask you to submit copies of the records to us for review. An On-Site Audit and/or Treatment Record Review may occur for a number of reasons, including, but not limited to:
- Reviews of facilities without national accreditation such as The Joint Commission, CARF or other agencies approved by us.
- Audits of high-volume clinicians.
- Routine random audits.
- Audits related to claims, coding or billing issues.
- Audits concerning quality of care issues.
- Audits related to a member complaint regarding the physical environment of an office or facility.

The audits may focus on the physical environment (including safety issues), policies and procedures, and/or thoroughness and quality of documentation within treatments records and/or accuracy of billing and coding. We have established a passing performance goal of 85% for both the Treatment Record Review and On-Site Audit. On-Site Audit or Treatment Record Review scores under 85% will require a written Corrective Action Plan (CAP). Scores under 80% require submission of a written CAP and a re-audit within six months of the implementation of the CAP. However, in some cases, a requesting committee may require a CAP and/or re-audit regardless of the scores on the audit tools. Billing records should reflect the member who was treated, the rendering clinician and the modality of care. Audits related to claims, coding or billing issues may require corrective action.

Treatment Record – Content Standards

When billing services for more than one family member, separate treatment records must be maintained. We require that all non-electronic treatment records are written legibly in blue or black ink. All treatment records must include the following:
- The Member’s name or identification number on each page of the record.
• The Member’s address; employer or school; home and work telephone numbers, including emergency contacts; marital or legal status; appropriate consent forms; and guardianship information.

• The date of service including start and stop time, the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS)/Revenue (REV) code billed, notation of session attendees, the rendering clinician’s name, professional degree, license, and relevant identification number as applicable.

• Treatment record entries should be made on the date services are rendered and include the date of service; if an entry is made more than 24 hours after the service was rendered, the entry should include the date of service, date of the entry, and a notation that this is a late entry.

• Clear and uniform modifications; any error is to be line through so that it can still be read, then dated and initialed by the person making the change.

• Clear documentation of medication allergies, adverse reactions and relevant medical conditions; if the member has no relevant medical history, this should be prominently noted.

• Clear and uniform medication tracking that provides a comprehensive summary of all medications taken by the patient from the onset of care through discharge includes the following (applicable for all prescribers):
  • Standing, P.R.N. and STAT orders for all prescription and over-the-counter medications.
  • The date medications are prescribed along with the dosage and frequency.
  • Informed member consent for medication, including the member’s understanding of the potential benefits, risks, side effects, and alternatives to the medications.
  • Changes or rationale for lack of changes in medication and/or dosage should be clearly documented along with the clinical rationale for the changes.
  • Discharge summaries should specify all medications and dosages at the time of discharge.

• A clear summary of presenting problems, the results of mental status exam(s), relevant psychological and social conditions affecting the Member’s medical and psychiatric status, and the source of such information.

• Prominent documentation (assessment and reassessment) of special status situations, when present, including but not limited to imminent risk of harm, suicidal or homicidal ideation, self-injurious behaviors, or elopement potential (for all overnight levels of care). It is also important to document the absence of such conditions.

• A medical and psychiatric history including previous treatment dates, clinician or facility identification therapeutic interventions and responses, sources of clinical data, and relevant family information.

• The behavioral health history includes an assessment of any history of abuse the Member has experienced.

• For adolescents, the assessment documents a sexual behavior history.

• For children and adolescents, past medical and psychiatric history should include prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual, and academic).

• For Members 12 years of age and older, documentation includes past and present use of nicotine or alcohol, as well as illicit drugs, prescribed or over-the-counter medications.

• Documentation of a DSM-IV-TR or successor diagnosis, including all five axes, consistent with the presenting problem(s), history, mental status examination, and other assessment data.

• Treatment plan documentation needs to include the following elements:
  • Specific symptoms and problems related to the identified diagnosis of the treatment episode.
  • Critical problems that will be the focus of this episode of care are prioritized; any additional problems that are deferred should be noted as such.
  • Relates the recommended level of care to the level of impairment.
  • Member (and, when indicated, family) involvement in treatment planning.
  • Treatment goals must be specific, behavioral measurable, and realistic.
  • Treatment goals must include a time frame for goal attainment.
  • Progress or lack of progress towards treatment goals.
  • Rationale for the estimated length of the treatment episode.
  • Updates to the treatment plan whenever goals are achieved or new problems are identified.
  • If the Member is not progressing towards specific goals, the treatment plan should be re-evaluated to address the lack of progress and modify goals as needed.

• Progress notes include:
  • Signature of the practitioner rendering services.
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• Treatment record entries include the date and start and stop time of service.
• Member strengths and limitations in achieving treatment plan goals and objectives.
• Treatment interventions that are consistent with those goals and objectives noted in the treatment plan.
• Dates of follow up visits.
• Documentation of missed appointments, including efforts made to outreach the Member

• Documentation of on-going discharge planning (beginning at the initiation of treatment) includes the following elements:
  • Criteria for discharge.
  • Identification of barriers to completion of treatment and interventions to address those barriers.
  • Identification of support systems or lack of support systems.
• A discharge summary is completed at the end of the treatment episode that includes the following elements:
  • Reason for treatment episode.
  • Summary of the treatment goals that were achieved or reasons the goals were not achieved.
  • Specific follow up activities/aftercare plan

• Documentation of coordination of care activities between the treating clinician or facility and other behavioral health or medical clinicians, facilities, or consultants. If the member refuses to allow coordination of care to occur, this refusal and the reason for the refusal must be documented. Coordination of care should occur:
  • At the initiation of treatment.
  • Throughout treatment as clinically indicated.
  • At the time of transfer to another treating clinician, facility, or program.
  • At the conclusion of treatment.

• Documentation of referrals to other clinicians, services, community resources, and/ or wellness and prevention programs.
• Records related to billing must include all data elements required for submission of the claim.

Guidelines for Storing Member Records
Below are additional guidelines for completing and maintaining treatment records for Members.
• Practice sites and facilities must have an organized system of filing information in treatment records

• Treatment records must be stored in a secure area and the site must have an established procedure to maintain the confidentiality of treatment records in accordance with an applicable laws and regulations, including HIPAA.
• The site must have a process in place to ensure that records are available to qualified professionals if the treating clinician is absent.
• Treatment records are required to be maintained for a minimum period of seven years from the date of service, or in accordance with applicable state or federal laws or regulations, whichever is longer. Termination of the Agreement has no bearing on this requirement.
• Financial records concerning covered services rendered are required to be maintained from the date of service for 10 years, or the period required by applicable state or federal law, whichever is longer. Termination of the Agreement has no bearing on this requirement.

Audits of Sites and Records
On-site and record-only audits may occur with any contracted care provider. Both types of audits involve reviewing a sampling of treatment records. The on-site audit also involves a review of policies and procedures, including policies related to hiring and supervision of staff, discussion of services that are offered and a tour of the facility or office site.

Our representatives conduct site visits at clinician offices, agencies such as community mental health centers (CMHCs), facilities, and group care provider locations. On-site audits are routinely completed with CMHCs and facilities without national accreditation. In addition, audits are completed to address specific quality of care issues or in response to Member complaints about the quality of the office or facility environment.

Facilities and CMHCs that hold national accreditation through organizations such as the Joint Commission, CARF, COA, HFAP, NIAHO, CHAP, and/or AAAHC receive credit for meeting those standards of care for the identified accredited services or programs without additional review prior to the initial credentialing process. Facilities and CMHCs that are not accredited will be required to participate in an on-site audit prior to credentialing and a recredentialing audit prior to their specified recredentialing timeframe. Any facility or CMHC, regardless of their accreditation status, may be subject to an on-site audit for any Member complaints or suspected quality of care concerns brought to our attention.

During on-site and record-only audits for all types of care providers, chart documentation is reviewed, including (but not limited to) the assessment, diagnosis, treatment plan, progress notes, monitoring risk issues, coordination of care activities, and discharge planning. This process also verifies that services were
provided to Members. You are expected to maintain adequate medical records on all Members and document in the record all services that are provided. Prior to the audit, you will be notified of the specific types of charts that will be reviewed. Failure to adequately document services that are rendered and/or dates of services may lead to a request for a Corrective Action Plan (CAP). Please see the “Treatment Record Documentation Requirements” section of this manual for more information.

The audit tools are based on NCQA, the Joint Commission and Optum standards. These forms are used during audits and are available at Provider Express for reference: Home page > Clinical Resources > Forms > Optum Forms > Site Audit Tools

Compensation and Claims Processing
The network rate for eligible outpatient visits is reimbursed to you at the lesser of (1) your customary charge, less any applicable co-payments, coinsurance and deductibles due from the Member, or (2) the contracted fee maximum, less any applicable co-payments, coinsurance and deductibles due from the Member. Fee maximums can vary based on different insurance plans and are available upon request.

The contracted rate for facilities is referenced in the Payment Appendix of the facility Agreement and defines rates applicable to inpatient and/or outpatient care through that facility. When the contracted rates include physician fees, the facility is responsible for payment of all treating physicians and for notifying the physicians that payment will be made by the facility and not us. Financial records concerning covered services rendered are required to be maintained from the date of service for the greater of 10 years, or the period required by applicable state or federal law, whichever is longer. Any termination of the Agreement has no bearing on this legal obligation.

Co-payments, Coinsurance and Deductible
Depending on the member’s coverage type, the member might be responsible for some of the cost of behavioral health services such as copayments, coinsurance and/or deductible. Members should be billed for deductibles after claims processing yields an Explanation of Benefits indicating member responsibility.

For co-payments, we encourage you to require payment at the time of service if a co-payment is due. It is your sole responsibility to collect member payments due to you. Members are never to be charged in advance of the delivery of services. Benefit plans often provide for annual copayment or coinsurance maximums.

Balance Billing for Covered Services Is Prohibited
Under the terms of the agreement, you may not balance bill UHCCP members for covered services provided during eligible visits, which means you may not charge members the difference between your billed usual and customary charges and the aggregate amount reimbursed by us and Member expenses.

Claims Submission
UHCCP requires that the initial claim submission occurs within the deadlines set forth in the care provider’s contract. Providers have one year from the date of service to correct and resubmit claims, if the initial submission was received within the contracted time limit. Unless otherwise directed by us, care providers shall submit claims using current CMS (HCFA) 1500 or UB04 forms, (its equivalent or successor) whichever is appropriate. Please note that effective October 1, 2015 ICD-10 coding will be required in compliance with federal regulations. Please see the General Billing Guidelines in Chapter 13 for proper billing guidelines. CRS Behavioral Health claims and medical record attachments should be submitted electronically, if possible. Paper claims can also be submitted to:

Optum
P.O. Box 30760
Salt Lake City, UT 84130-0760

EDI/Electronic Claims
Electronic Data Interchange (EDI) is the exchange of information for routine business transactions in a standardized computer format. Both primary and secondary claims can be submitted by EDI. EDI offers care providers several advantages, including less paperwork, reduced postage, less time spent handling claims and faster turnaround time. When sending claims electronically, routing to the correct claim system is controlled by the Payer ID. Effective April 1st, 2014, CRS claims should be sent using Payer ID # 03432. Additional information regarding EDI is available on Provider Express “Claim Tips”. Online Claims Help can be found on UnitedHealthcareOnline.com in the Claims & Payments section.

To ensure proper processing of claims, it is important to promptly contact Network Management if you change your Tax ID number. You may make changes to your practice address online.

Coordination of Benefits (COB)
Some members are eligible for coverage under one or more additional health benefit plans. In these circumstances, payment for allowable expenses shall be coordinated with the other plan(s). It is the providers responsibility to inquire and collect information concerning all applicable health plans available or verifying member enrollment. All providers should verify member eligibility and insurance coverage prior to providing services.

You may not bill members for the difference between your billed usual and customary charge and the amount paid by the primary plan(s) and us.
Processing and Payment of Claims
All information necessary to process claims must be received by UHCCP no more than 90 calendar days from the date of service, or as dictated in your contract. Claims received after this time period may be denied. You may not bill the member for claim submissions that fall outside these established timelines. Any corrections or additions to a claim should be made within 365 days from the date of service.

We may make corrective adjustments to any previous payments for services and may audit claims submissions and payments to ensure compliance with applicable policies, standards, procedures, including without limitation, the Manual, the Credentialing Plan, the Agreement, and state and federal law. We may obtain reimbursement for overpayments directly or by offsetting against future payments due as allowed by law. The procedure for submitting and processing claims will be modified as necessary to satisfy any applicable state or federal laws.

DSM-5 and ICD-10 Information
In response to legislation passed on April 1, 2014 which delayed the ICD-10 implementation mandate, we revised plans and timelines related to the ICD-10 implementation and continued with the implementation of DSM-5 on October 1st, 2015 for CRS and GMH/SA products. CMS announced that the U.S. Department of Health and Human Services issued a rule on July 31, 2014 stating that ICD-10 implementation will occur October 1st, 2015

Optum Timeline
• ICD-10 implementation on October 1st, 2015: Use DSM-5 diagnostic criteria and labels, use ICD-10 billing codes associated with the DSM-5 conditions
• DSM-5 implementation on October 1st, 2015 for CRS and those members who are enrolled in both Medicare A and/or B and AHCCCS Medicaid benefits: Use DSM-5 diagnostic criteria and labels, use ICD-10 billing codes associated with the DSM-5 conditions

Provider updates can be found at providerexpress.com/content/ope-provexpr/us/en/admin-resources/dsm5_icd10.html
Please note the information found on this website states that DSM-5 was implemented on October 1st, 2014. This was the case for all Optum products other than CRS and GMH/SA, as these products aren’t going live with DSM-5 until October 1st, 2015.

Exclusion/Sanction/Debarment Checks
Care provider and affiliates must review federal exclusion lists (HHS-OIG and GSA) at the time of hire/contracting with their current employees/contractors, health care professionals, or vendors that work on Medicare Advantage, Part D or Medicaid programs to ensure that none are excluded from participating in Federal health care programs. For more information or access to the publicly accessible excluded party online databases, please see the following links:
• General Services Administration (GSA) List of Parties Excluded from Federal Procurement and Non-procurement programs is on the System for Award Measurement site: sams.gov/

What You Need to Do: Review applicable exclusion/sanction/debarment lists to ensure that none of your employees or contractors is excluded from participation in federal health care programs.

We have guidelines to address suspected fraud, waste and/or abuse by care providers. In accordance with your agreement, you are required to cooperate with the review process to include any requests for medical records. We are committed to the detection and investigation of potential fraud, waste and/or abuse. Such practices include, but are not limited to, filing fraudulent claims, fraudulent authorization of claims, misrepresentation of services provided, abuse of services in order to obtain a benefit (including personal or commercial gain) from us or a payor to which an individual or entity is not entitled. This identification process includes, but is not limited to, examining claims of care providers to identify outlier practice patterns. Once suspected fraud, waste and/or abuse is identified, appropriate interventions are implemented. Possible interventions may include, but are not limited to: outreach meetings and/or written correspondence to Providers, record review and/or site audit, individual case peer-to-peer reviews, and referral for further investigation. You are contractually required to cooperate in this process and participate in any activities related to the identification and correction of potential fraud, waste, and abuse.

Once an intervention has occurred, we continue to monitor the practice patterns of an identified care provider to ensure that the potential fraud, waste or abuse practice pattern has been corrected. Some examples of fraud are as follows:
• Paying, soliciting, offering or receiving:
  • A kickback or bribe in connection with the furnishing of treatment, services or goods for which payment is or may be made in whole or in part under the Medicaid program.
  • A rebate of a fee or charge made to a provider for referring a recipient to a provider.
  • Anything of value, with intent to retain it, and knowing it to be in excess of amounts authorized or rates established under the Medicaid program, as a precondition of providing treatment, care, services or...
goods or as a requirement for continued provision of treatment, care, services or goods.

- Providing the following with intent that a claim be relied upon for the expenditure of public money:
  - Treatment, services, or goods that have not been ordered by a treating care provider.
  - Treatment that is substantially inadequate when compared to generally recognized standards within the profession or industry.
  - Merchandise that has been adulterated, debased, mislabeled or is outdated.
  - Presenting or causing to be presented for allowance or payments with intent that a claim be relied upon for the expenditure of public money, any false, fraudulent, excessive, multiple or incomplete claims.

Examples of abuse include, but are not limited to:

- Inappropriate balance billing.
- Inadequate resolution of overpayments.
- Lack of integrity in computer systems.
- Failure to maintain confidentiality of information/records.
- High utilization of procedures or tests not medically necessary.
- Providing services that are not medically necessary.
- Providing poor quality medical services.
- Unbundling/exploding charges (e.g., the unpacking and billing separately of services that would ordinarily be all-inclusive).
- Coding a service at a higher level than what was rendered (i.e., up-coding).
- Violation of agreement by care provider.
- Breaches of agreement that result in Consumers being billed for amounts not allowed by the agreement.
- Failure to collect coinsurance and deductible amounts, as required by the member’s benefit plan.
- Excessive charges for services.
- Inappropriate documentation of services rendered.

In the event that we suspect fraud, waste and/or abuse, the allegation or complaint is forwarded for investigation. The investigation unit determines which claims are appropriate to review. In addition, suspicious billing patterns may be detected through established data tools and analysis. In general, identified claims, along with the Provider that submits these claims, are audited on a prospective basis. In accordance with our policy, audits of previously paid claims are completed on a retrospective basis.

All prospective reviews are completed in a timely manner, prior to a payment determination, to assess whether they validate the initial allegation. Any claim submitted by a care provider that matches suspected patterns under investigation may trigger a request for medical records. In some cases, additional investigative steps may be used in order to obtain accurate information related to a claim. Upon completion of the investigation the claim is adjudicated. Either timely payment is made or, in the event that a claim denial is issued, the denial notification includes the Provider’s standard appeal rights.

Billing records should reflect the member who was treated, the rendering clinician and the modality of care. Audits related to claims, coding or billing issues may require corrective action. Findings of billing inconsistent with our policies by in-network Providers may result in such actions as clarification of proper procedure, a Corrective Action Plan (CAP), a change in network availability status, or may result in termination of your Agreement. In the case of retrospective review, we and our Payors reserve the right to pursue recoupment of funds paid. The Credentialing Committee may recommend termination. In that event, the care provider is notified in writing and provided with information about appeal rights, if applicable, and in compliance with state and federal laws.

As warranted, care providers will be reported to the Arizona Department of Insurance, licensing board(s), and any other regulatory agencies based on the outcome of the investigation and as required by state and federal laws. Throughout this process, we adhere to state law, ERISA guidelines, and confidentiality standards.

Provider Dispute Resolution Process
The Provider Dispute Resolution process is available to you, or your authorized representative, please see Chapter 14 for the Provider Appeals and Dispute processes.

Crisis Line
Cochise, Gila, Graham, Greenlee, La Paz, Santa Cruz, Yuma Counties Crisis Line: 866-495-6735
Pima County Crisis Line: 800-796-6762
Maricopa County Crisis Line: 800-631-1314
Apache, Cochino, Mohave, Navajo, Yavapai Counties Crisis Line: 877-765-4090

As in any emergency situation, any member, regardless of eligibility, can be referred to an emergency room for an evaluation and possible admission or calling the Crisis Lines listed above.
Section 1:
Services for CRS Fully Integrated and CRS Partially Integrated-Behavioral Health Members

Members do not require a referral when contacting a behavioral health provider for services. Members can call Member Services at 800-348-4058 and ask for the contact information for a behavioral health provider. Referrals to behavioral health providers are based on where member resides, member request, provider specialty and expertise.

Both members and care providers can find the list of behavioral health network providers by using the ‘Searchable Directory’ feature located on the website at UHCCommunityPlan.com under Find a Physician, via uhccommunityplan.com/az/medicaid/childrens-rehabilitative-services/lookup-tools.html#find-a-provider which provides you a list of contracted behavioral health providers, or by contacting Member Services for assistance or to mail out a copy of the Provider Directory.

The behavioral health services covered are:

- Behavioral Health Case Management Service.
- Emergency and Non-Emergency Transportation.
- Evaluation and Assessment.
- Individual, Group and Family Therapy and Counseling.
- Inpatient Hospital Services (the Contractor may provide services in alternative inpatient settings that are licensed by the Arizona Department of Health Services, Division of Assurance and Licensure, the office of Behavioral Health Licensure, in lieu of services in an inpatient hospital. These alternative settings must be lower cost than traditional inpatient settings. The cost of the alternative settings will be considered in capitation rate development).
- Non-Hospital Inpatient Psychiatric Facilities Services (Level 1 residential treatment centers and sub-acute facilities).
- Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis.
- Opiod Agonist Treatment.
- Partial Care (supervised day program, therapeutic day program and medical day program).
- Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services).
- Psychotropic Medication.
- Psychotropic Medication Adjustment and Monitoring.
- Respite Care (with limitations).
- Rural Substance Abuse Transitional Agency Services.
- Behavioral Health Therapeutic Home Care.

Behavioral Health Screenings

Members should be screened by their PCP for behavioral health needs during routine or preventative visits. EPSDT and Behavioral Health Screening for members up to 21 years of age in accordance to the AHCCCS periodicity schedule. Based on screening Tools Best Practices Guidelines, PCP will refer to T/BRHA when appropriate.

Behavioral health services are covered for CRS enrolled member’s depending on their coverage type. Below are the services by coverage type that require prior authorization.

A complete prior authorization list is available online at UHCCommunityPlan.com
### Service | CRS Fully Integrated (Acute-CRS-BH services) | CRS Partially Integrated (Acute-CRS services. AI receiving BH from T/RBHA) | Partially Integrated DDD/CMDP (All CRS & BH services) | CRS Only (DDD/CMDP/AI Enrolled in primary HP and T/RBHA)
---|---|---|---|---
| • Acute Inpatient admission | Call: 866-604-3267 Fax: 888-899-1499 | Refer to T/RBHA | Call: 866-604-3267 Fax: 888-899-1499 | Refer to T/RBHA
| • Residential Treatment Center (Level 1) | | | |
| • Residential Behavioral Health Facility - Level II/III Group Home | | | |
| • Behavioral Health Day Program: | | | |
| • Supervised Day Program | | | |
| • Therapeutic Day Program | | | |
| • Medical Day Program | | | |
| • Out of State placements | | | |
| • Neuropsychological Testing | | | |
**Section 2: Services for CRS Only and CRS Partially Integrated Acute Care Members**

The CRS Fully Integrated and CRS Partially Integrated-BH services are covered in Section 1 of this chapter.

AHCCCS covers behavioral health services (mental health and/or substance abuse service) within certain limits for all members. The following outlines the service delivery system for behavioral health services.

Title XIX and Title XXI Members are eligible to receive medically necessary behavioral health services. Services are provided through the Arizona Department of Health Services and its contracts with Regional Behavioral Health Authorities (RBHA) and Tribal Regional Behavioral Health Authorities (T/RBHA). American Indian members may receive behavioral health services from an IHS/638 Facility, a T/RBHA, or be referred to a RBHA. Services are listed in the amount, duration and scope section of this policy and are described with limitations in the Behavioral Health Services Guide.

**RBHA Covered Services for Title XIX and Title XXI Members**

Covered services include:

- Behavioral Management (behavioral health personal care, family support/home care training, self-help/peer support).
- Behavioral Health Case Management Service (limited).
- Emergency and Non-Emergency Transportation.
- Evaluation and Assessment.
- Individual, Group and Family Therapy and Counseling.
- Inpatient Hospital Services (the Contractor may provide services in alternative inpatient settings that are licensed by the Arizona Department of Health Services, Division of Assurance and Licensure, the office of Behavioral Health Licensure, in lieu of services in an inpatient hospital. These alternative settings must be lower cost than traditional inpatient settings. The cost of the alternative settings will be considered in capitation rate development).
- Non-Hospital Inpatient Psychiatric Facilities Services (Level 1 residential treatment centers and sub-acute facilities).
- Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis.
- Opioid Agonist Treatment.
- Partial Care (supervised day program, therapeutic day program and medical day program).
- Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services).
- Psychotropic Medication.
- Psychotropic Medication Adjustment and Monitoring
- Respite Care (with limitations).
- Rural Substance Abuse Transitional Agency Services.
- Behavioral Health Therapeutic Home Care.

Refer to the Behavioral Health Services Guide for further information on AHCCCS covered behavioral health services and settings.

**RBHA Referrals: Initiating a Referral**

RBHA referrals are based on the county and zip codes (See RBHA Listing at end of chapter). Although members have been auto enrolled for BH benefits to activate those benefits members have to contact the RBHA and schedule a first time appointment referred to as an “Intake” appointment. Referrals to the RBHA do not require a prior authorization from the health plan or a doctor’s order.

There are several ways that a referral can be made to a RBHA:

- The provider, parent or legal guardian, or member may contact the RBHA directly by phone.
- Providers may fax a referral using the current ADHS/DBHS Form 3.3.1 Referral for Behavioral Health Services. Referral form is available at: azdhs.gov/bhs/provider/documents/forms/pm3-3-1.pdf
- Schools or State agencies may also refer members.
- Member can call the RBHA on their own and schedule their own appointment also known as a self-referral.
RBHA Referrals: Initiating a Referral for a DD/ALTCS Member
To initiate a referral to the RBHA for a DD/ALTCS member, you may contact the RBHA or you may contact the member’s DD/DES Support Coordinator directly. If the member is unable to give you the coordinator’s name or telephone number, you may call Health Care Services of the Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) at: 602-771-8080 during normal business hours to obtain this information. Please have the member’s name and date of birth available. Referral form is available at: azdhs.gov/bhs/provider/forms/pm3-3-1.pdf.

RBHA Referrals: When to Make a RBHA Referral
- Refer to RBHA if member has been admitted to an inpatient hospital with a primary substance abuse or behavioral health diagnosis.
- Refer to RBHA if a member has experienced a sentinel event (e.g. attempted suicide, unintentional overdose within the most recent past).
- Refer to RBHA if member has a substance abuse or addiction not currently in remission for a period no less than 1 year.
- Refer to RBHA if member is currently, receiving services for substance abuse or addiction.
- Refer to RBHA if member has poor response to psychotropic medications and may need additional behavioral health services and more intense medication monitoring.
- Refer to RBHA if member require services outside of the scope of PCPs expertise or comfortability level.
- Refer to RBHA if member presents with a diagnosis other than ADHD, anxiety depression.

RBHA Referrals: Referral for Member Not Established on Psych Medication
If a member is not currently established on a BH medication, and you are planning to refer to RBHA for services, UnitedHealthcare suggests you do not start member on a medication that may have to be changed after member is assessed by a RBHA Prescriber. (If CURRENTLY prescribing medications for anxiety, ADHD, depression, please refer to Section VII. RBHA REFERRALS-TRANSFER OF CARE) Fill out and fax: a ADHS RBHA referral form for behavioral health services.

RBHA Referrals: Transfer of Care to the RBHA
When a PCP has initiated medication-management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP or UnitedHealthcare that the member should be transferred to a T/RBHA prescriber for evaluation and/or continued medication management services, the following steps should be taken:
- Fill out and fax: ADHS/DBHS 3.3.1 Referral for Behavioral Health Services: to appropriate RBHA. (RBHA Listings at end of chapter).

Current copy of RBHA Referral Form can be obtained by going to the link: azdhs.gov/bhs/provider/documents/forms/pm3-3-1.pdf
- PCP will maintain continuity of care for these members until they can be established with a RBHA provider to receive behavioral health services and/or medication evaluation and management.
- Fill out ADHS/DBHS 3.3.1 Referral for Behavioral Health Services. When transferring care AHCCCS requires the referral include at a minimum:
  - The reason for the referral.
  - Medication trials/failures.
  - Current diagnosis.
  - Date of last PCP visit and/or hospitalization.
  - Lab/diagnostic results.
  - Other pertinent information.

- PCP oversight for continuity of care during transition is a priority as it may take 30 days or more to transition member. Your oversight is essential to prevent any lapse of medication coverage during this period of transition.
  - FORMULARY MEDICATIONS – Call UnitedHealthcare Community Plan Pharmacy Prior Notification at 800-305-0023 or fax to: 866-940-7328, and request a “bridge” or “temporary supply” of medication until member can be seen by RBHA prescriber.
  - To see if prior authorization is required, view MEDICAID PREFERRED DRUG LIST at: UHCCommunityPlan.com.
  - Should you need further assistance, contact UnitedHealthcare Community Plan Behavioral Health Coordinator at 877-885-8455 # 61053.

For current copy go to link: azdhs.gov/bhs/provider/documents/forms/pm3-3-1.pdf
Transfer of Care From the RBHA/Step Therapy

Step Therapy
Step Therapy Drugs appearing on the Preferred Drug List (PDL) require a trial and failure of a specific covered drug(s), before a member can receive the Step Therapy Drug. The Step Therapy Drugs are covered automatically if the members' pharmacy history shows that the required drug(s) have been tried first. If the pharmacy history shows that the required drug had not been tried, the prescriber will need to submit a prior authorization request. UnitedHealthcare Community Plan asks the prescriber to submit information explaining why the member cannot use the required drug(s) first. However, members that have been stabilized on a medication while in service through the RBHA for the treatment of ADHD, anxiety and/or depression, will be maintained on that medication when discharged and seeing PCP for medication management. In the event that the PCP identifies a change in the member’s condition, the PCP may utilize STEP Therapy until the member is stabilized once again. UnitedHealthcare Community Plan will cover the cost of the medication and dose that the member had been stabilized on.

Transfer of Care
Transfer of Care PCPs may continue with medication management of members who have been treated by the RBHA for behavioral health disorders of uncomplicated ADHD, anxiety or depression for a period no less than 6 months, under these conditions:

- Is within physician’s scope of practice and expertise.
- PCP’s may request these medications by submitting a completed UnitedHealthcare Pharmacy Prior Authorization Form indicating STEP therapy has already been completed, or is medically contraindicated, and member needs to continue on current medication and dosage on which member has been stabilized, unless there is subsequently a change in medical condition of the member. PDL drugs requiring STEP Therapy are routinely covered only after a sufficient trial of an indicated first-line agent has been adequately tried and failed.

Before faxing the completed Pharmacy Prior Authorization Form with documentation, please indicate on the Pharmacy Prior Authorization Form:
- “Request for STEP Therapy Medication”.
- State if the request is “Expedited” or “Routine”.
- To prevent any lapse in medication coverage, or for assistance with this process, call UnitedHealthcare Pharmacy at 800-305-0023 or fax to 800-853-3844

UnitedHealthcare Pharmacy Prior Authorization Form can be obtained at UHCCommunityPlan.com

Behavioral Health Screenings
Members should be screened by their PCP for behavioral health needs during routine or preventative visits. EPSDT and Behavioral Health Screenings for members up to 21 years of age in accordance to the AHCCCS periodicity schedule. Based on screening Tools Best Practices Guidelines, PCP will refer to T/RBHA when appropriate.

PCP Coordination of Care Responsibilities
The Primary Care Physician is responsible for ensuring that a medical record is established when behavioral health information is received from the RBHA or provider about an assigned member even if the PCP has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member’s medical record as soon as one is established. PCP shall respond to T/RBHA/provider information requests pertaining to the behavioral health recipient within 10 business days of receiving the request. The response should include all pertinent information including, but not limited to, current diagnoses, medications, laboratory results, last PCP visit, and recent hospitalizations.

The PCP is to document and initial the RBHA documentation received on one of their assigned health plan members. The signature indicates their knowledge that the member is receiving Behavioral Health services.
MRR Audits are conducted at least every three years for behavioral health providers. The objectives of Medical Record Review activities are to evaluate:

- Compliance with medical record requirements
- Documentation for the presence of information that conforms to accepted standards of medical practice, which includes evidence of continuity and coordination of care.
- Presence of medical record confidentiality policies

**Medication Management Services**

PCP may provide medication management services (prescriptions, medication monitoring visits, laboratory and other diagnostic tests necessary for diagnosis and treatment of behavioral disorders) to members with diagnoses of ADHD, anxiety, and depression as long as it is within their expertise, scope of practice, and comfort level with UnitedHealthcare formulary medications available to treat these disorders.

- Refer to UnitedHealthcare Formulary to see if prior authorization (PA) is required. To request PA, please call UnitedHealthcare Pharmacy Prior Authorization at 800-305-0023 or fax a completed PA Request Form to 866-940-7328.
- UnitedHealthcare Community Plan Pharmacy Prior Authorization form can be obtained at [UHCCommunityPlan.com](http://UHCCommunityPlan.com) under the Provider Forms Section.

**Consultations Through the T/RBHAs**

PCPs may contact the RBHAs and request a telephonic consultation with a psychiatrist regarding medication management, transition of care, and treatment options for a member with a behavioral health diagnosis with co-morbidities by contacting RBHA Member Services, following the prompts for ‘Consultations’, or fax 3.3.1 RBHA Referral for Behavioral Health Services Form. For “type of service requested” indicate “one-time consultation”. Under “reason for referral” section, indicate if you are requesting telephonic consultation for medication management, phone number and best time to be contacted. Member does not have to be RBHA enrolled for PCP to obtain a consultation.

**Behavioral Health Best Practices and Guidelines**

PCP’s may treat UnitedHealthcare members with behavioral health disorders of: ADHD, anxiety and depression that are considered “uncomplicated”. UHCCP defines uncomplicated as an individual who does not have multiple behavioral health diagnoses in which treatment/medication is required simultaneously, receiving services for substance abuse, prior inpatient psychiatric treatment within the last year, history of dangerous or harmful behavior toward self or others (includes overdoses and suicide attempts). AHCCCS has developed a set of clinical “tool kits” that include assessments and algorithms to assist PCPs in assessing the needs of the children/adolescents (ages 8-17), and adults (age 18 and above), the need and type of medication, and if a RBHA referral is indicated.

You can obtain these Guidelines on our website at [UHCCommunityPlan.com](http://UHCCommunityPlan.com) under the Clinical Practice Guidelines section.

**Diabetic Members Admitted to Arizona State Hospital**

Diabetic members who are admitted to the Arizona State Hospital (AzSH) for behavioral health services will receive training to use a glucometer and testing supplied during their stay at AzSH. Upon discharge from AzSH, the PCP will be notified and provided with the information on the brand and model of equipment and supplied that should be continued to be prescribed.

The PCP must ensure that members are issued the same brand and model of both glucometer and supplied they were trained on during their admission. UnitedHealthcare Community Plan will coordinate with AzSH to ensure that the member has sufficient testing supplies to last until member is scheduled an office visit with the PCP.

In the event the member’s mental status renders him/her incapable or unwilling to manage their medical condition and that condition requires medically necessary ongoing medical care, UnitedHealthcare Community Plan will coordinate with the RBHA, member guardian, and AzSH to obtain the appropriate discharge placement and follow-up care.

**Establishing and Documenting in the Medical Record**

AHCCCS requires the following:

- The PCP is responsible for ensuring that a medical record is established when behavioral health information was received from the RBHA/provider about an assigned member even if the PCP has not yet seen the assigned member.
- In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member’s medical record as soon as one is established.
Chapter 8 Behavioral Health

- The PCP will respond to RBHA/Provider information requests pertaining to ADHS behavioral health recipient members within 10 business days of receiving the request. The response should include all pertinent information, including but not limited to:
  - Current diagnosis.
  - Medications.
  - Laboratory results.
  - Last PCP visit.
  - Recent hospitalizations.
- PCP will initial and date incoming documents from RBHA/provider related to behavioral health treatment to demonstrate that the records were reviewed.
- Document and maintain all appropriate information and communication on members potentially needing or who are currently receiving behavioral health services (this would include but not be limited to medication trial and errors, medication education, response to treatment, behavioral health referrals, coordination and/or transfer of care).

The PCP shall provide timely updates to behavioral health providers regarding a member’s change in health status. The update must include but is not limited to: diagnosis of chronic conditions, support for the petitioning process for Arizona Long Term Care System (ALTCS) and the integrated program, and all medication prescribed.
Section 3: Behavioral Health Benefits for Medicaid Members with Medicare Coverage

Effective October 1st, 2015, UnitedHealthcare Community Plan will be providing the behavioral health services for members 18 years of age and older, who are enrolled in AHCCCS for both their Medicaid and Medicare A/B benefit coverage.

Members do not require a referral when contacting a behavioral health provider for services. Members can call Member Services at 800-348-4058 and ask for the contact information for a behavioral health provider. Referrals to behavioral health providers are based on where member resides, member request, provider specialty and expertise.

Both members and care providers can find the list of behavioral health network providers by using the ‘Searchable Directory’ feature located on the website Live and Work Well via liveandworkwell.com/public/ which provides you a list of contracted behavioral health providers, or by contacting Member Services for assistance or to mail our a copy of the Provider Directory.

The behavioral health services covered for members with Medicare and Medicaid coverage through AHCCCS are available:

- Behavioral health counseling
- Medication services
- Case management

For a complete list of covered services, please refer to the ADHS Website: azdhs.gov/bhs/covserv.htm

Crisis Line

Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties: 866-495-6735

Maricopa County Crisis Line: 800-631-1314 or 602-222-9444
Apache, Coconino, Gila, Mohave, Navajo and Yavapai Counties: 877-756-4090

As in any emergency situation, any member, regardless of eligibility, can be referred to an emergency room for an evaluation and possible admission or calling the Crisis Lines listed above.

Behavioral Health Screenings

Members should be screened by their PCP for behavioral health needs during routine or preventative visits.

The current prior authorization lists are available online at UHCCommunityPlan.com.

Provider Registration

Care providers must be registered with AHCCCS as a Title XIX/XXI provider. All provider types are registered with mandatory and optional Categories of Service (COS). The COS will determine the specific services for which the provider can bill. For the purposes of behavioral health, the following COS are relevant:

01 – Medicine
06 – Physical Therapy
09 – Pharmacy
10 – Inpatient Hospital
12 – Pathology & Laboratory
13 – Radiology
14 – Emergency Transportation
16 – Outpatient Facility Fees
26 – Respite Care Services
31 – Non-Emergency Transportation
39 – Habilitation
47 – Mental Health Services

A provider’s AHCCCS ID number will be terminated for inactivity if the provider has not submitted a claim or encounter within the past 24 months, as of January 2014.

Coordination of Benefits (COB)

Some members are eligible for coverage under one or more additional health benefit plans. In these circumstances, payment for allowable expenses shall be coordinated with the other plan(s). It is the care provider’s responsibility to inquire and collect information concerning all applicable health plans available or verifying member enrollment. Care providers are encouraged to verify member eligibility on the AHCCCS website to see a complete eligibility for those members receiving GMH/SA services. All care providers should verify member eligibility and insurance coverage prior to providing services. You may not bill members for the difference between your billed usual and customary charge and the amount paid by the primary plan(s) and us.
This program only pertains to those members that have both Medicare and Medicaid coverage, even if their Medicare coverage is with another health plan. Payment for the behavioral health and physical health services is determined by primary diagnosis. The services provided to a UHCCP member with a primary behavioral health diagnosis will have their claims processed by UHCCP. If behavioral health related services are not submitted with a primary behavioral health diagnosis, the claim should be submitted to the Primary Medicare Replacement plan for processing. This might be UHCCP or another Medicare replacement program.

Billing for Services

The information provided in this section is for general information purposes only. Care providers shall conform all billing practices to comply with all federal, state and local laws, rules, regulations, standards and executive orders including all AHCCCS provider manuals, policy guidelines and standards. Care providers must use appropriate ICD-10, CPT, HCPCS, CDT and Health Insurance Portability and Accountability Act Transactions and Code Sets (HIPAA TCS) compliance standards.

- **Service Codes**
  There are two types of codes that can be billed for services provided. These include:
  
  a. AHCCCS Allowable Codes that may be paid for with Title XIX/XXI funds and/or non-TitleXIX/XXI funds depending on the person’s eligibility status. To bill AHCCCS allowable codes, the care provider must be an AHCCCS registered provider.
    
    1. CPT
    
    2. HCPCS
    
    3. National Drug Codes (NDC)
    
    4. UB-04 Revenue Codes
  
  b. Codes that are not allowable under AHCCCS/ Codes that are not allowable under AHCCCS and can only be paid for with non-Title XIX/XXI funds. If there is not an applicable AHCCCS allowable code, then these codes may be used to bill for the service. These codes may be billed regardless of the person’s Title XIX/XXI eligibility status.

- **Billing Provider Types**
  AHCCCS provides an Allowable Procedure Code Matrix which provides a listing of the service codes that can be billed by each provider type. In addition to having the correct provider type, care providers also have to be registered to provide the COS in which the service code is classified.

- **Modifiers**
  It is sometimes necessary to clearly identify/delineate the service being provided; a ‘modifier’ must be submitted along with the service code. In this circumstance, codes are assigned modifiers as described in the ACOM Chapter. The following is a list of modifiers used in this guide:
  
  GT – Via interactive audio and video telecommunication systems – the physical location of the provider, when providing services via telecommunication, is the location used as the billable place of service.
  
  HB- Adult Program, non geriatric
  
  HC – Adult Program, Geriatric
  
  HG – Opioid addiction treatment program
  
  HK – Specialized mental health programs for high risk populations
  
  HN – Bachelor’s degree program (for staff not designated as behavioral health professionals)
  
  HO – Master’s degree level (for behavioral health professionals)
  
  HQ – Group setting
  
  HR – Family/couple with client present
  
  HS – Family/couple without client present
  
  HT – Multi-disciplinary team
  
  HW – Funded by the State Mental Health Agency
  
  TF – Intermediate level of care
  
  TG – Complex/high level of care
  
  TN – Rural

- **Place of Service (POS) Codes**
  Accurate POS codes must be submitted on claims and encounters to specify where service was rendered. The following is a link to the Centers for Medicare and Medicaid Services (CMS) POS table that lists POS codes and their descriptions: [cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html](http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html).

- **Group Payment ID**
  Providers may have an organization act as the financial representative if there is an arrangement authorized. This organization must register with AHCCCS as a group payment provider. The organization may not provide services or bill as the service provider.

- **Diagnosis Codes**
  Payment for the behavioral health and physical health services is determined by primary diagnosis. The services provided to a UHCCP member with a primary diagnosis from the list provided below will have their behavioral health claims processed by UHCCP. This program only pertains to those members that have both Medicare and Medicaid coverage, even if their Medicare coverage is with another health plan. If behavioral health related services are not submitted with one
of the listed diagnosis codes in the primary position, the claim should be submitted to the Primary Medicare Replacement plan for processing. This might be UHCCP or another Medicare replacement program. Effective October, 1st, 2015, care providers must utilize the ICD-10 procedure codes. Inpatient UB-04 encounters/claims submitted by inpatient provider types (02, 71, 78, B1, B2, B3, B5 and B6) must be submitted indicating a principal diagnosis code for mental health or substance abuse from the list provided below:

- General Billing Limitations
  a. A care provider can only bill for their time spent providing the actual service. For all services, the care provider may not bill any time associated with note taking and/or medical record upkeep as this time has been included in the rate.
  b. For all services except case management and assessment services, the provider may not bill any time associated with phone calls, leaving voice messages, sending emails and/or collateral contact with the enrolled person, family and/or other involved parties.
  c. The care provider may only bill the time spent in face-to-face direct contact; however, when providing assessment or case management services, the care provider may also bill indirect contact. Indirect contact includes phone calls, leaving voice messages and sending emails (with limitations), picking up and delivering medications, and/or collateral contact with the enrolled person, family and/or other involved parties.
  d. A care provider should bill all the time spent in directly providing the actual service, regardless of the assumptions made in the rate model. Care providers must indicate begin and end times on all progress notes.
  e. A professional who supervises the behavioral health professional, behavioral health technician and/or behavioral health paraprofessional providing the service may not bill this supervision function as a HCPCS/CPT code. Employee supervision has been built into the service code rates. Supervision means direction or oversight of behavioral health services provided by a qualified individual in order to enhance therapeutic competence and clinical insight and to ensure client welfare by guiding, evaluating, and advising how services are provided.
  f. If the person and/or family member(s) misses their appointment, the care provider may not bill for the service.
  
g. Parents (including natural parent, adoptive parent and stepparent) may only provide personal care services if the adult child receiving services is 21 years or older and the parent is not the adult child’s legal guardian. Under no circumstances may the spouse be the personal care services provider.
  h. Parents (including natural parent, adoptive parent and stepparent) who are certified Habilitation providers may only encounter/bill for applicable covered behavioral health services delivered to their adult children who are 21 years or older.
  i. When necessary, covered services, in addition to those offered through a DLS Level I Behavioral Health facility, may be delivered to the enrolled person. See the billing limitation section associated with each specific service for additional information.
  j. For services with billing units of 15 minutes, the first unit of service can be encountered/billed when one or more minutes are spent providing the service. To encounter/bill subsequent units of the service, the provider must spend at least one half of the billing unit for the subsequent units to be encountered/billed. If less than one half of the subsequent billing unit is spent providing the service, then only the initial unit of service can be encountered/billed.
  k. More than one provider agency may bill for certain services provided to a behavioral health recipient at the same time if indicated by the person’s clinical needs.
  l. If otherwise allowed, service codes may be billed on the same day as ‘admission to’ and ‘discharge from’ inpatient services.
  m. A single provider cannot bill for any other covered service while providing transportation to client(s).
  n. Payment for services related to Provider-Preventable Conditions is prohibited, in accordance with 42 CFR Section 447.26. Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC). Additional information regarding the prohibition of payment for services related to Provider-Preventable Conditions is located in the AHCCCS Medical Policy Manual (AMPM), Chapter 900, Policy 960.
  o. CPT codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer to Appendix B.2, Allowable Procedure Code Matrix on the ADHS website to identify providers who can bill using CPT codes.
• Telehealth Services
  While telehealth services is not a treatment service ("modality") ADHS/DBHS does recognize real time telehealth services as an effective mechanism for the delivery of certain covered behavioral health services (see ADHS/DBHS Policy 410 Use of Telemedicine). The following types of covered behavioral health services may be delivered to persons enrolled with a T/RBHA utilizing telehealth services technology:
  – Diagnostic consultation and assessment
  – Psychotropic medication adjustment and monitoring
  – Individual and family counseling
  – Case management

A complete listing of the services that can be billed utilizing telehealth services can be found in Appendix B.2, Allowable Procedure Code Matrix on the ADHS website. Services provided through telehealth should be billed/encountered as any other specialty consultation with the exception that the ‘GT’ modifier must be used to designate the service being billed as telehealth services.
Chapter 9 Acute/Medicaid Dental Services

Covered Dental Services


Children under the age of 21 are covered for a wide spectrum of preventive and restorative services. Covered dental services for this age group include:

- Exams.
- Cleanings.
- Fluoride treatment.
- X-rays.
- Sealants.
- Amalgam or resin restorations.
- Stainless steel or composite crowns.
- Limited cast crowns.
- Pulp therapy.
- Space Maintainers.
- Extractions.
- Appropriate anesthesia.

Adults over the age of 21 are covered for Limited Medical and Surgical Services by a dentist. Additional details regarding these benefits can be located in Chapter 300 of the AHCCCS Medical Policy Manual.

Appointment Availability Standards

AHCCCS has established appointment availability standards which need to be met for both new and established members. Please see below for the appointment availability standards, appointments must be available within these standards.

For Primary Care Appointments,

- Emergency appointments – same day of request
- Urgent care appointments – within two days of request
- Routine care appointments – within 21 days of request

For Specialty Referrals Appointments,

- Emergency appointments – within 24 hours of referral

For Dental Appointments,

- Emergency appointments – within 24 hours of request
- Urgent care appointments – within three days of request
- Routine care appointments – within 45 days of request

For Maternity Care Appointments,

- First trimester – within 14 days of request
- Second trimester – within seven days of request
- Third trimester – within three days of request
- High risk pregnancies – within three days of identification of high risk by UHCCP or maternity care provider, or immediately if an emergency exists.

For CRS Behavioral Health Appointments,

- Emergency appointments – Same day or within 24 hours
- Urgent Care appointments for CMDP members – No later than 72 hours after notification by DES/CPS that a child has been or will be removed from their home
- Initial Services appointment – Within seven days of referral
- Ongoing Services appointment – Within 23 days of initial appointment.

Prior Authorization (PA)

A prior authorization (PA) number cannot be issued by phone or fax. Emergency treatment done where PA could not be requested in advance; must be mailed to UnitedHealthcare for retrospective review. Surgical center or hospital authorizations may continue to be called or faxed into the UnitedHealthcare Dental Unit if emergency or urgent treatment needs to be rendered at a hospital or surgi-center. PA requests and retro-reviews should be sent to:

UnitedHealthcare Community Plan
Dental Unit
P.O. Box 2020
Milwaukee, WI 53201
Billing

All dental service billing, except services requiring Prior Authorization or treatment requiring retrospective review as noted or indicated on the dental matrix for UnitedHealthcare members, should be sent to UnitedHealthcare Dental using the current ADA claim form. Members cannot be billed for AHCCCS covered services. Members may request services from providers that are not covered by AHCCCS. Those members must sign a release form stating that they understand the service is not covered under AHCCCS and that they are responsible for the bill. Dental claims should be submitted to:

UnitedHealthcare Community Plan
Dental Claims
P.O. Box 2185
Milwaukee, WI 53201

Providers should direct all dental claim inquiries to UnitedHealthcare Dental. Contacting the Network Management Department creates unnecessary delays in resolving issues, including questions about claim resubmissions. Care providers can reach UnitedHealthcare Dental directly at 855-812-9208. Claim status may also be checked online at UHCproviders.com.

You must register using your UnitedHealthcare Dental provider ID, not with your AHCCCS ID. If you do not know your UHC Dental provider number, contact UHC Dental at 855-812-9208 and a UHC Dental customer service representative will assist you.

EPSDT Oral Care

As part of the physical examination, the physician, physician’s assistant or nurse practitioner should perform an oral health screening pursuant to the EPSDT guidelines and regulations. Please refer to Chapter 6 for EPSDT specific information.

Dental Contact Information

<table>
<thead>
<tr>
<th>Service/Process</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Benefit Providers</td>
<td>855-812-9208</td>
</tr>
<tr>
<td>Customer Service</td>
<td></td>
</tr>
<tr>
<td>Member Eligibility</td>
<td>855-812-9208</td>
</tr>
<tr>
<td>Claims Status</td>
<td>855-812-9208</td>
</tr>
</tbody>
</table>

Dental Procedure Codes

The Dental Procedure Code Matrix, which contains outlining procedures, associated CDT codes, whether or not prior authorization is required, and additional documentation needed for prior authorization as appropriate, can be viewed online at UHCproviders.com.
Chapter 10 Member Rights and Responsibilities

UnitedHealthcare Community Plan’s Member Handbook contains a section regarding the member rights and responsibilities when accessing services. UnitedHealthcare members are asked to adhere to this personal code of conduct when presenting for services in your office or facility. If a member appears not to be conducting himself or herself in a reasonable manner of behavior (e.g. use of abusive language, office disruption, or other uncooperativeness, potential threats of bodily harm), please contact any of the following, depending on the severity and/or life-threatening aspects of the situation; your local police or fire department, the Arizona Department of Child Protective Services or Adult Protective Services, your UnitedHealthcare Member Services Department, or AHCCCS.

Member Rights
Members have the right to:

• Plan allows the member to change their doctor that is contracted with UnitedHealthcare up to three times per year.
• Request information about the financial condition of the health plan.
• Know if they need stop-loss insurance for very large claims.
• Request information on whether or not UnitedHealthcare has physicians’ incentive plans that affect the use of referral services.
• Know how UnitedHealthcare compensates doctors.
• A summary of the member survey results.
• Be treated with respect and with recognition of the member’s dignity and need for privacy, including protection of any information that identifies a particular member, except when otherwise required or permitted by law and confidentiality of health and medical records and other member information. (Refer to the Medical Records requirement included in Chapter 11 of this manual).
• Not to be discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
• Have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds as well as members with visual or auditory limitation. Options include access to a language interpreter, a person proficient in sign language for the hearing impaired and written materials available in Braille for the blind or in difference formats, as appropriate.
• Have the opportunity to choose a primary care provider (PCP), within the limits of the provider network, and choose other providers as needed from among those affiliated with the network. This also includes the right to refuse care from specified providers.
• Participate in decision-making regarding their health care, and/or have a representative facilitate care or treatment decisions, including the right to refuse treatment, when the member is unable to do so.
• Have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience of retaliation.
• Be provided with information about formulating advance directives within the requirements of federal and state law.
• Receive information, in a language and format that the member understands, about member rights and responsibilities, the amount, duration and scope of all services and benefits, service providers, services included and excluded as a condition of enrollment, and other information including:
  • Provisions for after-hours and emergency health care services. Information provided must notify members that they have the right to access emergency health care services from contracting or non-contracting providers without prior authorization, consistent with the member’s determination of the need for such services as prudent layperson.
  • Information about available treatment options (including the option of no treatment) or alternative courses of care.
  • Procedures for obtaining services, including authorization requirements and any special procedures for obtaining mental health and substance abuse services, or referrals for specialty services not furnished by the member’s PCP.
  • Procedures for obtaining services outside the geographic service area of the health plan.
  • Provisions for obtaining AHCCCS-covered services that are not offered or available through the health plan, and notice of the right to obtain family planning services from an appropriate AHCCCS-registered provider, and
  • A description of how the health plan evaluates new technology for inclusion as a covered benefit. Be provided with information regarding grievances, appeals and requests for hearing.
• Have the right to complain about the managed care organization.
• Have access to review his/her medical records in accordance with applicable federal and state laws, and/or have the right to request, receive a copy, amend or correct his or her medical records as specified in Title 45 of the Code of Federal Regulations (CFR) Part 164.526.
• Be free to exercise his/her rights and that the exercising of those rights will not adversely affect the treatment of the member by the health plan or its providers.

Member Responsibilities

Member responsibilities include:
• Reading and following Member Handbook.
• Treating all UnitedHealthcare staff and health care providers with respect and dignity.
• Protecting their insurance card and show it before obtaining services.
• Know the name of their PCP.
• Seeing their PCP for their healthcare needs.
• Using the emergency room for life-threatening care only and go to their PCP or urgent care center for all other treatment.
• Following their doctor’s instructions and treatment plan and telling the doctor if the explanations are not clear.
• Bringing the appropriate records to the appointment, including their immunization records until the child is 18 years old.
• Making an appointment before they visit their PCP or any other UnitedHealthcare health care provider.
• Arriving on time for appointments.
• Calling the office at least one day in advance if they must cancel an appointment.
• Being honest and direct with their PCP, including giving the PCP the member’s health history as well as their child’s.
• Telling their AHCCCS, UnitedHealthcare, and their DDD support coordinator if they have changes in address, family size, or eligibility for enrollment.
• Tell UnitedHealthcare if they have other insurance.
• Give a copy of their living will to their PCP.

Division of Developmental Disabilities (DD)/Arizona Long Term Care System (ALTCS) Members

DD/ALTCS members or their responsible person(s) are assisted with their rights and responsibilities through their DES/DDD Support Coordinator. Their member rights and responsibilities include:
• Maintaining their ALTCS eligibility redetermination appointments.
• Selecting a health plan at the time of ALTCS application.
• Selecting a PCP within 10 days of notification of plan enrollments.
• Coordinating all necessary covered medical services through their PCP.
• Notifying their AHCCCS eligible worker and UnitedHealthcare of changes in their address or phone.
• Arriving on time for their appointments or calling ahead if they can’t make it.
• Providing all the information to their PCP that is requested by the PCP.
• Providing DES/DDD and UnitedHealthcare with all the information, including changes, in private and public insurance, third-party liability, financial assistance, or other benefits received by the DD/ALTCS member.
• Pursuing eligibility with Children’s Rehabilitative Services (CRS) when referred by DES/DDD or UnitedHealthcare.
• Directing any complaints or problems to DES/DDD Managed Care Operations Health Care Services, Member Services, or their UnitedHealthcare DD Liaison as soon as possible.
• Participating in family-centered consultations at the request of UnitedHealthcare, their Support Coordinator or other personnel.

Advance Directives

Members have the right to make health care decisions for themselves, including the right to accept or refuse treatment and to execute an advance directive. An advance directive is a written instruction, such as a living will or a durable power of attorney for health care that is recognized under state law and relates to the provision of health care when an individual is incapacitated.
Chapter 10 Member Rights and Responsibilities

There may be several types of advance directives available to a member. Care providers must comply with state law requirements regarding advance directives in the state(s) in which they practice. Members are not required to have an advance directive and a provider cannot condition the provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive. Care providers should document in a member’s medical record whether or not the member has executed an advance directive. If a member does have an advance directive, a copy of it should be maintained in the member’s medical record. The member (or the member’s designee) should keep the original. Providers should not send a copy of a member’s advance directive to UnitedHealthcare.

If a member has a complaint about non-compliance with an advance directive requirement, the member may file a complaint with the UnitedHealthcare medical director, the UnitedHealthcare Physician Reviewer, and/or the state survey and certification agency.
Chapter 11 Medical Records

All practitioner medical records must comply with UnitedHealthcare Community Plan’s standards. These standards are based on nationally recognized regulatory accreditation minimum medical record standards and AHCCCS standards. Practitioners must take into consideration professional and community standards as well as implement a process to assess and improve the content, legibility, organization, and completeness of member health records. The Quality Management department for UnitedHealthcare coordinates the on-site visits to conduct medical record reviews for compliance with the following medical record standards:

Medical Record Content

The primary care provider (PCP) must maintain a comprehensive record that incorporates at least the following components:

- Documentation of identifying demographics including the member’s name, address, telephone number AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and if applicable, guardian or authorized representative.
- Initial history for the member that includes family medical history, social history and preventive laboratory screenings. The initial history for members under age 21 should also include prenatal care and birth history.
- Past medical history including:
  - For all members, past medical history includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received.
  - Past medical history must be documented for members under age 21 on their first visit and for members age 21 or over when seen three or more times. Past medical history should be easily identifiable and include disabilities, serious accidents, operations, illnesses, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, immunizations, hospitalizations, surgeries, emergent/urgent care received and familial/hereditary disease. For children’s and adolescents (18 years and younger) past medical history includes prenatal care, birth history, operations, childhood illnesses, immunizations, preventive laboratory screening, family medical history and social history.
  - Immunization history must be documented and maintained in a separate, distinguishable immunization record. Immunizations are administered per the following recommended schedule or notations are present for exceptions to the schedule.
    - For all adult members age 21 and older, record must indicate member’s immunization status for Td. For all female members of childbearing age, record must indicate blood titer and/or immunization status for rubella.
    - For members age 65 and older, record must indicate immunization status for influenza and pneumococcal.
Chapter 11 Medical Records

- For at-risk DD/ALTCS members, record must indicate immunization status for influenza and pneumococcal.
- For all members age 21 and over and at high risk, record must indicate immunization status for influenza pneumococcal and/or hepatitis B.
- For members under age 21, immunizations must be documented and given according to the Centers for Disease Control (CDC) immunization recommendations. There must be a complete immunization record documented. If no record is available, documentation must be present regarding immunization status e.g., “up to date” (UTD), stating who reported the status and that a copy was requested for the medical records.
- Dental history if available, and current dental needs and/or services.
- Current problem list.
- Documentation, initiated by the member’s PCP to signify review of diagnostic information including: Laboratory tests and screenings; Radiology reports; physical examination notes, and/or other pertinent data.
- Reports from referrals, consultations and specialists. Emergency/urgent care reports; hospital discharge summaries, and behavioral health referrals and services provided, if applicable.
- Documentation as to whether or not an adult member has completed advance directives.
- Documentation related to requests for release of information and subsequent release.
- Documentation that reflects diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers as appropriate to promote continuity of care and quality management of the member’s health care.
- Obstetric providers must also complete a risk assessment tool for obstetric patients (i.e. Mutual Insurance Company of Arizona Risk Assessment Tool [MICA] or American College of Obstetrics and Gynecology [ACOG]). Lab screenings for members requiring obstetric care must also conform to ACOG guidelines.
- Documentation that physician or other practitioner has notified each member of reproductive age verbally or in writing of the family planning services available.
- If assistants are allowed to provide services, the member’s record must contain documentation indicating supervision by a licensed professional who is authorized by the licensing authority to provide the supervision.
- Other medical information, including:
  - Height, weight, blood pressure and temperature must be documented on the initial visit.
  - Allergies/no known allergies (NKA) must be documented in a uniform location on the medical record.
  - Medication allergies and adverse reactions must be listed if present.
  - Smoking/alcohol (for members seen three or more times) – notation concerning cigarettes and alcohol is present.
  - Substance use (for members seen three or more times) – notation concerning recreational/illicit substance use is present.
  - Physical exam and findings – plan of action and treatment consistent with diagnoses and Member Education/Instructions.
  - For member’s birth through 20 years, EPSDT items as listed on the corresponding EPSDT Tracking Form. (See Chapter 6, EPSDT for periodic screening requirements).
  - Preventive services according to UnitedHealthcare’s screening guidelines.
  - Any behavioral health/substance abuse information received from a specialty BH practitioner providing covered services through UnitedHealthcare or the Regional Behavioral Health Authorities (RBHAs).

PCP Additional Medical Record Standards

In addition to the standards listed above, PCPs must comply with additional medical records standards as listed below:
- Establishment of a medical record when information is received about a member or documentation of information in an appropriately labeled file if member has not been seen.
- Initial history for the member that includes family medical history, social history, and preventive laboratory screenings. Initial history for members under age 21 should also include prenatal care and birth history.
- Documentation of immunization services must be entered into the Arizona State Immunization System (ASIIS).
Organizational Provider Medical Record Standards

Organizational providers (e.g., hospitals, nursing facilities, rehabilitation clinics, etc.) must maintain a record of services provided to a member, including:

- Physician or practitioner orders for the service.
- Applicable diagnostic or evaluation documentation.
- A plan of treatment.
- Periodic summary of member’s progress toward treatment goals.
- Date and description of service modalities provided.
- Signature/initials of provider for each service.

Sharing Medical Records and Information

Providers must comply with the following standards:

- Appropriate and confidential exchange of member information among providers, including behavioral health providers to ensure that:
  - A provider making a referral transmits necessary information to the provider receiving the referral.
  - A provider furnishing a referral service reports appropriate information to the referring provider.
- Providers must request information from other treating providers as necessary to provide appropriate and timely care.
- Information about services provided to a member by a non-network provider (e.g., emergency services, behavioral health etc.) is transmitted to the member’s PCP.
- When a member chooses a new PCP within the network, the member’s records are transferred to the new provider within 10 working days of the change in continuity of care, or if a member subsequently enrolls with a new health plan, sharing of member information is accomplished in a manner to keep it confidential while promoting continuity of care.
- Information form, or copies of records may be released only to authorized individuals, and the provider must ensure that unauthorized individuals cannot gain access to, or alter, member records.
- Original medical records must be released only in accordance with federal or state laws, AHCCCS policy and contracts, compliance with the Health Insurance Portability and Assurance Act (HIPAA) requirements and 42 CFR 431.300 et seq.
- Confidentiality of member information must be protected by the policy and/or procedures as required by law. There must be documentation that office staff are informed of and agree to confidentially standards.
- Records for members transitioning to a new contractor must be shared in a manner to keep it confidential while promoting continuity of care.

PCPs must forward medical records within ten working days of a PCP change.
Quality Management (QM) Program

UnitedHealthcare strives to continuously improve the care and service provided by the plan and by our health care delivery system. UnitedHealthcare Community Plan Quality Management (QM) Program establishes the standards that encompass all quality improvement activities within the health plan. Three pillars that support our success in this endeavor are:

- Clinical quality and excellence.
- Access and affordability.
- Customer service and operational excellence.

The program’s components include:

- Measure performance against established benchmarks for quality improvement (clinical and non-clinical) as identified by the QM Program and activities identified in the QM Work Plan.
- Review of the quality and utilization of clinical care and service, including inpatient and outpatient care provided by hospitals, providers and ancillary providers.
- Ensure compliance with applicable regulatory and contractual requirements including state and federal regulations.
- Identify and target specific member populations when appropriate such as AHCCCS, DDD, CRS or Medicare.
- Analyze, identify and address:
  - Opportunities to improve quality of care – continuity and coordination of care.
  - Areas of under- and over-utilization – areas that will improve patient safety – member and provider satisfaction.
  - Access to and availability of care.
  - Solicit member and provider input on performance and QM activities.
- Implement procedures for members with special health care needs including:
  - Identifying members with special health care needs.
  - Ensuring assessment by an appropriate health care professional.
  - Identifying medical procedures to address and/or monitor the need or condition – Ensuring adequate care coordination among providers.
  - Ensuring mechanism to allow direct access to a specialist as appropriate.

Peer Review

Peer review is the mechanism to review suspected substandard or inappropriate care or inappropriate professional behavior by a provider while providing care to a UnitedHealthcare member. If the findings of an investigation indicate that a provider has potentially provided substandard or inappropriate care, or has exhibited inappropriate professional conduct, UnitedHealthcare will refer such cases to the Provider Advisory Committee (PAC) for peer review. The scope of actions that may be taken by the PAC include, but are not limited to, development of a corrective action plan with time frames for improvement, education, counseling, monitoring and trending of data. In addition, recommendations to the Quality Management Committee (QMC) for contract termination and/or referral to the appropriate state, federal or regulatory agencies may be made. All peer review information is confidential.

Provider Profiling

Primary care provider (PCP) profiles summarize utilization history and quality indicators for PCPs with sufficient data to generate statistically significant profiles. Lists of member care opportunities are provided to show assigned members without claims evidence of needed care.
Credentialing

Credentialing with UnitedHealthcare Community Plan

UHCCP is a participant of the Arizona Association of Health Plans (AzAHP), which utilizes the council for Affordable Quality Healthcare (CAQH) Universal Provider DataSource for all practitioner credentialing and re-credentialing applications. Providers need to complete the appropriate Data Form (Practitioner or Organizational) found on our website at UHCCP.com under the Provider Forms section. Send the completed form and necessary attachments to UnitedHealthcare Community Plan via fax: 612-234-0211. New care providers and existing care providers are re-credited with the AzAHP credentialing process.

National Credentialing Line

You can also initiate the credentialing process by calling our National Credentialing line at 877-842-3210.

Please see How To Join UnitedHealthcare Community Plan Provider Network in Chapter 1 for additional information regarding credentialing.

National Credentialing Committees

The National Credentialing Committee’s purpose is to conduct initial credentialing and re-credentialing of care providers that may provide care and services to members of UnitedHealthcare and/or affiliated health plans, including UnitedHealthcare.

- The National Credentialing Committee’s responsibilities are:
  - Review and provide meaningful discussion of care provider files that do not meet initial screening criteria.
  - Make recommendations regarding credentialing decisions.
  - Review and provide input on UnitedHealthcare Credentialing Plan and policies.
  - Review of follow-up or pended issues from previous meetings.
  - Review committee membership annually to determine adequate spread of specialty representation.

- The National Credentialing Committee’s membership will include but will not be limited to:
  - A medical director from a UnitedHealthcare health plan serving as the committee chairperson.
  - Maximum of seven licensed independent providers representing different specialties.
  - Other representatives as requested by the committee chairperson.

  - Chief Medical Office, UnitedHealthcare (if UnitedHealthcare providers are reviewed).
  - The National Credentialing Committee meets a minimum of one time per month and reports on health-plan specific activity at least quarterly to the UnitedHealthcare Provider Advisory Committee (PAC) through the CMO.

Quality Management Committee

The Board of Directors has delegated responsibility for the oversight of the plan’s quality improvement activities to the QMC. The QMC is the decision-making body that is ultimately responsible for the implementation, coordination and integration of all quality-management activities for the health plan.

- The responsibilities of the AMC include:
  - Provide program direction and continuous oversight of quality management activities in the areas of clinical care, service, patient safety, administrative processes, compliance, network management and credentialing.
  - Review, prioritize and align the annual QM Work Plan with strategic objectives of the organization.
  - Review and approve benchmarks, performance goals and standards for quality activities.
  - Analyze and evaluate the QM Program annually and assess the overall effectiveness of the program. Recommend policy decisions based on this evaluation.
  - Submit the QM Program Description, QM Work Plan and Annual Evaluation of the QM Program to the Board of Directors for review and approval.
  - Report at least annually, or more frequently as needed, on health plan quality activities to the Board of Directors.
  - Analyze members complaints/appeals and satisfaction. Development and implement action plans to address any identified performance issues.
  - Develop network access and availability standards and review performance against standards at least annually.
  - Monitor, evaluate and implement improvement plans for access and availability of network providers.
  - Develop and implement procedures to ensure that UnitedHealthcare staff and providers are informed of information related to their performance (i.e., results of studies, AHCCCS Performance Measures, profiling data, etc.).
  - Monitor and evaluate the cultural needs of the membership.
• Assess organizational providers.
• Review reports and recommendations from national and local committees and provide feedback, follow-up and direction to the committees.
• Act upon recommendations of committees in areas with high level operational implications. These issues include service and provider contract terminations, sanctions, legal actions and reports to state regulatory boards.
• Ensure actions taken as a result of recommendations are reported to the appropriate agencies, including AHCCCS, DDD, and CRSA.
• Incorporate findings from the quality improvement activities into strategic program and resource planning. Change programs to address identified needs.
• Ensure provider participation in the QM program through planning, design implementation or review.
• Ensure compliance with regulatory requirements and accrediting organizations.
• Provide oversight to applicable UnitedHealth Group business partners.
• Provide local delegation oversight as applicable, and as defined by State regulatory definitions
• Review and make final recommendation of approval or denial of delegation pre-assessment and annual audit results of providers.
• Review and approve National Credentialing Plan, with addendum for regulatory requirements as applicable.
• The UnitedHealthcare Community Plan Quality Management Committee membership includes:
  - Chief Administrative Office UnitedHealthcare.
  - Chief Executive Officer.
  - Chief Operating Office.
  - Chief Medical Officer.
  - Chief Financial Office.
  - Vice President, Quality Management.
  - Vice President, Health Services.
  - Vice President, Operations.
  - Vice President, Medicare Operations.
  - Vice President, Network Management, UnitedHealth Networks.
  - Compliance Officer.
  - Contracted Network Providers (2).
  - The QMC is chaired by the Chief Medical Office. A minimum of 51 percent of committee membership constitutes a quorum. The QMC meets at least quarterly and reports to the Board of Directors of UnitedHealthcare.

Provider Advisory Committee (PAC)

The Provider Advisory Committee (PAC) incorporates activities of peer review and credentialing and is responsible for evaluating the quality, continuity, accessibility, availability and cost-effectiveness of the medical care rendered within the provider network as well as other peer review activities.

The PAC functions include:
• Review summary status reports of clinical issues referred through other committees (including items from national credentialing committee functions).
• Review results of provider medical record reviews and profiling activities.
• Monitor credentialing processes for compliance with health plan procedures.
• Make recommendations to the QMC regarding provider terminations, sanctions or board notifications.
• Review network adequacy and accessibility indicators.
• Review provider satisfaction survey results.
• Provide a summary report of committee activities to the QMC on a quarterly basis.
• Monitor performance on clinical indicators, such as HEDIS®, AHCCCS and DD performance measures, and make recommendations as appropriate.
• Review and approve Disease-Management Programs and Clinical Practice Guidelines.
• Conduct and/or review barrier analysis for clinical issues and develop appropriate interventions.
• Review summary data regarding quality of care cases, trends and recommended actions.
• Incorporate findings of national and regional committees, UnitedHealth Group Executive Medical Policy Committee (EMPC), UnitedHealth Group National Medical Technology Assessment Committee (MTAC) and UnitedHealthcare National Pharmacy and Therapeutics Committee in clinical recommendations.
• Conduct peer review evaluations as needed, for high-level quality of care cases and provider appeals.
• Review peer review evaluations for quality of care.
• Review and make final approval relating to credentialing/re-credentialing issues and potential quality of care trends.
Chapter 12 Quality Management

The membership of the Provider Advisory Committee is composed of:
- Network primary care and specialty physicians.
- Chief Medical Officer.
- Medical Directors.
- Vice President Quality Management.
- Ad hoc members including:
  - Dental Director.
  - Credentialing Coordinator – QA Analysts.

Voting membership is restricted to the network physicians. At least five physicians serve on the PAC with three voting physicians constituting a quorum. A strict conflict of interest policy and confidentiality policy is in force for this committee. Members may not participate in peer review activities in which they have a direct or indirect interest in the outcome. The peer review includes at least one member of the involved party’s specialty when appropriate and must meet state regulatory requirements. At the discretion of the CMO, a UnitedHealth Group network of specialty physicians is available to review and report findings on specific cases to the PAC. The PAC meets monthly. Members may attend by teleconference if necessary. The Chief Medical Office of UnitedHealthcare chairs the PAC. The PAC reports at least quarterly to the QMC.

Medical Record Reviews

The objectives of Medical Record Review activities are to evaluate:
- Compliance with medical record requirements
- Documentation for the presence of information that conforms to accepted standards of medical practice, which includes evidence of continuity and coordination of care.
- Presence of medical record confidentiality policies

MRR Audits are conducted at least every three years for ambulatory facilities, hospitals and nursing facilities and include the following services:
- Ancillary.
- Emergency.
- Dental.
- EPSDT.
- Family planning.
- Obstetric.
- Pharmacy.
- Prevention and Wellness.

- Primary Care.
- Specialty Care.
- Other (DME/Medical Supplies, Home Health Services, Therapies, Transportation, etc.).

Medical records information may be disclosed without the consent of an applicant, member or eligible person for purposes related to administration of the program, and only to the extent required in performance of their duties to the following person, e.g., Employees of contractors and sub-contractors. [Arizona Administrative Code Section R9-22-512, paragraph F.2] AHCCCS is not required to obtain written approval of a member before requesting the member’s designated record set from a health care provider or any agency. For purposes relating to the treatment, payment, or health care operations, AHCCCS may request sufficient copies of records necessary for administrative purposes, free of charge [AHCCCS Medical Policy Manual, Chapter 600, Section 630, Item 3].

Quality Improvement Projects (QIPs)

Quality improvement projects (also known as Performance Improvement Projects – (PIPs) may be designed for the entire plan population or a targeted population or subgroup. QIPs are studies designed to include measurement of performance, UnitedHealthcare interventions, improving performance and systematic and periodic follow-up on the effect of the interventions. Quality indicators are objective, clearly defined based on current clinical knowledge or health services research and capable of measuring outcomes such as changes in health status, functional status and enrollee satisfaction, or valid proxies of those outcomes. Interventions are evaluated and refined to achieve demonstrable improvement. Results of evaluations and recommendations are reviewed and approved by the QMC. Current QIPs or PIPs are defined in detail as part of UnitedHealthcare’s annual QM Work Plan.
Provider Satisfaction

Provider satisfaction surveys are designed to:
- Assess which services are important to health plan providers and providers.
- Determine provider satisfaction with UnitedHealthcare processes.

Provider satisfaction surveys are conducted annually. The survey results are summarized and reviewed by the Services Quality Improvement Committee, the Provider Advisory Committee and the Quality Management Committee to identify areas for improvement and develop action plans.

Practitioner Communications

UnitedHealthcare shares pertinent study, survey, or review results with practitioners through multiple communications channels, such as practitioner and provider fax blasts, newsletters, practitioner and provider training sessions and forums, and the UnitedHealthcare website, [UHCCommunityPlan.com & UnitedHealthcareOnline.com](http://UHCCommunityPlan.com & UnitedHealthcareOnline.com). UHCCP recommends that practitioners and providers check the website often as it is regularly updated with helpful information.
Chapter 13 Billing and Encounter Submission

Claims submitted to UnitedHealthcare Community Plan shall be compliant with claims processing rules as defined by AHCCCS. Claims submitted shall include:

- The submission of a clean claim.
- Current Federal Tax Identification Number (TIN).
- Servicing location.
- A National Provider Identification Number (NPI).
- The prior authorization number shall be documented on the CMS 02/12 1500 Claim Form.
- Valid service-specific diagnostic and procedure codes.
- Modified, CPT, Diagnosis and HCPCS codes shall be current and accurate where appropriate.
- Appropriate number of units.
- Operative report for surgical procedures.
- Physicians orders and progress notes for durable medical equipment (DME).
- All Explanation of Benefits (EOBs) that relate to the claim. The provider must bill and obtain a copy of the EOB or Remittance Advice (RA) when a member has coverage from any other private insurance. IF claim is denied or paid in full from primary carrier, the claim should still be submitted to UHCCP.

Claims submitted without the above information or with inaccurate codes will be returned to the provider for proper resubmission and/or denied.

FQHC/RHC Payment and Billing Information

Effective 04/01/2015, UnitedHealthcare Community Plan will begin paying the lessor of the all-inclusive per visit PPS rate or billed charges on a per claim basis, replacing the current method of reimbursing claims by the capped fee-for-service fee schedule. This will affect all Acute, DD and Dual Complete/Dual Complete One members. AHCCCS has established a provider type for FQHCs and FQHC Look-Alikes (C2) and a provider type for RHCs (29). AHCCCS has required that all FQHCs, FQHC-LAs, and RHCs re-register under the applicable provider types, and obtain a unique NPI, not already associated with another active AHCCCS provider ID, for each clinic covered by the CMS FQHC, FQHC-LA, or RHC designation. The new NPIs will be used for claim submissions beginning with dates of service on and after 04/01/2015. Please make sure that the correct AHCCCS registered Site Name and NPI for FQHC/RHC services are billed on your FQHC/RHC claim. Incorrect NPI submissions for FQHC services may result in claim denials.

FQHC/RHC Locations

The FQHC/RHC location is the address attached to your AHCCCS NPI and provider type C2 or 29. The PPS rate shall apply to services submitted at that address and NPI. Any services not provided at that location shall be billed according to AHCCCS FFS Provider Manual.

FQHC/RHC Billing and Procedure Codes

Beginning 04/01/2015, all FQHC, FQHC-LA (look-alikes), and RHC visits must be billed using the Form 1500 or the ADA form. For purposes of reimbursing visits beginning 04/01/2015, AHCCCS has adopted HCPCS code T1015 for reporting physical health, behavioral health, and dental visits. This procedure code should be reported on Form 1500 claims and ADA form claims. A claim for an FQHC, FQHC-LA or RHC visit must include all appropriate procedure codes describing the services rendered in addition to visit code T1015.

A visit will be identified by, and reimbursement for the visit will be associated with, HCPCS code T1015; all other services reported on the claim will be bundled into the visit and valued at $0.00, and reason code CO 45 for Acute, CRS and DD.
A visit will be identified by, and reimbursement for the visit will be associated with, HCPCS code T1015; all other services reported on the claim will be bundled into the visit and valued at $0.00, and reason code CO 45 for Acute, CRS and DD. Further billing instructions are available in the AHCCCS Fee-For-Service Provider Manual.

Billing services for Medicare Dual Complete

UHCCP Participating providers in our Medicare Dual Complete product should submit all FQHC/RHC medical claims on a CMS 1500, billing appropriate Medicare codes as well as the AHCCCS T1015 code. Our claim system will automatically process first the Medicare claim, then create a claim copy and adjudicate the Medicaid claim eliminating the need to submit a secondary claim.

Billing services for Long Term Care

Claims submitted to UnitedHealthcare Community Plan LTC (Long Term Care) will have all other services denied with a denial code of 0059 – Svc Included in Primary Procedure.

FQHC/RHC Billing – Practitioner

The FQHC/RHC AHCCCS (provider type C2 or 29) NPI will be billed in box 24J of claim form CMS-1500 (or it’s electronic equivalent). The actual practitioner (provider) participating in the service should be reported on all claims as outlined below.

CMS Form 1500 (Paper claims)

ITEM NUMBER 19 - TITLE: Additional Claim Information (Designated by NUCC)

- Do not enter a space, hyphen, or other separator between the qualifier code and the number.
- When reporting a second item of data, enter three blank spaces and then the next qualifier and number/code/information.

Example:

- XX (Qualifier)/NPI (10 characters)/Provider Name (last, first 20 characters) = 1 participating provider
- XX (Qualifier)/NPI (10 characters)/Provider Name (last, first 20 characters) 3 blanks Qualifier/NPI (10 characters)/Provider Name (last, first 20 characters) = 2 participating provider
837 Professional (EDI)

Examples:
- One Servicing Provider
  - 2300 NTE*XX NPI (10 characters) Provider Name (last, first 20 characters)

- Two Servicing Provider
  - 2300 NTE*XX NPI (10 characters) Provider Name (last, first 20 characters) 3 blanks Qualifier NPI (10 characters)
  - Provider Name (last, first 20 characters)

<table>
<thead>
<tr>
<th>Loop</th>
<th>Element</th>
<th>Description</th>
<th>ID</th>
<th>Min. Max.</th>
<th>Use</th>
<th>Note</th>
<th>Expected Value</th>
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<td>NTE02</td>
<td>Claim Note Text</td>
<td>AN</td>
<td>1-80</td>
<td>R</td>
<td>Expect Claim Note Text</td>
<td>Ex: 1 Provider XX 1234567890 Smith, John Ex: 2 Providers XX 1234567890 Smith John XX 0987654321 Smith Jane</td>
</tr>
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Note: To report Participating Providers beyond 2 occurrences, the loop should be repeated as needed as defined in the standards for the transaction.

Example 1:
Electronic claim only where FQHC/RHC rendering provider is also the billing provider

<table>
<thead>
<tr>
<th>Loop</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010AA / NM109</td>
<td>Billing Provider NPI</td>
<td>FQHC/RHC Provider ID</td>
</tr>
<tr>
<td>2310B / NM109</td>
<td>Rendering Provider NPI</td>
<td>Not Submitted – can only be submitted when different than billing provider</td>
</tr>
</tbody>
</table>

Example 2:
Electronic claim only where FQHC rendering provider is NOT the billing provider (i.e. FQHC is associated to an AHCCCS Group Billing Provider)

<table>
<thead>
<tr>
<th>Loop</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010AA / NM109</td>
<td>Billing Provider NPI</td>
<td>Associated Billing Provider (Group Biller associated to FQHC/RHC)</td>
</tr>
<tr>
<td>2310B / NM109</td>
<td>Rendering Provider NPI</td>
<td>FQHC Rendering Provider</td>
</tr>
</tbody>
</table>
Chapter 13 Billing and Encounter Submission

ADA Form (Paper Claims):
Field 35. Remarks.
Examples:
- XX (Qualifier) NPI (10 characters) Provider Name (last, first 20 characters) = 1 participating provider
- XX (Qualifier) NPI (10 characters) Provider Name (last, first 20 characters) 3 blanks Qualifier NPI (10 characters) Provider Name (last, first 20 characters) = 2 participating providers

837 Dental (EDI)
Examples:
- One Servicing Provider
  - 2300 NTE*XX NPI (10 characters) Provider Name (last, first 20 characters)
- Two Servicing Provider
  - 2300 NTE*XX NPI (10 characters) Provider Name (last, first 20 characters) 3 blanks Qualifier NPI (10 characters) Provider Name (last, first 20 characters)

Note: To report Participating Providers beyond 2 occurrences, the loop should be repeated as needed as defined in the standards for the transaction

Inpatient Hospital DRG-Based Payment
Effective Oct. 1, 2014, inpatient hospital claims will no longer be paid using a tiered per diem fee schedule but per an All Patient Refined-Diagnosis Related Group (APR-DRG) – based payment system. This will affect all claims with a discharge date on or after October 1st, 2014 and will apply to all acute/general hospitals under provider type 02. The same payment methodology will be used for both in and out-of-state hospitals. Rehabilitation and long term care hospitals will be split to a new provider type and will continue to be paid under a per diem rate. Claims for inpatient services that are covered by a RBHA or TRBHA, where the primary diagnosis upon admission is a behavioral health diagnosis, shall be reimbursed as indicated by ADHS. The APR-DRG will not apply to certain hospital types:
- Claims from a free-standing rehabilitation facility
- Claims from a free-standing long term care facility
- Claims paid both a per diem rate with outlier provision
- Claims from a free-standing psychiatric facility
- These are paid a per diem rate established by ADHS
- Claims from an Indian Health Service Facility or tribally operated 638 facility
- These are paid at the OMB rate
- Claims for transplant services under AHCCCS contract

For additional information, please visit the AHCCCS website at [azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/DRGbasedpayments.htm](http://azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/DRGbasedpayments.htm)

AHCCCS Provider Identification Number
All health care professionals who participate in the AHCCCS program must register and receive an AHCCCS generated provider registration number. The registration number is a six-digit number issued by the AHCCCS Administration and is obtained through a formal registration process. Providers are responsible for obtaining their AHCCCS Provider Registration ID numbers. In addition, you must also register your NPI with AHCCCS. If a provider is notified by AHCCCS that the provider registration number has been changed, the provider should notify UHCCP as soon as possible. The provider should contact AHCCCS Provider Registration at 602-417-7670 for help in acquiring an AHCCCS ID number.

Provider registration packets and related forms are available online at [azahcccs.gov/PlansProviders/NewProviders/registration.html](http://azahcccs.gov/PlansProviders/NewProviders/registration.html)

A current Federal Tax Identification Number and NPI are required on all claims.

The provider must also register their NPI with UnitedHealthcare.

You can register by going to www.UnitedHealthcareOnline.com and completing the form found under the UnitedHealthcare link available at [UnitedHealthcareOnline.com >Tools > Resources > Welcome Kit for New Physicians and Providers](http://UnitedHealthcareOnline.com/). The Forms can be returned to UnitedHealthcare by faxing to 855-773-3156. Information about AHCCCS requirements for the registration and use of NPI’s can be found at: [azahcccs.gov/PlansProviders/NewProviders/registration.html](http://azahcccs.gov/PlansProviders/NewProviders/registration.html)
Acceptable Claim Forms

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

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

- A UB-04 form is used to submit claims for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other providers as required by AHCCCS.

UnitedHealthcare Community Plan will not process claims received on any other type of claim form. All AHCCCS billing guidelines and requirements must be followed.

Group ID Numbers

UnitedHealthcare Community Plan added a Group ID number to the Member ID cards; AHCCCS/Medicaid, CRS, and DD. If submitting the member’s group ID number, please submit in box 11 of 1500 claims form or box 62 of UB04 claim form. See Chapter 3 for a list of applicable group numbers. Claims for Long Term Care members will still require a Group ID number to be submitted on all claims.

AHCCCS Approved Codes, Units and Values

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

- Place of service codes.
- Revenue codes.
- Diagnosis codes.
- CPT codes.
- Modifiers
- ICD-10 procedure and condition codes (ICD-9 prior to 10/01/15).UnitedHealthcare Community Plan will apply AHCCCS billing and payment requirements to all claims submitted. This applies to the application of max-unit guidelines, age/gender guidelines, place of service/procedure combinations, procedure/modifier combinations, duplicate claim billing, duplicate line-item, and revenue/procedure/modifier combination guidelines.

Billing Multiple Units

Reminder when billing multiple units

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

Ambulance Claims

Ambulance claims must include both the ambulance point of origin and destination address, city, state, and zip in box 32 of the HCFA form. The accident state must be listed in box 10 and ambulance claims must not bill diagnosis code 799.99. Please see Chapter 13 for additional billing guidelines for CMS-1500 and UB claim forms

National Drug Code (NDC)

All providers must submit the National Drug Code (NDC) on all claims with procedure codes for physician-administered drugs in outpatient clinical settings. Claims must include NDC and unit of measurement for the drug billed, HCPCS/CPT code and units of service for the drug billed and actual metric decimal quantity administered.

Clean Claims and Timely Claim Submission Requirements

A “clean claim” is defined in the Arizona Revised Statutes as one that can be processed without obtaining additional information from the provider of service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim selected for medical review by UHCCCP. UnitedHealthcare Community Plan requires that the initial claim submission occurs within deadlines set forth in the provider’s contract. Providers should consult their contract to determine their initial filing requirement. Providers have one year from the date of service to correct and resubmit claims, if the initial submission time period has been met. Failure to adhere to these requirements will result in the denial of claims. Mail initial claims, medical record attachments and encounters to:
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Timely Filing Guidelines

UnitedHealthcare Community Plan requires that the initial claim submission occurs within deadlines set forth in the provider’s contract. Providers should consult their contract to determine their initial filing requirement. UnitedHealthcare Community Plan shall not pay a claim initially submitted more than six months after the end date of service, inpatient claims date of discharge or date of eligibility posting, whichever is later, or pay a clean claim submitted more than 12 months after date of service; unless a shorter time period is specified in the contract or as directed by AHCCCS. Claim payment requirements pertain to both contracted and non-contracted providers. The receipt date of the claim is the date stamp on the claim, the date electronically received or he date the claim is received at the UHCCP’s specified claim mailing address. Date of payment is the paid date on the check or other form of payment. Claims submission deadlines shall be calculated from the claim end date of service, inpatient claim date of discharge or the effective date of eligibility posing, whichever is later.

Reconsideration Process

UnitedHealthcare Community Plan is committed to improving the experience on all reconsiderations. Within this informal request, a full medical necessity review will be performed without the need to file a formal claim dispute. This offers a faster turn around time and ease of submission with the ability to request online or by calling Provider Services.

Providers should use the Reconsideration Process prior to submitting a claim Dispute so that the claim can be reviewed for payment. Some denials that would be appropriate for a Reconsideration are listed below.

- No Authorization on file/Lack of medical necessity
- Exceeds Timely Filing
- Denied for Additional Documentation
- Denied for Coordination of Benefits Information
- Resubmission of Corrected Claim
- Previously processed but rate applied incorrectly resulting in over/underpayment
- Resubmission of a bundled claim

Please make sure to include all appropriate and pertinent documentation to support the services provided when submitting the Reconsideration request. Reconsiderations can be submitted either online at UHCOntline.com/LINK, calling Provider Services at 800-445-1638, or by mailing with a Reconsideration Form to the claims and medical record mailing address for the members program. All claim Reconsiderations must be submitted with UHCCP no later than 12 months from the date of service, 12 months from the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claims submission, whichever is later.

Note: This Reconsideration Process is not to be used for DRG Outlier Payment Reconsideration. Please submit reconsiderations for DRG Outlier Payments to Med Review as documented on the Med Review letter received.

Provider Claim Disputes Process

All claim resubmissions and/or Claim Disputes challenging claim payments, denials or recoupments must be file with UHCCP no later than 12 months from the date of service, 12 months from the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claims submission, whichever is later.

Electronic Claims and Encounter Submission

UnitedHealthcare offers many of our providers the option of submitting claims and encounters to UnitedHealthcare by electronic data interchange (EDI). EDI offers providers several advantages, including less paperwork, reduced postage, less time spent handling claims and faster turnaround. UnitedHealthcare Community Plan can accept claims electronically when UHCCP is secondary and there is no need to send a paper claim as backup. If you are interested in billing electronically, visit the UnitedHealthcare Provider Portal at UHCCommunityPlan.com for EDI information and submit claims electronically on UnitedHealthcareOnline.com.

Providers may also contact the Provider Service Center at 800-445-1638.
Electronic Data Interchange (EDI)

For information on a variety of EDI transaction, please see our webpage at: UHCCommunityPlan.com under the Electronic Data Interchange (EDI) section.

EDI Support Services
EDI Support Services provides support for all electronic transactions involving claims and electronic remittances. Please call us for assistance with any of these transactions at 800-210-8315 or e-mail at: ac_edi_ops@uhc.com. If you are experiencing technical problems, need assistance in using UnitedHealthcare Community Plan online, have login or User ID/Password issues, please call UnitedHealthcare Community Plan EDI Support at: 800-210-8315 or email at: ac_edi_ops@uhc.com.

EDIT Training – for more information on EDI training, please see our website at UHCCommunityPlan.com in the Electronic Data Interchange (EDI) section.

Important EDI Payer Information
• Claim Payer ID: 03432
• ERA Payer ID: 03432

Companion Guides
Companion Guides are available at UHCCommunityPlan.com in the Electronic Data Interchange (EDI) section.

Informational Material on EDI, EFT and ERA
For more information on EDI, EFT and ERA’s, please see our website at UHCCommunityPlan.com in the Electronic Data Interchange (EDI) section.

• 270/271 Real-Time Electronic Eligibility Inquiry and Response Transactions.
• 276/277 Real-Time Electronic Claim Status and Response Transactions.
• EDI, EFT, and ERA Fact Sheet.
• Money in the Bank with EFT.
• EDI, EFT, and ERA FAQ.
• UnitedHealthcare Community Plan EFT Enrollment Form (PDF 73.84 KB).

General Billing Guidelines
Claims will be considered for reimbursement only if billing requirements are met and are a covered benefit for the enrolled member. If prior authorization was required, the prior authorization number must be entered in the appropriate field on the claim form. Submitting a referral with the claim does not guarantee reimbursement. Reimbursement for services depends on the member’s enrollment on the date(s) of service, medical necessity, limitations and exclusions as stated in rules governing the plan, and UnitedHealthcare policies and procedures. Exclusions include inpatient hospital services for occupational illnesses and injuries, and excessive, inappropriate or non-covered charges. We may make corrective adjustments to any previous payments for services and may audit claims submissions and payments to ensure compliance with applicable policies, standards, procedures, including without limitation, the manual, the Credentialing Plan, the agreement, and state and federal law. We may obtain reimbursement for overpayments directly or by offsetting against future payments due as allowed by law.

CMS 02/12 1500 Claim Form
The CMS 1500 claim form is used to bill for most non-facility services, including professional services, transportation, and durable medical equipment. Ambulatory surgery centers and independent laboratories also must bill for services using the CMS 1500. Claims submitted on/after April 1, 2014 will need to be submitted on the new 02/12 1500 Claim Form regardless of service date.

• CPT and HCPCS procedure codes must be used to identify all services.
• ICD-10 diagnosis codes are required (ICD-9 prior to 10/01/15).

NOTE: This chapter applies to paper CMS 1500 claims submitted to UnitedHealthcare Community Plan. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on UHCCommunityPlan.com in the Electronic Data Interchange (EDI) section. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.
Completing the Claim Form

The following instructions explain how to complete the paper CMS 1500 claim form and whether a field is “Required,” “Required if applicable,” or “Not required.”

1. Program Block — Required
   Check the second box labeled “Medicaid.”

1a. Insured’s ID Number Required — Required
   Enter the recipient’s UHCCP ID number. If there are questions about eligibility or the member’s number, contact the AHCCCS Verification Unit or verify the member’s eligibility on UnitedHealthcareOnline.com. Behavioral health providers must be sure to enter the client’s CRS ID number, not the client’s BHS number.

2. Patient’s Name — Required
   Enter recipient’s last name, first name, and middle initial as shown on the insurance ID card.

3. Patient’s Date of Birth and Sex — Required
   Enter the recipient’s date of birth. Check the appropriate box to indicate the patient’s gender.

4. Insured’s Name — Not Required

5. Patient’s Address — Required
   (can be used for member verification)

6. Patient’s Relationship to Insured — Not Required

7. Insured’s Address — Required (if applicable)

8. Other Insured’s Name — Required (if applicable)
   If the recipient has no coverage other than AHCCCS, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the recipient, enter “Same.”

9a. Other Insured’s Policy or Group Number — Required (if applicable)
   Enter the group number of the other insurance.

9b. Reserved for NUCC Use — Not Required

9c. Reserved for NUCC Use — Not Required

9d. Insurance Plan Name or Program Name — Required (if applicable)
   Enter name of insurance company or program name that provides the insurance coverage.

10. Is Patient’s Condition Related to: — Required (if applicable)
    Check “YES” or “NO” to indicate whether the patient’s condition is related to employment, an auto accident, or other accident. If the patient’s condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.

10d. Claim Codes (Designated by NUCC) — Not Required

11. Insured’s Group Policy or FECA Number — Not Required (not required on claims submitted with dates of service after April 1st, excluding ALTCS members) for claims with dates of service prior to 04/01/16

11a. Insured’s Date of Birth and Sex — Required (if applicable)

11b. Other Claim ID (Designated by NUCC) — Not Required

11c. Insurance Plan Name or Program Name Required (if applicable)

11d. Is There Another Health Benefit Plan Required (if applicable)
    Check the appropriate box to indicate coverage other than AHCCCS. If “Yes” is checked, you must complete Fields 9a-d.
12. Patient or Authorized Person’s Signature — Not required

13. Insured’s or Authorized Person’s Signature — Not required

14. Date of Illness or Injury — Required (if applicable)

15. Other Date — Not Required

16. Dates Patient Unable to Work in Current Occupation — Not required

17. Name of Ordering/Referring Provider or Other Source — Required (if applicable)
The Order/Referring provider is required on all HCFA 1500 claim forms billing laboratory services.

17a. AHCCCS ID or NPI Number of Ordering/Referring Provider — Required (if applicable)
The ordering provider is required for:
Laboratory
Radiology
Medical and Surgical Supplies
Respiratory DME
Enteral and Parenteral Therapy
Durable Medical Equipment
Drugs (J-codes)
Temporary K codes
Orthotics
Prosthetics
Temporary Q codes
Vision codes (V codes)
97001 – 97546

Ordering providers can be an M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Podiatrist, Psychologist, or Certified Nurse Midwife.

17b. NPI # of Referring Provider

18. Hospitalization Dates Related to Current Services — Not required

19. Reserved for Local Use — Not required except for FQHC/RHC billing. See section for FQHC/RHC

20. Outside Lab and ($) Charges — Not required

21. Diagnosis Codes — Required
Enter at least one ICD-10 (ICD-9 prior to 10/01/15) diagnosis code describing the recipient’s condition.
Behavioral health providers must not use DSM-4 diagnosis codes. Up to twelve diagnosis codes in priority order (primary condition, secondary

22. Claim Resubmission Code — Required (if applicable)
Enter the appropriate code (“A” or “V”) to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled “Original Reference No.”

23. Prior Authorization Number — Not required
UnitedHealthcare Community Plan automatically searches for an authorization on file that matches the member and DOS on the claim.

24A. Date(s) of Service and NDC — Required (effective 7/1/12)
In Field 24A of the CMS-1500 Form in the shaded area, enter the NDC Qualified of N4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC Units of Measure Qualified, followed by the NDC Quantity. All should be left justified in the pink shaded area above the Date of Service.

• The billed units in column G (Days or Units) should reflect the HCPCS units and not the NDC units. Billing should not be based off the units of the NDC. Billing based on the NDC units may result in underpayment to the provider.

The beginning and ending service dates must be entered in the non-shaded area.
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#### 24B. Place of Service — Required
Enter the two-digit code that describes the place of service. (see end of chapter for Place of Service (POS) list)

#### 24C. EMG – Emergency Indicator — Required (if applicable)
Mark this box with a “☑,” an “X,” or a “Y” if the service was an emergency service, regardless of where it was provided.

#### 24D. Procedures, Services, or Supplies — Required
Enter the CPT or HCPCS procedure code that identified the service provided. If the same procedure is provided multiple times on the same date of service, enter the procedure once only. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definition must be consistent with the HCPCS and CPT manuals.

For some claims billed with CPT/HCPCS codes, procedure modifier 42 must be used to accurately identify the service provider and avoid delay or denial of payment.

#### 24E. Diagnosis Pointer — Required
Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the letter of the appropriate diagnosis. Enter only the reference number from Field 21 (A-L), not the diagnosis code itself. If more than one number is entered, they should be in descending order of importance.

#### 24F. $ Charges — Required
Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at $50.00 and three units were provided, enter $150.00 here and three units in Field 24G.

#### 24G. Units — Required
Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS manuals.

#### 24H. EPSDT/Family Planning — Not required

#### 24I. ID Qualifier — Required (if applicable)

#### 24J. (SHADED AREA) — Required (if applicable)
– Use for COB INFORMATION
- Use this SHADED field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a recipient’s Deductible has been met, enter zero (0) for the Deductible amount. For recipients and service covered by a third party payer, enter only the amount paid.
- Always attach a copy of the Medicare or other insurer’s EOB to the claim. If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should “zero fill” Field 24J (Shaded area). Leaving this field blank will cause the claim to be denied.

#### 24J. (NON SHADED AREA)
– RENDERING PROVIDER ID # — Required
Rendering Provider’s AHCCCS Registered NPI is required for all providers that are mandated to maintain an NPI #. For atypical provider types, the AHCCCS ID must be used.

#### 25. Federal Tax ID Number — Required
Enter the tax ID number and check the box labeled “EIN.” If the provider does not have a tax ID, enter the provider’s Social Security Number and check the box labeled “SSN.”

#### 26. Patient Account Number — Required (if applicable)
This is a number that the provider has assigned to uniquely identify this claim in the provider’s records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and the provider’s own accounting or tracking system.

#### 27. Accept Assignment — Not required

#### 28. Total Charge — Required
Enter the total for all charges for all lines on the claim.

#### 29. Amount Paid — Required (if applicable)
Enter the total amount that the provider has been paid for this claim by all sources other than UHCCP. Do not enter any amounts expected to be paid by UHCCP.

#### 30. Reserved for NUCC Use — Not Required
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31. **Signature and Date — Required**
The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.

32. **Service Facility Location Information — Required**
Ambulance claims must include point of origin, and destination; Address, city, state and zip.

32a. **Service Facility NPI # — Required (if applicable)**

32b. **Service Facility AHCCCS ID #**
*(Shaded Area) — Required (if applicable)*

33. **Billing Provider Name, Address and Phone # — Required**
Enter the provider name, address, and phone number. If a group is billing, enter the group biller’s name, address, and phone number.

33a. **Billing Provider NPI # — Required (if applicable)**

33b. **Other ID – AHCCCS ID #**
*(Shaded Area) — Required (if applicable)*

**Note – NPI is required for all providers that are mandated to maintain an NPI number. For atypical provider types, box 33b must be completed.**
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**UB-04**

The UB-04 claim form is used to bill for all hospital inpatient, outpatient, and emergency room services. Dialysis clinic, nursing home, free-standing birthing center, residential treatment center, and hospice services also are billed on the UB-04.

- Revenue codes are used to bill line-item services provided in a facility.
- Revenue codes must be valid for the service provided.
- Revenue codes also must be valid for the bill type on the claim.
  - For example, hospice revenue codes 651, 652, 655, 656 can only be billed on a UB-04 with a bill type 81X-82X (Special Facility Hospice).
  - If those revenue codes are billed with a regular inpatient bill type (11X – 12X), the claim will be denied.
- ICD-10 (ICD-9 prior to 10/01/15) diagnosis codes are required.
  - AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.
- ICD-10 procedure codes must be used to identify surgical procedures billed on the UB-04 (use ICD-9 prior to 10/01/15).
- CPT/HCPCS and modifier must be used to identify other services rendered.

*NOTE:* This section applies to paper claims submitted to UHCCP. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on our website at UHCCommunityPlan.com. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

**Completing the UB-04 Claim Form**

The following instructions explain how to complete the UB-04 claim form and whether a field is “Required,” “Required if applicable,” or “Not required.” The instructions should be used to supplement the information in the AHA Uniform Billing Manual for the UB-04.

1. **Provider Data — Required**
   - Enter the name, address, and phone number of the provider rendering service. P.O. Boxes or lockboxes are not allowed.

2. **Unassigned — Not required**

3. **Patient Control No. — Required (if applicable)**
   - This is a number that the facility assigns to uniquely identify a claim in the facility’s records. UHCCP will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the Claim Reference Number and the facility’s accounting or tracking system.

4. **Bill Type — Required**
   - Facility type (first digit), bill classification (second digit), and frequency (third digit). See UB Editor Manual for codes.

5. **Fed Tax No. — Required**
   - Enter the facility’s federal tax identification number.

6. **Statement Covers Period — Required**
   - Enter the beginning and ending dates of the billing period.

   OR

   - [Image]

7. **Patient Name/Identifier — Required**
   - Enter the recipient’s last name, first name, and middle initial as they appear on the AHCCCS ID card.

8. **Patient Address — Required**

9. **Patient Birth Date — Required**

10. **Patient Sex — Required**

11. **Admission/Start of care date — Required**

12. **Admission hour — Required (if applicable)**

13. **Priority (type) of Admission/New changes**
   - Required for inpatient claims. Enter the code that best describes the recipient’s status. An Admit Type must be completed if bill type is 011X, 012X, 018X, 022X, or 041X.
   - For bill type 011X, valid admission type codes are 1-5 and 9.
     1. Emergency: Patient requires immediate medical intervention for severe, life threatening or potentially disabling conditions. Documentation must be attached to claim.
     2. Urgent: Patient requires immediate attention. Claim marked as urgent will not qualify for emergency service consideration.
     3. Elective: Patient’s condition permits time to schedule services.
     4. Newborn: Patient is newborn. Newborn source of admission code must be entered in Field 15.
5. Trauma Center: Visit to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation.

15. Point of Origin for Admission or Visit — Required

16. Discharge Hour — Required (if applicable)
Enter the code which best indicates the recipient’s time of discharge. Required for inpatient claims when the recipient has been discharged. See UB Editor for code structure.

17. Patient discharge status — Required

Required for all claims. Enter the code that best describes the recipient’s status for this billing period

01 Discharged to home or self-care (routine discharge)
02 Discharged/Transferred to a short-term general hospital for inpatient care
03 Discharge/Transferred to SNF with Medicare Certification in anticipation of skilled care
04 Discharge/Transferred to a facility that provides custodial or supportive care
05 Discharge/Transferred to a designated cancer center or children’s hospital
06 Discharge/Transferred to home under care of an organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
09 Admitted as an inpatient to this hospital
20 Expired
21 Discharged/Transferred to Court/Law Enforcement
30 Still a patient
40 Expired at home
41 Expired in a medical facility (e.g., hospital, SNF, or ICF or free-standing hospice
42 Expired, place unknown (hospice only)
43 Discharged/Transferred to a federal health care facility
50 Discharged to Hospice –home
51 Discharged to Hospice –medical facility (certified providing hospice level of care
61 Discharge/Transferred within this institution to a hospital-based Medicare-approved swing bed
62 Discharge/Transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
63 Discharge/Transferred to a Medicare-certified long term care hospital (LTCH)
64 Discharge/Transferred to a nursing facility certified under Medicaid but not certified under Medicare
65 Discharged/Transferred to a psychiatric hospital or psychiatric distinct part/unit of hospital
66 Discharges/Transfers to a Critical Access Hospital
70 Discharged/Transferred to another type of healthcare institution not defined elsewhere in this code list

18-28. Condition Codes — Required (if applicable)
Enter the appropriate condition codes that apply to this bill. See UB Editor for codes.

In-state, non-IHS inpatient hospitals may request outlier consideration for a claim by entering “61” in any Condition Code field

To bill for self-dialysis training, free-standing dialysis facilities approved to provide self-dialysis training must enter “73” in any Condition Code field and bill revenue code 841 (Continuous Ambulatory Peritoneal Dialysis, per day) or revenue code 851 (Continuous Cycling Peritoneal Dialysis, per day).

To bill for multiple distinct/independent outpatient visits on the same day facilities must enter “GO”.

29. Accident State — Required (if applicable)

31-34. Occurrence Codes and Dates — Required (if applicable)

35-36. Occurrence Span codes and dates — Required (if applicable)

38. Responsible Party Name and Address — Required (if applicable)

39-41 Value Codes and Amounts — Required (if applicable)

42. Revenue Code — Required
Enter the appropriate revenue code(s) that describe the service(s) provided. See UB Editor for revenue codes and abbreviations. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes. Accommodation days should not be billed on outpatient bill types.

43. Revenue Code Description/NDC code — Required (if applicable) (effective 7/1/12) Enter the description of the revenue code billed in Field 42. See UB Editor for description of revenue codes. To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):
43. The NDC Qualified of N4 in the first 2 positions on the left side of the field
44. The NDC 11-digit numeric code, without hyphens.
44. **HCPCS/Rates — Required** (if applicable)
   Enter the inpatient (hospital or nursing facility) accommodation rate. Dialysis facilities must enter the appropriate CPT/HCPCS code for lab, radiology, and pharmacy revenue codes. Hospitals must enter the appropriate CPT/HCPCS codes and modifiers when billing for outpatient services.
   - Form locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC

45. **Service Date — Required**
The dates indicated outpatient service was provided on a series bill. The date of service should only be reported if the From and Through dates in Form Locator 6 are not each other on the form. Enter the date in MM/DD/YY or MM/DD/YYYY format.

46. **Service Units — Required**
Number of units for ALL services must be indicated. If accommodation days are billed, the number of units billed must be consistent with the patient status field (Field 22) and statement covers period (Field 6). If the recipient has been discharged, AHCCCS covers the admission date to, but not including, the discharge date. Accommodation days reported must reflect this. If the recipient expired or has not been discharged, AHCCCS covers the admission date through last date billed.
   - Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered

47. **Total Charges — Required**
Total charges are obtained by multiplying the units of service by the unit charge for each service. Each line other than the sum of all charges may include charges up to $999,999.99. Total charges are represented by revenue code 001 and must be the last entry in Field 47. Total charges on one claim cannot exceed $999,999,999.99.

48. **Non-covered Charges — Required** (if applicable)
Enter any charges that are not payable by AHCCCS. The last entry is total non-covered charges, represented by revenue code 001. Do not subtract this amount from total charges.

50. **(A–C) Payer — Required**
Enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the recipient and from which the provider might expect some reimbursement. If there are other payers, UHCCP should be the last entry. If there are no payers, UHCCP will be the only entry.

51. **(A–C) Healthplan Identification No. — Required**
Enter the facility’s ID number as assigned by the payer(s) in Fields 50 A, B, and/or C. The facility’s six-digit AHCCCS service provider ID number should be listed last. Behavioral health providers must not enter their BHS provider ID number.

52. **(A–C) Release of Information — Not required**

53. **(A–C) Assignment of Benefit — Not required**

54. **(A–C) Prior Payments — Required** (if applicable)
Enter the amount received from Medicare Part B (Inpatient Only) or any other insurance or payer other than UHCCP, including the patient, listed in Field 50. If the recipient has other insurance but no payment was received, enter “0.” The “0” indicates that a reasonable attempt was made to determine available coverage and obtain payment. Enter only actual payments received. Do not enter any amounts expected from UHCCP.

55. **(A–C) Amount due — Not required**

56. **National Provider Identifier (NPI) Billing Provider — Required**

57. **Other (Billing) Provider Identifier — Required if applicable**

58. **(A–C) Insured’s Name — Not Required**
Enter the name of insured covered by the payer(s) in Field 50.

59. **(A–C) Patient’s Relationship To Insured — Not required**

60. **(A–C) Patient CERT. - SSN — HIC — ID NO. — Not required**
Enter the recipient’s CRS ID number. If there are questions about eligibility or the CRS ID number, contact the AHCCCS Verification Unit. Behavioral health providers must be sure to enter the client’s CRS ID number, not the client’s BHS number.

61. **(A–C) Group Name — Not required**

62. **(A–C) Insurance Group Number — Not required**

63. **(A–C) Treatment Authorization — Not required**
Enter the authorization number for services provided
64. Document Control Number — Not required

65. (A–C) Employer Name — Not required

66. Diagnosis and Procedure Code
   Qualified — Required

67. Principal Diagnosis Code — Required
   Enter the principal ICD-10 (ICD-9 prior to 10/01/15) diagnosis code. Behavioral health providers must not use DSM-4 diagnosis codes.

69. Admitting Diagnosis — Required
   Required for inpatient bills. Enter the ICD-10 diagnosis code that represents the significant reason for admission (ICD-9 prior to 10/01/15).

70. Patient’s Reason for Visit Not — Required

72. E-Codes — Required (if applicable)
   Enter trauma diagnosis code, if applicable.

74. Principal Procedure Code and Dates — Required (if applicable)
   Enter the principal ICD-10 procedure code (ICD-10 prior to 10/01/15) and the date the procedure was performed during the inpatient stay or outpatient visit. Enter the date in MM/DD/YY or MM/DD/YYYY format. If more than one procedure is performed, the principal procedure should be the one that is related to the primary diagnosis, performed for definitive treatment of that condition, and which requires the highest skill level.

76. Attending Provider name and identifier — Required (if applicable)

77. Operating Physician Name and Identifier — Required (if applicable)

78-79. Other Physician Not — Required

80. Remarks — Required (if applicable)
   Required on resubmissions, adjustments, and void. Enter the CRN of the claim being resubmitted, adjusted, or voided. For resubmissions of denied claims, write “Resubmission” in this field

81. Other Procedure Codes — Required (if applicable)
   Enter other procedure codes in descending order of importance.
Electronic Claims and Encounter Submission

UnitedHealthcare offers many of our providers the option of submitting claims and encounters to UnitedHealthcare by electronic data interchange (EDI). EDI offers providers several advantages, including less paperwork, reduced postage, less time spent handling claims and faster turn-around. UnitedHealthcare Community Plan can accept claims electronically when UnitedHealthcare Community Plan is secondary and there is no need to send a paper claim as backup. If you are interested in billing electronically, visit the UnitedHealthcare Provider Portal at UHCCommunityPlan.com or contact the Provider Service Center at 800-445-1638.

Sample Overpayment Report

*The information provided below is sample data only for illustrative purposes. Please populate and return with the data relevant to your claims that have been overpaid.

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Date of Service</th>
<th>Original Claim #</th>
<th>Date of Payment</th>
<th>Paid Amount</th>
<th>Amount of Overpayment</th>
<th>Reason for Overpayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>11111</td>
<td>01/01/12</td>
<td>51612312</td>
<td>01/31/12</td>
<td>115.03</td>
<td>115.03</td>
<td>Double payment of claim</td>
</tr>
<tr>
<td>22222222</td>
<td>02/02/12</td>
<td>51612313</td>
<td>03/15/12</td>
<td>279.34</td>
<td>27.19</td>
<td>Contract states $50, claim paid 77.29</td>
</tr>
<tr>
<td>3333333</td>
<td>03/03/12</td>
<td>51612314</td>
<td>04/01/12</td>
<td>131.41</td>
<td>99.81</td>
<td>You paid 4 units, we billed only 1</td>
</tr>
<tr>
<td>44444444</td>
<td>04/04/12</td>
<td>51612315</td>
<td>05/02/12</td>
<td>412.26</td>
<td>412.26</td>
<td>Member has other insurance</td>
</tr>
<tr>
<td>55555555</td>
<td>05/05/12</td>
<td>51612316</td>
<td>06/15/12</td>
<td>332.63</td>
<td>332.63</td>
<td>Member Terminated</td>
</tr>
</tbody>
</table>

Place of Service Codes

<table>
<thead>
<tr>
<th>POS-19</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Office</td>
</tr>
<tr>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>20</td>
<td>Urgent Care</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Room - Hospital</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
</tr>
<tr>
<td>25</td>
<td>Birthing Center</td>
</tr>
<tr>
<td>26</td>
<td>Military Treatment Center</td>
</tr>
<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>32</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
</tr>
<tr>
<td>34</td>
<td>Hospice</td>
</tr>
<tr>
<td>41</td>
<td>Ambulance - Land</td>
</tr>
<tr>
<td>42</td>
<td>Ambulance – Air or Water</td>
</tr>
<tr>
<td>50</td>
<td>Federally Qualified Health Center (FQHC)</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient Psychiatric Facility</td>
</tr>
<tr>
<td>52</td>
<td>Psychiatric Facility Partial Hospitalization</td>
</tr>
<tr>
<td>53</td>
<td>Community Mental Health Center</td>
</tr>
<tr>
<td>54</td>
<td>Intermediate Care Facility/Mentally Retarded</td>
</tr>
<tr>
<td>55</td>
<td>Residential Substance Abuse Treatment Facility</td>
</tr>
<tr>
<td>56</td>
<td>Psychiatric Residential Treatment Center</td>
</tr>
<tr>
<td>61</td>
<td>Comprehensive Inpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>62</td>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>65</td>
<td>End Stage Renal Disease Treatment Facility</td>
</tr>
<tr>
<td>71</td>
<td>State or Local Public Health Clinic</td>
</tr>
<tr>
<td>72</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>81</td>
<td>Independent Laboratory</td>
</tr>
<tr>
<td>99</td>
<td>Other Unlisted Facility - Taxi</td>
</tr>
</tbody>
</table>
Chapter 13 Billing and Encounter Submission

Overpayment

A provider must notify UnitedHealthcare Community Plan of an overpayment on a claim. A request to have an adjustment completed can be requested or a refund check can be sent with the following information:

- A statement of authorization for Community Plan to recover the funds in question from a person in your office or company who has the authority to, for example, sign checks or approve financial decisions.
- The name and contact information for the person mentioned above.
- The overpayment amount and the reason for the request.
- If you are sending a check, the amount for the check you are sending must be included with the written request along with the check number.

A list of claims must accompany the letter and needs to include the following information:

- Member ID as applicable for the product (e.g., AHCCCS, CRS, Medicare, etc.).
- Date of service.
- Date of payment.
- Original claim number (if known).
- Amount paid.
- Amount of Overpayment.
- Overpayment reason.

Mail Adjustment Request to:
Community Plan Claims
P.O. Box 5290
Kingston, NY 12402-5290

Mail Refund Check to:
UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402

Refunds requested by UnitedHealthcare Community Plan should be sent with an Overpayment Notification Letter to:
UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 740804
Atlanta, GA 30374

Helpful Hints:
- Make sure the letter is authorized by an individual in your office or company authorized to sign checks and financial documents, such as an office or principal.
- Include the contact information for the person mentioned above.

- Please note that recovery requests greater than $50,000 or older than one year from payment will be submitted to AHCCCS for approval and may take more time to complete.

A sample letter template can be found on our website at UHCCommunityPlan.com under Provider Forms section.

Customer Service Telephone Number:
If you have any questions or problems, please call 800-445-1638.

Billing Guidelines for Obstetrical Services

The reporting procedure below must be followed when submitting OB delivery claims to UnitedHealthcare. OB guidelines effective 04/01/14. These procedures must be followed or the claim will be denied by UnitedHealthcare.

- Utilize CPT Evaluation and Management codes (99201-99215*) or OB visits (59425-59426) to report prenatal visits
  - The beginning date of service is equal to the initial prenatal visit and the ending date of service is equal to the last prenatal visit prior to delivery
  - Use one unit with the appropriate charge should be entered in the charge column

* Only use CPT Evaluation and Management (E/M) codes 99201-99215, when 3 or less prenatal visits are performed, and bill with 1-3 units

- Utilize global delivery code (59400, 59519, 59610 and 59618).
- If the PCO provides prenatal services but does not perform the delivery, you must indicate on the claim “Prenatal Visits Only” or provide documentation that the provider did not perform delivery.

Billing Guidelines for Transplants

UnitedHealthcare Community Plan requires the Transplant Centers to coordinate and prepare the transplant packet containing all invoices for services related to the transplant. No invoices are to be billed outside the transplant packet by subcontractors or non-transplant department within the transplant organization. Claims not included in the packet will be denied if not included in the transplant packet.

Provider Responsibilities

- The provider shall be responsible for all professional services associated with the referenced transplantation services.
- The provider shall ensure and facilitate all required referrals and evaluations to complete the pre-transplant evaluation process in a timely manner once the member is referred to the center as a possible candidate.
• Failure on the part of the contractor to provide medical documentation or obtain prior authorization may result in denial of reimbursement.

• The provider shall provide, in a timely fashion, all information/documentation requested. All documentation will be provided by the contractor at no additional charge.

• The provider shall ensure that subcontracted providers do not bill the health plan directly for service reimbursed under this contract.

• Providers are responsible for submitting claims within six months of the date of service for all services provided to AHCCCS members relating to covered organ and tissue transplant services.

• Contractors will be paid at the contracted rates in effect for each covered component after the invoices for all medically necessary services relating to the component have been submitted to AHCCCS and meet the clean claim criteria pursuant to A.R.S. 36-2904(H).

• All medically necessary services provided to the transplant recipient that are related to the transplant should be billed using the appropriate diagnosis/CPT codes (see FFS Provider Manual, Chapter 24 on the AHCCCS website) and procedure/revenue codes, as appropriate to meet clean claim status:
  • UB-04 (Form B) – all contracted transplant services provided by the facility, including accommodation days, organ acquisition, and related inpatient or outpatient hospital services must be submitted on the UB-04 form using the proper revenue codes and bill types. Services must be itemized as they would be on any non-transplant encounter and must not include physician or other non-facility services.
  • HCFA 1500 (Form A) – all physician and other professional services provided as part of the transplant contract, including transportation and medical supplies must be submitted on the HCFA 1500 form using the proper CPT and HCPCS procedure codes. Services must be itemized as they would be on any non-transplant encounter. The new 02/12 1500 Claim Form will be required effective April 1, 2014.
  • Universal Drug (Form C) – any prescription drugs covered under the transplant contract should be submitted on a Form C.

Hospital and Clinic Method of Billing Professional Services

AHCCCS Billing policy requires hospital and clinics billing for professional services bill on a CMS 1500 with the servicing provider’s AHCCCS number in box 33.

The “pay to” name in box 33 may be the hospital or clinic name but the AHCCCS number must be that of the individual servicing provider. This is necessary to ensure compliance with federal regulations.

Therefore, any provider rendering service to a UnitedHealthcare member must have an individual AHCCCS ID number. This number must be used on the CMS 1500

EXAMPLE: Dr. A is a contracted physician with Good Care Hospital. The hospital does the billing for Dr. A for any services performed at the hospital. Dr. A’s provider number would be entered in box 33, but the address could be Good Care Hospital. Once the claim is received at UnitedHealthcare the payment would be made directly to the hospital. If Dr. A bills for services rendered at his/her private office the address in box 33 would be the private address and reimbursement would be made to the address. Providers should contact the UnitedHealthcare Provider Service Center at 800-445-1638 for answers to additional questions.

Observation vs. Inpatient Reimbursement Guidelines

Observation services are those reasonable and necessary services provided on a hospital’s premises for evaluation to determine whether the member should be admitted for inpatient care, discharged or transferred to another facility. Observation services include: the use of a bed, periodic monitoring by a hospital’s nursing or, if appropriate, other staff necessary to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis.

Amount, Duration and Scope

• Observation must be ordered in writing by a physician, or other individual authorized by hospital staff bylaws, to admit patients to the hospital or to order outpatient diagnostic tests or treatments.

• The medical record must document the basis for observation services.

• Severity of the signs and symptoms of the member

• Degree of medical uncertainty that the member may experience an adverse occurrence

• Need for diagnostic studies that appropriately are outpatient services to assist in assessing whether the member should be admitted
Inappropriate Use
The following examples are considered inappropriate use of observation care:

- Substitution of Observation services for physician ordered inpatient services - Services that are not reasonable, cost effective and necessary for diagnosis or treatment of member
- Services provided solely for the convenience of the member or physician
- Excessive time and/or amount of services medically required by the condition of the member
- Services customarily provided in a hospital-based outpatient surgery center and not supported by medical documentation of the need for Observation.

Reimbursement
If the inpatient admission request from the hospital does not meet inpatient criteria, the case will be reviewed to see if it meets observation criteria.

- If the case meets observation criteria:
  - The inpatient authorization will be denied and a claim note will be entered to pay the claim at observation
  - If the reimbursement for observation is greater than the inpatient rate:
    - The claim will be reimbursed at the inpatient rate.
  - If the case does not meet inpatient or observation criteria:
    - The authorization will be denied. The hospital will be notified by ICM or via the Hospital Notification Form that is sent to the Facility and Denial Coordinator. The hospital will also be notified via the Hospital Communication Log, which is sent to the HCLs and Denial Coordinator.

Hospital may appeal using the process outlined in Chapter 14; Provider Claim Disputes, Appeals and Grievances.

UnitedHealthcare Community Plan Remittance Advice
All online transactions for members enrolled in Acute Medicaid, DD, CRS, and UnitedHealthcare Dual Complete will be accessible on UnitedHealthcareOnline.com as well as LINK.

If you are not already registered on UnitedHealthcareOnline.com, you may do so directly on the website. Physicians and other healthcare professionals should continue to use UHCCommunityPlan.com for online administration for dates of service prior to April 1, 2014 enrollment and claim systems transition. Below is an explanation of fields found on the UnitedHealthcare claim remittance advice that are issued and received prior to April 1, 2014:

1. **Line of Business** – One EOB covers all claims submitted for UnitedHealthcare members, with separate sections for each product – Acute, SOBRA, Developmentally Disabled; Developmentally Disabled—Ventilator Dependent; Title XIX Waiver Group.
2. **Introductory Line** – tagline indicating if claims are newly processed, prior processed claims that have shown up before, adjustments or claims that will show up again on another remit (e.g. when a provider is in a negative balance).
3. **Provider Name** – Name of the provider who performed the service
4. **Provider ID** – UnitedHealthcare Identification number of the provider who performed the service
5. **Member Name** – first and last name of the member
6. **Member ID** – Acute, SOBRA, Developmentally Disabled, Ventilator Dependent, or Title XIX Waiver Group number given to the member by UnitedHealthcare or the respective program
7. **Claim Number** – claim number generated by UnitedHealthcare
8. **Auth Number** – authorization number for the service covered by this claim
9. **Account Number** – Patient account number assigned by the provider (if applicable)
10. **Total Billed Amount** – Total amount billed on the claim by Provider
11. **PCP Name** – Member’s Primary Care Physician Name
12. **PCP ID** – Member’s Primary Care Physician ID
13. **Place of Service** – Code indicating where services on each claim were rendered by Provider.
14. **Total Paid Amount** – Total amount paid for each claim
15. Diagnosis Codes – All diagnosis codes submitted by Provider for the claim
16. Service (From/Thru) – Date(s) of services
17. Units – Units submitted on claim
18. Proc Code – Procedure code of service
19. MOD 1 – Modifier code (if applicable)
20. MOD 2 – Modifier code (if applicable)
21. Amount Billed – Amount billed by provider
22. Adjusted Amount – Amount that is due to UnitedHealthcare as a result of a reversal or adjustment of the original claim
23. Amount Allowed – Amount allowed per UnitedHealthcare provider agreement or non-participating rate
24. Deductible Amount – Portion of payment for which the member is responsible before benefit is payable
25. Other Insurance – Payment made by other insurers
26. Co-Pay Amount – Amount for which the member is responsible
27. Co-Ins Amount – Percentage of allowed amount for which the member is responsible
28. Withhold Amount – Amount withheld, if any, according to the contract
29. PBID – (Payment Before Interest or Discount) Amount due to Provider after deductions for other insurance, copay, co-insurance, adjustments and deductible amounts have been made from the Allowed Amount.
30. Interest/Discount – Calculated penalty applied to qualified claims. If the value in this field is negative, a discount was applied
31. Net Paid – Amount paid to the provider after penalty payment has been applied or discount has been taken
32. C/S (Claim Status) – Indicator if Claim Line is Paid, Denied, Captitated, Adjusted or Informational
33. Reason Codes – Codes that define the payment or denial reasons are explained on the last page of this report
34. Claim Total – Total amount of that claim
35. Member Total – Total amount of claims for that Member for the Provider
36. Provider Total – Total amount of all claims payable to that Provider
37. Line of Business Total – Total amount of each major category for the specific line of business. This information is aggregated on the last page of this report.
38. Vendor Total – Total dollars to be paid to the Vendor
39. Vendor Information – The Vendor’s name, vendor ID number, tax ID number, the remit date and the corresponding check number are listed on each page.

Providers can also view remits on the UnitedHealthcare Provider Portal. This web-based portal offers the convenience of online support 24-hours-a-day, 7-days-a-week. This site was developed specifically with the providers in mind allowing for personal support. To access the online services, go to UnitedHealthcareOnline.com. For further information on claim remits, contact the UnitedHealthcare Provider Service Center.

Resubmitting a Claim

If a provider feels a claim has not been properly processed, UnitedHealthcare has provided several options for providers. If a provider has met the initial submission requirements as stated in the contract, the provider then has up to 12 months from the date of service to resubmit a clean claim. Please see Timely Filing Guidelines within this chapter for additional timely filing guidelines for resubmitting a claim.

UnitedHealthcare Provider Portal

All online transactions for members enrolled in Acute Medicaid, DD, CRS, and UnitedHealthcare Dual Complete and Dual Complete One will be accessible on UnitedHealthcareOnline.com.

If you are not already registered on UnitedHealthcareOnline.com, you may do so directly on the website. At UnitedHealthcareOnline.com, providers can verify member eligibility, check claim status, submit claims, request an adjustment, review a remittance advice, or review or download a member roster.

Provider Service Center

This is the primary point of contact for providers who require assistance. The Provider Service Center is staffed with Provider Service representatives trained specifically for UnitedHealthcare. The Provider Service Center can assist you with questions on Medicaid benefits eligibility, claims resolution; forms required to report specific services, billing questions, etc. and can be reached at 800-445-1638. The Provider Service Center works closely with all departments in UnitedHealthcare.
Resubmission of Paper Claims

Provider must use the following steps to resubmit a claim for reconsideration or submitting a corrected claim paper:

- Submit a copy of the claim.
- Submit a copy of the remittance advice.
- Submit with a cover letter or completed Reconsideration Form with the reason for resubmitting the claim, and any correction(s) that were made. Sign and date the cover letter and provide UnitedHealthcare with a contact telephone number. The Reconsideration Form is available online at UHCCommunityPlan.com under the Provider Forms section.
- Mail the claim with medical record attachments and a cover letter to:

UnitedHealthcare Community Plan
Claims Resubmission
P.O. Box 5290
Kingston, NY 12402-5290

How to Submit Your Corrected Claims Electronically

Please follow these guidelines when electronically submitting a corrected claim to UnitedHealthcare Community Plan in the ANSI-837 professional or institutional format.

### 837P (Professional) Claims

- In Loop 2300 (Claim Information), the CLM segment must have one of these qualifier codes:
  - CLM05-3 – “7” (Replacement); the corrected claim will process as a replacement claim and reverse the original claim on file.
  - CLM05-3 – “8” (Void); the original claim on file will be voided and any previous payments will be recouped.

- The REF*F8 segment must include the original claim number ID, exactly as it appeared in the original claim being corrected—no additional characters.

### 837I (Institutional) Claims

- In Loop 2300 (Claim Information), the CLM segment must have one of these qualifier codes:
  - CLM05-3 – “7” (Replacement); the corrected claim will process as a replacement claim and reverse the original claim on file.
  - CLM05-3 – “8” (Void); the original claim on file will be voided and any previous payments will be recouped.

- The REF*F8 segment must include the original claim number ID, exactly as it appeared in the original claim being corrected—no additional characters.

### Professional (837 P)

<table>
<thead>
<tr>
<th>2300 CLM</th>
<th>Claim Loop Claim Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLM05-3</td>
<td>Claim Frequency Type Code</td>
</tr>
<tr>
<td></td>
<td>1, 7, 8</td>
</tr>
<tr>
<td></td>
<td>1=Original claim submission</td>
</tr>
<tr>
<td></td>
<td>7=Replacement</td>
</tr>
<tr>
<td></td>
<td>8=Void</td>
</tr>
</tbody>
</table>

### Institutional (837 I)

<table>
<thead>
<tr>
<th>2300 CLM</th>
<th>Claim Loop Claim Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLM05-3</td>
<td>Claim Frequency Type Code</td>
</tr>
<tr>
<td></td>
<td>1, 2, 3, 4, 7, 8</td>
</tr>
<tr>
<td></td>
<td>1=Original claim submission</td>
</tr>
<tr>
<td></td>
<td>2=Interim – First Claim</td>
</tr>
<tr>
<td></td>
<td>3=Interim – Continuing Claim</td>
</tr>
<tr>
<td></td>
<td>4=Interim – Last Claim</td>
</tr>
<tr>
<td></td>
<td>7=Replacement</td>
</tr>
<tr>
<td></td>
<td>8=Void</td>
</tr>
</tbody>
</table>

If you have any questions about submitting corrected claims, please contact Provider Services at 800-445-1638.

Inquiring About a Claim

UnitedHealthcare has developed multiple options for to help providers when inquiring about claims; the UnitedHealthcare Provider Service Center, and the UnitedHealthcare Provider Portal.

Provider Service Center

The Provider Service Center is the primary point of contact for providers who require assistance with claims. The Provider Service Center is staffed with Provider Service representatives trained specifically for UnitedHealthcare and can be reached at 800-445-1638. They work closely with all departments in UnitedHealthcare to resolve issues. By following a few guidelines, you can help UnitedHealthcare provide you with prompt, efficient service. Please have all applicable information ready before you call:
Chapter 13 Billing and Encounter Submission

- Provide the Member’s ID number, date of service, procedure code, amount billed, provider’s ID Number and claim number (if known).
- Allow 45 days from date of submission prior to inquiring about a claim.
- Limit telephone inquires to a maximum of 5 per call.

UnitedHealthcare Provider Portal
All online transactions for members enrolled in Acute Medicaid, DD, CRS, and UnitedHealthcare Dual Complete One will be accessible on UnitedHealthcareOnline.com. If you are not already registered on UnitedHealthcareOnline.com, you may do so directly on the website. The web-based provider portal offers the convenience of online support 24-hours-a-day, seven-days-a-week. This site was developed specifically with the providers in mind allowing for personal support. On the provider portal, providers can verify member eligibility, check claim status, submit claims, request an adjustment, review a remittance advice, or review a member roster. To access the provider portal, go to UHCCommunityplan.com and choose the Health Professionals tab. Access to the Provider Portal is available under the Claims and Member Information section. Follow the instructions for obtaining a user ID. You will receive your user ID and password within 48 hours.

LINK and Online Claim Reconsideration
Through our partnership with Optum, UnitedHealthcare is taking another step forward in helping to ease our providers’ administrative burden with the addition of new features and functions on LINK, which replaced the Optum Cloud Dashboard. LINK is a cloud-based website where registered providers can submit reconsideration requests electronically when attachments, such as medical notes, are required. Registration is required to access to LINK. To access the LINK, or for more information, please visit UnitedHealthcareOnline.com. Click on Tools & Resources, select Health Information Technology and then LINK: Learn More

Resolving Claim Issues
To resolve claim issues, providers should first contact the Provider Service Center (800-445-1638), use the online Provider Portal, or resubmit the claim via mail. Providers should allow up to 30 days for UnitedHealthcare to receive payment for initial claims and 30 days to receive a response to adjustment requests.

Provider Central Service Unit (PCSU)
The PCSU provides assistance for all contracted UnitedHealthcare Community Plan Dual Complete (HMO SNP) providers to resolve escalated issues, including complex and large volume issues involving UnitedHealthcare Dual Complete (HMO SNP) claims. A PCSU representative will track each issue until agreement that it is resolved, even if it is referred to an outside expert or adjuster for resolution. When calling the PCSU, providers should be prepared to provide the representative a detailed explanation of specific issues and what was expected under the terms of the contract. To contact the PCSU, call 800-718-5360.

Valid Proof of Timely Filing Attachments
Below is a list of documents that will be accepted as proof of timely filing:
- UnitedHealth Group correspondence (data entry send back letter) OR
- A computer generated activity page/print screen listing the date the claim was submitted to UnitedHealthcare Submission must contain:
  - Member Name, identifying information.
  - DOS.
  - Billed amount.
  - Date submitted to insurance.
- Electronic Claims – Acceptance Report must include:
  - Universal Electronic Data Interchange (EDI) acceptance code A1:19 coding and an acceptance date within the timely filing period, or
  - A combination of a version of the words accepted by payer, acknowledged by payer or received by UnitedHealthcare
  - A billing statement indicating the date in which the provider became aware the member had UnitedHealthcare Community Plan
- Other insurance carrier Denial/rejection EOB or letter (e.g. terminated coverage, not their member).
• A letter from an OB provider indicating that the provider was not able to complete all of the services required to bill the global code as the patient was no longer in the provider’s care or lost coverage.

• Primary carrier Explanation of Benefit (EOB) showing payment. Date on EOB must be submitted within timely filing limits.

**Tips for successful claims resolution**

• Do not allow claim issues to accumulate or go unresolved. Provider contracts only allow a limited time to request an adjustment.

• If the provider cannot verify that a claim is on file then the provider should contact the Provider Service Center at 800-445-1638.

• Providers should not resubmit claims that have been validated as on file unless submitting a corrected claim.

• File claims disputes within contractual time requirements.

• When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid, and why.

Reason Code 151, “Payment Denied/Reduced Info Does Not Support” is used to identify the claim/service submitted has exceeded the maximum daily frequency allowed for the procedure. If exceeding the maximum daily frequency is required, please submit the medical records justifying medical necessity. If you have any questions about the maximum daily frequency of a CPT/HCPCS, please contact the Provider Service Center at 800-445-1638.

**Third Party Resources**

UnitedHealthcare is, by law, the payer of last resort for AHCCCS eligible members. Therefore, providers must bill and obtain an Explanation of Benefits (EOB) from any other insurance or source of health care coverage prior to billing UnitedHealthcare, as required by contract.

Providers should refer to their contract for submission deadlines concerning third party claims. Once the provider has billed the other carrier and received an EOB, the claim may then be submitted to UnitedHealthcare. Please attach a copy of the EOB to the submitted claim. The EOB must be complete in order to understand the paid amount or the denial reason.

Providers often have timely filing guidelines documented in their contract which indicate how many days from the date of service they have to submit claims to UnitedHealthcare. If the timely filing deadline is approaching and the provider has not received the EOB from the other insurance carrier, the provider should submit the claim to UnitedHealthcare without the EOB to prevent a potential timely filing denial for the claim being submitted after the submission deadline date. A corrected claim or resubmission can then be submitted once the primary carrier’s EOB is received. Any claim received over 12 months from the date of service will be denied. Other insurance carriers’ requirements must be met or the claim may be denied.

**Coordination of Benefit**

**Standard COB**

UnitedHealthcare Community Plan is considered the payer of last resort. Providers should identify and verify any other insurance coverage for the member. Other coverage that is identified should be billed as the primary carrier. When billing UnitedHealthcare as the final payer, submit the primary payer’s Explanation of Benefits or remittance advice with the claim. Claims are processed according to the AHCCCS Contractor Operations Manual (ACOM), Chapter 400, section 434.

**Medicare Dual Cost Sharing**

A group of UnitedHealthcare members are dual eligible for both Medicaid and Medicare. Claims for dual-eligible members will be paid according to the Medicare Cost Sharing Policy. UnitedHealthcare will not be responsible for cost sharing should the payment to the primary payer be equal to or greater than what the provider would have received under Medicaid. Additional information regarding Medicare Cost Sharing is available in the Dual Complete Provider Manual.

**Billing Members**

If a member requests a service that is not covered by AHCCCS, providers should have the member sign a release form indicating understanding that the service is not covered by AHCCCS and the member is financially responsible for all applicable charges.

**Missed Appointment Fee**

In accordance with ARS 36-2930.01, providers (physicians, nurse practitioners, and physician assistants) will be allowed to charge a $3 fee for missed appointments for certain AHCCCS members who live outside of Maricopa and Pima counties. Providers are permitted to charge 1) Persons who are eligible for AHCCCS Care who live in a rural county and 2) Adults who are eligible for AHCCCS for Families with Children under Section 1931 of the Social Security Act who live in a rural county when certain conditions are met (see below). A missed appointment is one where the member is more than 20 minutes late for the scheduled appointment or has failed to cancel the appointment at least 24 hours in advance. Please refer to the AHCCCS website for additional information regarding Penalty’s for Missed Appointments on [azahcccs.gov](http://azahcccs.gov).
Chapter 13 Billing and Encounter Submission

If you have received either a payment or a denial for payment with which you do not agree, UHCCP has provided the following optional resources. Utilization of these resources does not constitute the filing of a claim dispute. If you wish to file a claim dispute, please refer to the Claim Dispute section below.
Chapter 14 Provider Claim Disputes, Appeals, and Grievances

UnitedHealthcare Community Plan
Online Services

Visit our web site for physicians, hospital administrators and other health care professionals at UHCCCommunityPlan.com.

This is your best source for submitting adjustments requests, checking patient eligibility information, secondary coverage and claim status, as well as viewing panel rosters, remittance advices, and HEDIS profile reports. You can also review reimbursement policies, change the information we have about your practice and register for electronic funds transfer (EFT).

UnitedHealthcare Community Plan
Provider Service Center

Many of these same transactions can also be completed by calling our toll free provider service line at 800-445-1638. UnitedHealthcare Provider Services can help clarify any denials or other actions relevant to claims and to help with a possible resubmission of a claim with modifications. Once a claim is timely submitted, a provider has one year from the date of service (or some other period if specified per contract) to correct the initial claim submission and to resubmit the claim for reprocessing.

Reconsideration Process

UnitedHealthcare Community Plan is committed to improving the experience on all reconsiderations. Within this informal request, a full medical necessity review will be performed without the need to file a formal claim dispute. This offers a faster turn around time and ease of submission with the ability to request online or by calling Provider Services.

Providers should use the reconsideration process prior to submitting a claim Dispute so that the claim can be reviewed for payment. Some denials that would be appropriate for a reconsideration are listed below.

- No Authorization on file/Lack of medical necessity
- Exceeds Timely Filing
- Denied for Additional Documentation
- Denied for Coordination of Benefits Information
- Resubmission of Corrected Claim
- Previously processed but rate applied incorrectly resulting in over/underpayment
- Resubmission of a bundled claim

Please make sure to include all appropriate and pertinent documentation to support the services provided when submitting the Reconsideration request. Reconsiderations can be submitted either online at UHCOncile.com/LINK, calling Provider Services at 800-445-1638, or by mailing with a Reconsideration Form to the claims and medical record mailing address for the members program. All claim Reconsiderations must be submitted with UHCCP no later than 12 months from the date of service, 12 months from the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claims submission, whichever is later.

Note: This Reconsideration Process is not to be used for DRG Outlier Payment Reconsideration. Please submit reconsiderations for DRG Outlier Payments to Med Review as documented on the Med Review letter received.

Claim Disputes

If you wish to file a claim dispute to maintain your rights, follow the instructions provided below. All providers of services to UHCCP members may file a claim dispute based on a claim denial, dissatisfaction with a claim payment, or recoupment action by UnitedHealthcare. You may challenge the claim denial or adjudication by filing a formal claim dispute with the UnitedHealthcare Appeals and Claim Disputes Department. Pursuant to AHCCCS guidelines, all claim disputes challenging claim payments, denial's or recoupment's must be filed in writing no later than 12 months from the date of services, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later. The claim dispute must state with particularity the factual and legal basis for the relief requested, along with all supporting documentation such as claims, remits, medical review sheets, medical records, correspondence, etc. Incomplete submissions or those which do not meet the criteria for a claim dispute will be denied.
Chapter 14 Provider Claim Disputes, Appeals, and Grievances

All claim disputes must be submitted in writing to:

UnitedHealthcare Community Plan  
Appeals & Claim Disputes  
1 East Washington, Suite 900  
Phoenix, AZ 85004

State Fair Hearings

STATE FAIR HEARINGS RIGHTS: If you disagree with the health plan’s claim dispute decision, you may submit a written request for a State Fair Hearing within thirty (30) days of receipt of the Notice of Decision to the following address:

UnitedHealthcare Community Plan  
State Fair Hearing Coordinator  
Appeals & Claim Disputes  
1 East Washington, Suite 900  
Phoenix, AZ 85004

In your request for State Fair Hearing, reference the following information:

• Re: Request for State Fair Hearing.
• UnitedHealthcare Claim Dispute Number.
• UnitedHealthcare Member Name and ID.

Filing an Appeal on Behalf of a Member

Care providers may assist members in filing an appeal on their behalf with the member’s written permission. UnitedHealthcare does not restrict or prohibit a provider from advocating on behalf of a member. The appeal may be filed either verbally or in writing and must be received within sixty days from the date of the Notice of Action letter. If the member or the provider on behalf of the member believes that the member’s health or ability to function will be harmed unless a decision is made in the next three days; the member or the provider on behalf of the member can ask for an expedited appeal. Expedited appeals are resolved within three business days. If we do not agree that an expedited appeal is needed, we will write you within two days, and we will also try to call you. Then we will decide your appeal within 30 days.

For expedited appeals, please call 800-348-4058. Reasons for filing an appeal include:

• The denial or limited authorization of a requested service, including the type of level of service.
• The reduction, suspension, or termination of a previous authorization.
• The denial, in whole or in part, or payment of a service.
• Failure to provide service in a timely manner.
• Failure of the health plan to act timely.
• For residents of a rural area with only one health plan, the denial of the member’s request to obtain services outside of the network.

Send written appeals to:

UnitedHealthcare Community Plan  
1 East Washington, Suite 900  
Phoenix, AZ 85004

UnitedHealthcare Dual Complete appeals should be sent to:

UnitedHealthcare Dual Complete  
Attn: Appeals  
PO Box 31364  
Salt Lake City, UT 84131-0364

Grievances

Providers may file a grievance (any expression of dissatisfaction not related to claims payment) at any time by contacting the provider service center at 800-445-1638 or send written grievances to:

UnitedHealthcare  
Grievances  
1 East Washington, Suite 900  
Phoenix, AZ 85004

Providers may also file a grievance on behalf of a member with the member’s permission. Reasons for filing a grievance include:

• UnitedHealthcare failing to provide services to you in a timely manner.
• UnitedHealthcare failing to act within the time frame given for grievances, appeal, and requests for State Fair Hearing.
Chapter 15 Fraud and Abuse

Fraud and Abuse

Fraud and abuse by member, practitioner or care provider actions, hurts everyone – UnitedHealthcare Community Plan, AHCCCS, taxpayers, members and other practitioners/providers. Combating fraud, waste and abuse is the responsibility of members, healthcare providers and insurers alike. It is your responsibility to report members or other providers you suspect are committing fraud and abuse. Your assistance in notifying us and cooperating with any potential fraud and abuse occurrence is vital and appreciated in conjunction with our mutual ongoing efforts to coordinate the most effective health outcomes possible for our members. If you notice a trend of patients requesting a particular product or service you do not feel is necessary, you should reach out to your provider representative to notify them of the issue.

You can also call the UnitedHealthcare Special Investigations Unit Fraud Hotline at 877-401-9430.

Care providers must establish an effective training program for all staff on the following aspects of the Federal False Claims Act provisions:

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

AHCCCS has recently published to its website an e-learning seminar – “Fraud Awareness for Providers” that discusses provider and member fraud. Any training must be appropriately documented and may be requested at any time by AHCCCS or UnitedHealthcare Community Plan.

We encourage you as UnitedHealthcare/AHCCCS providers to have your staff review/listen to this seminar. azahcccs.gov/Fraud/CBTHealthplanproviderfraud/healthplanproviderfraudfs.htm. Please call UnitedHealthcare Provider Services at 800-445-1638 if you have any questions.

Definitions of Fraud and Abuse

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

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

Abuse of a member: Any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement emotional or sexual abuse, or sexual assault.

Examples of Fraud and Abuse include:

- Administrative of Financial:
  - Kickbacks.
  - Falsifying credentials.
  - Fraudulent credentials.
  - Fraudulent enrollment practices.
  - Fraudulent third party liability reporting.
  - Fraudulent recoupment practices.

- Falsifying Claims/Encounters:
  - Alteration of a claim.
  - Incorrect coding.
  - Double billing.
  - False data submitted

- Falsifying Services:
  - Billing for services or supplies not provided.
  - Misrepresentation of services/supplies.
  - Substitution of services.

- Member issues:
  - Resource misrepresentation (transfer and/or hiding).
  - Residency.
  - Household composition.
  - Citizenship status.
  - Unreported income.
  - Misrepresentation of medical condition.
  - Failure to report third party liability.
Chapter 15 Fraud and Abuse

Fraud and Abuse Policies and Procedures

UnitedHealthcare Community Plan care providers must have established policies and procedures on site that meet AHCCCS requirements along with a process for reporting incidences of health care acquired conditions, abuse, neglect, exploitation, injuries and unexpected death. The policies and procedures should specify the process of submitting a report of health care acquired conditions, abuse, neglect, exploitation, injuries and unexpected death.

This information is available below for your reference as well as online at azahcccs.gov

Reporting Fraud and Abuse

A form from the AHCCCS website is available on UHCommunityPlan.com under the Provider Forms section to assist in reporting of fraud and abuse.

If any such actions, activities, or behaviors come to your attentions, please mail your documentation of the issue regarding a UnitedHealthcare member to:

UnitedHealthcare Community Plan
Compliance Office
1 East Washington, Suite 900
Phoenix, AZ 85004

Any incidents involving non-UnitedHealthcare members must be reported to the AHCCCS – OIG immediately by completing and submitting the reporting form available on the AHCCCS-OIG website at azahcccs.gov>Fraud>ReportFraud

All documentation that would assist AHCCCS in its investigation shall be attached to the form.

All information provided to UnitedHealthcare regarding a potential fraud or abuse occurrence will be maintained in the strictest confidence in accordance with the terms and conditions of UnitedHealthcare Community Plan’s Confidentiality Policy. A copy of this policy is available upon request. Any information developed, obtained or shared among participants in an investigation of a potential fraud and abuse occurrence is maintained specifically for this purpose and no other. Any questions or concerns a provider may have regarding confidentiality should be addressed to the attention of the UnitedHealthcare Compliance Officer. HIV-related information should not be disclosed when releasing information related to fraud and abuse.

UHCCP members are instructed through the Member Handbook to safeguard their AHCCCS ID cards as they would any other private and personal identification information, such as a driver’s license or checkbook. If you have any concerns regarding a member’s enrollment with UnitedHealthcare when he or she presents for non-emergent or non-urgent services:

- Ask for another form of identification preferably one with a photograph
- Use UnitedHealthcareOnline.com, or UnitedHealthcare Community Plan’s IVR phone line to confirm enrollment
- Contact the UnitedHealthcare Member Services Department for verification

Any questions remain regarding a member’s enrollment with UnitedHealthcare, please notify UnitedHealthcare’s Member Services Department, Compliance Office, or the AHCCCS Administration at the above telephone numbers.

Integrity of Claims, Reports and Representation to Government Entities

The Deficit Reduction Act of 2005 (DRA) was signed into law in early 2006. The DRA encourages states to have in place false claims legislation. It further requires that any entity receiving annual Medicaid payments of $5 million or more to provide written policies available to all employees, contractors and agents (including care providers), detailed information about the False Claims Act and any state laws that pertain to civil or criminal penalties for making false claims and statements, and the whistleblower protection under such laws, including the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.

A number of federal and state regulations govern information provided to the government, including the Federal False Claims Act, State False Claims Acts and other regulations and protections. UnitedHealthcare requires compliance with the requirements of federal and state laws that prohibit the submission of false claims in connection with federal health care programs, including Medicare and Medicaid. Federal and state governments have adopted a number of statutes to deter and punish misrepresentations with regard to health care programs. Failure to comply with these laws could result in civil and criminal sanctions imposed by government entities and UnitedHealthcare.

Federal False Claims Act

The federal False Claims Act prohibits knowingly submitting (or causing to be submitted) to the federal government a false or fraudulent claim for payment or approval. It also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false
or fraudulent claim paid or approved by a state Medicaid program, the federal government or its agents, such as a carrier or other claims processor. Civil penalties can be imposed on any person or entity that violates the federal False Claims Act, including monetary penalties of $5,500 to $11,000 as well as damages of up to three times the federal government’s damages for each false claim.

**Federal Fraud Civil Remedies**

The Program Fraud Civil Remedies Act of 1986 also allows the government to impose civil penalties against any person who makes, submits or presents false, fictitious or fraudulent claims or written statements to designated federal agencies, including the U.S. Department of Health and Human Services, which is the federal agency that oversees the Medicare and Medicaid Programs.

**State False Claims Acts**

Several states, including Arizona, have enacted broad false claims laws modeled after the federal False Claims Act or have legislation pending that is similar to the federal False Claims Act. Other states have enacted false claims laws that have provisions limited to health care fraud.

**Whistleblower and Whistleblower Protections**

The federal False Claims Act and some state false claims acts permit private citizens with knowledge of fraud against the U.S. Government or state government to file suit on behalf of the government against the person or business that committed the fraud. Individuals who file such suits are known as a “qui tam” plaintiff or “whistleblower”. The federal False Claims Act and some state false claims acts also prohibit retaliation against an employee for investigating, filing or participating in a whistleblower action.

Providers must establish an effective training program for all staff on the following aspects of the Federal False Claims Act provisions:

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

All training must be appropriately documented and may be requested at any time by AHCCCS or UHCP.
Chapter 16 Glossary

Action
- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of a payment for a service;
- Failure to provide services in a timely manner;
- Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition or grievances; or
- Denial or a rural enrollee’s request to obtain services outside the Contractor’s network when the contractor is the only Contractor in the rural area.

Active Treatment
Means there is a current need for treatment or evaluation for continuing treatment of the qualifying condition or it is anticipated that treatment or evaluation for continuing treatment of the qualifying condition will be needed within the next 18 months.

AHCCCS
The Arizona Health Care Cost Containment System which is composed of AHCCCSA, contractors, and other arrangements through which health care services are provided to eligible persons as defined by Arizona Revised Statutes, Title 36, Chapter 29.

AHCCCSA
The Arizona Health Care Cost Containment System Administration.

AHCCCS Benefit
AHCCCS covered medical services.

ALTCS (Arizona Long Term Care System)
A component of AHCCCS which, in addition to acute care and behavioral health services, provides long term care services to eligible elderly and/or physically disabled (E/PD) members, and developmentally disabled (DD/ALTCS) members. UnitedHealthcare provides long term care (sometimes referred to as “ALTCS”) services to DD/ALTCS members as a separate line of business.

Ancillary Provider Services
Refers to supplemental health care services such as pharmacy, medical supplies, equipment, transportation, laboratory, etc., either prescribed or referred by a physician.

UnitedHealthcare
Community Plan

Appeal (member)
The request for review of an action.

Authorization
An administrative procedure whereby UnitedHealthcare approves medical services rendered to members, such as hospitalization, referrals to a specific physician specialist, etc.

Auto Assignment
An automated method of enrolling AHCCCS eligible persons with an AHCCCS-contracted health plan.

Billed Charges
Charges billed by a provider rendering service(s) to a UnitedHealthcare member.

Board Certified
A physician who has successfully completed a required residency in an approved training facility and meets, or is in the process of meeting, the experience requirements for examination of the respective board.

Capitation Payment
A predetermined periodic payment, based upon the number of assigned members that is made to a provider by UnitedHealthcare for providing covered services for a specific period of time.

Categorically Eligible
Individuals who are mandatorily eligible under federal law because they receive TANF or SSI benefits. These individuals are not required to complete a separate AHCCCS eligibility determination.

Certified Nurse Midwife (CNM)
Is an individual certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Arizona by the State Board of Nursing. CNMs practice independent management of care for pregnant women and newborns, providing antepartum, intrapartum, postpartum, gynecological, and newborn care, within a health care system that provides for medical consultation, collaborative management, or referral.

Chief Medical Director
A physician designated by UnitedHealthcare to have overall administrative responsibility for the direction of UnitedHealthcare’s medical delivery system.
**Chiropractic Services**
Treatment provided by a licensed chiropractor that meets uniform minimum Medicare standards, by means of manual manipulation of the spine to correct a subluxation demonstrated by X-ray. Any such services require prior authorization.

**Chronic**
Means expected to persist over an extended period of time.

**Claim Dispute**
A dispute involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

**Claim Adjustment**
A previously paid claim that requires additional research due to an overpayment or underpayment.

**Claim Resubmission**
A previously denied claim requiring additional documentation or correction. (Example: EOB, Proof of Timely Filing, Corrected CPT code, Diagnosis Code, Provider ID, Member ID, etc).

**Clean Claim**
Refers to the term as defined by Arizona Revised Statues 36-2904.H and AHCCCS rules within Title 9 of the Arizona Administrative Codes.

**CMS**
Centers for Medicare and Medicaid Services, the federal regulatory agency for these programs.

**Concurrent Review**
A type of patient/medical care evaluation study performed while a patient is still hospitalized.

**Contract**
Refers to the present and future Agreement between UnitedHealthcare Community Plan and the State of Arizona for the purpose of providing health care services under the AHCCCS program.

**Contracted Health Professionals**
Refers to those primary care physicians, physician specialists, medical facilities, allied health professionals and ancillary service providers under contract with UnitedHealthcare who provide specific covered services to members, and represent those individuals and entities to be utilized through the UnitedHealthcare prior authorization and referral policies and procedures.

**Contractor**
Refers to UnitedHealthcare Community Plan

**Co-payment**
Refers to a monetary amount, specified by the AHCCCS Director that the member pays directly to the participating health practitioner/provider at the time covered services are provided.

**Co-payment Levels**
Copayment requirements will be indicated via a member specific copayment level found in all AHCCCS eligibility verification processes other than Interactive Voice Response (IVR). Every member will be assigned a copayment level which will reflect whether they are exempt from copayments, subject to option (nominal) copayments, or subject to mandatory copayments.

**Covered Services**
Refers to those specific services delineated in Annex B and/or C of the provider contract or mentioned in AHCCCS Rules.

**CRS**
Effective 10/1/13, Children’s Rehabilitative Services (CRS) is an integrated, statewide plan managed by UnitedHealthcare Community Plan for the provision of AHCCCS covered specialty care, primary care and behavioral health services. CRS coverage depends on the enrolled member’s CRS Coverage Type, which is either CRS Fully Integrated, Partially Integrated-Acute, Partially Integrated-BH or CRS Only.

**CRS Covered Condition**
Effective 10/1/13, AHCCCS makes CRS eligibility determinations for CRS enrollment. A CRS covered condition is based upon meeting AHCCCS eligibility requirements as define in A.A.C. R9-22-1303.

**CRS Provider**
Means a person who is authorized by written agreement with UHC to provide covered CRS services to a member or covered support services to a member or a member’s family.

**DDD**
Division of Developmental Disabilities – a program under DES to provide acute care and other therapies for those members with developmental disabilities. UnitedHealthcare provides acute care services to these members through a separate line of business. These members are referred to as DD/ALTCS members.

**DES**
Arizona Department of Economic Security.

**DHS**
Arizona Department of Health Services.

**Discharge Planning**
Identification of the need and provision for a patient’s health care requirements after discharge from the hospital.

**Disenrollment**
The discontinuance of a member’s eligibility to receive covered services from a Contractor. The member’s name is deleted from the approved list of members furnished by AHCCCSA to the Contractor.
DME
Durable Medical Equipment – includes wheelchairs, oxygen equipment, hospital beds, walkers, etc.

Elective
Usually refers to medical procedures, particularly surgery, not immediately necessary to maintain life or health; procedures which can often be scheduled weeks or months in advance.

Emergency Dental Services
Services and operational procedures required to eliminate acute infection, prevent pulpal death and related imminent tooth loss, treat injuries to teeth or supportive structures, or provide palliative therapy for pericoronitis associated with impacted teeth.

Emergency Medical Services
Services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:

- Placing the member’s health in serious jeopardy;
- Serious impairment of bodily functions; or,
- Serious dysfunction of any bodily organ or part.

Encounter
A record of medical services provided to a member.

Enrollment
The process by which a person who has been determined eligible becomes a member in a contractor’s plan under AHCCCS. During the enrollment process, the person often has more than one plan from which to choose.

EPSDT Services
Providers are required to participate in the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program for all assigned members under the age of twenty-one (21) years in accordance with the AHCCCS EPSDT periodicity schedule.

Expedited Appeal (member)
The review process for a member appeal request in which the Health Plan determines that taking the time for a standard resolution could seriously jeopardize the member’s life, health, or ability to attain, maintain, or retain maximum function.

Extended Family Planning
The Family Planning Extension program has ended as of December 31, 2013 due to AHCCCS State Law ARS 36-2907.04, Arizona’s Section 1115 Waiver with the federal government, and AHCCCS Rule R9-22-202.

Federally Qualified Health Care Center (FQHC)
FQHCs are facilities or programs more commonly known as Community Health Centers, Migrant Health Centers and Health Care for the Homeless Programs. An entity may qualify as an FQHC if it: (i) receives a grant and funding pursuant to Section 330 of the Public Health Service Act; (ii) is receiving funding from such a grant under a contract with the recipient of a grant and meets the requirements to receive a grant pursuant to Section 330 of the Public Health Service Act; (iii) is determined by the Secretary of DHHS to meet the requirements for receiving such a grant (look-alike) based on the recommendation of HRSA within PHS; or, (iv) was treated by the Secretary of the Department of Health and Human Services (DHHS) as a Federally Funded Health Center (FFHC) for purposes of Part B Medicare as of January 1, 1990.

Fee-For-Service (FFS) Payment
A payment made to a provider by UnitedHealthcare for certain covered services that is the lower of the provider’s billed and usual charge or UnitedHealthcare’s fee schedule.

FQHC/RHC Visit
A ‘visit’ is defined as a face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incidental to another service.

Functionally Limiting
Means a restriction having a significant effect on an individual’s ability to perform an activity of daily living as determined by a CRS provider.

Grievance
Any expression of dissatisfaction other than the appeal of actions or denial of payment.

HIFA
Health Insurance Flexibility and Accountability Act. The waiver for parents of eligible SOBRA children who are not otherwise eligible for AHCCCS coverage.

Home Health Care (Home Health Services)
Medical care services provided in the home, often by a visiting nurse, usually for recovering patients, aged homebound patients, or patients with a chronic disease or disability.

Hospital
A health care institution that is:

- Licensed by the Department of Health Services pursuant to A.R.S. Title 36, Chapter 4, Article 2, as a hospital; and,
- Certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined to meet the requirements of such certification.
**Inpatient**
A patient admitted to an overnight medical facility such as a hospital.

**Length of Stay**
The number of days a patient is an inpatient, per episode. The length of time a patient is hospitalized. Total number of days for which a patient is hospitalized, either totally or in a particular unit or level of care; abbreviated as LOS.

**Medicaid**
A federal/state program under Title XIX of the Social Security Act that provides federal matching grants, at the state’s option, for a medical assistance program for recipients of federally aided public assistance and SSI benefits and the medically indigent. Certain minimal programs and services must be included to receive federal matching funds, however, states may optionally include additional services at state expense.

**Medical Director**
An independent contractor used by UnitedHealthcare to support the Chief Medical Office.

**Medically Eligible**
Means meeting the medical eligibility requirements (CRS - A.A.C R9-22-1303)

**Medically Necessary**
Refers to those covered services required to preserve and maintain the health status of a member, according to AHCCCS, and subject to review and concurrence by a UnitedHealthcare Medical Director.

**Medicare**
A federal program under Title XVIII of the Social Security Act that provides health insurance for persons aged 65 and older, and for other specified groups. Part A of Medicare covers hospitalization and is compulsory and Part B of the program covers outpatient services and is voluntary.

**Member**
Refers to an individual who has been determined AHCCCS eligible and enrolled with UnitedHealthcare to receive services pursuant to the Agreement.

**Missed Appointment**
One where a member is more than 20 minutes late for the scheduled appointment or has failed to cancel the appointment at least 24 hours in advance.

**Occupational Therapy**
Medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual’s ability to perform those tasks required for independent functioning.

**Out-Of-Area Care**
Care received by a UnitedHealthcare enrollee when they are outside of their geographic territory.

**Outpatient**
A person who goes to a licensed health care institution or a facility for care and services but who does not occupy an inpatient bed.

**Pharmaceutical Services**
Medically necessary drugs prescribed by a primary care physician, a practitioner, or other physician or dentist upon referral by a primary care physician and dispensed in accordance with Arizona law.

**Physician Services**
Services provided within the scope of practice of medicine or osteopathy as defined by state law or under the personal supervision of an individual licensed under state law to practice allopathic medicine or osteopathy.

**Practitioner**
Generally used to identify physicians, dentists, pharmacies, nurses, etc., who provide medical care.

**Preventative Health Care**
Those health care activities aimed at protection against, and early detection and minimization of disease or disability.

**Primary Care Obstetrician (PCO)**
An obstetrician who provides obstetrical and primary care to assigned pregnant members.

**Primary Care Physician (PCP)**
A physician such as a family practitioner, pediatrician, internist, general practitioner or obstetrician who serves as a gatekeeper for their assigned members’ care.

**Prior Authorization**
A unit under the direction of the UnitedHealthcare Health Services Department that is an essential component of any managed care organization. Prior authorization is the process where health care providers seek approval prior to rendering services as required by UnitedHealthcare policy.
Provider
Generally used to identify hospitals, nursing homes, home health agencies, etc., that provides medical services.

Provider Preventable Services
Services provided for a condition that meets the definition of a ‘health care-acquired condition’ or an ‘other provider-preventable condition’ as defined in 42 CFR 447.26.

QMB
Qualified Medicare Beneficiary.

Quality Management (QM)
A methodology used by professional health personnel to the degree of conformance to desired medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.

Retrospective Review
After the fact. Used often with respect to utilization management – as with retrospective review and approval or denial of emergency room use.

RBHA
Regional Behavioral Health Authority. These are the entities through which state and federally funded behavioral health services are provided.

Rural Health Clinics (RHCs)
RHCs are clinics located in areas designated by the Bureau of Census as rural and by the Secretary of the DHHS as medically underserved or having an insufficient number of physicians and meets the requirements under 42 CFR 491.

SOBRA
Refers to a special Title XIX eligibility classification of pregnant women, mothers and babies, who are members of UnitedHealthcare.

Specialist (PSP)
A physician duly licensed in the State of Arizona and has completed a residency or fellowship in his or her specialty and has been approved to sit for the board examination for the specialty.

SSI
Supplemental Security Income under Title XVI of the Social Security Act, as amended.

State Fair Hearing
An administrative hearing that can be requested if the member or provider does not agree with a Notice of Decision or Notice of Appeal Resolution from the UnitedHealthcare Appeals and Claim Dispute Department.

TANF
Temporary Assistance to Needy Families.

Telemedicine
The practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video, and date communications that occur in the physical presence of the patient.

Third Party Recoveries
A general term applied to health care benefit payments. It derives from the fact that under normal market transactions, there are only two parties, the consumer and the supplier, but under a benefit plan, a third party (e.g., government, an insurance company, an employer) is ultimately responsible to pay the costs of services provided to a covered person.

Title XIX
Section of Social Security Act which describes the Medicaid program coverage for eligible persons.

Title XXI
Section of the Social Security Act, referred to in federal legislation as the State Children’s Health Insurance Program (SCHIP). The Arizona version of SCHIP is referred to as KidsCare.

UHCCP
UnitedHealthcare Community Plan

Utilization Management (Utilization Control)
Systematic means for reviewing and controlling patients’ use of medical care services, and providers’ use of medical care resources. Usually involves data collection, review and/or authorization, especially for services such as specialist referrals and emergency room use, and particularly costly services such as hospitalization.

Utilization Review
System of review conducted by professional health personnel of the appropriateness, quality of and need for health care services rendered to patients covered by Medicare or other third party payers, including AHCCCS.

Visit
All services received in one day from a single provider, or components of the same service received in one day from multiple providers, e.g. a surgery in an Ambulatory Surgical Center (ASC) where both the ASC and the surgeon provide the same service.