Table of Contents

- **Chapter 1: Introduction** 1
  - Purpose of Administrative Manual 1
  - Overview 1

- **Chapter 2: How to Reach Us** 3
  - Contacts 3
  - Provider Services 3

- **Chapter 3: Enrollee Identification** 4
  - Enrollee Identification 4
  - Enrollee ID Card 4

- **Chapter 4: Benefits** 5
  - Covered Services 5
  - UnitedHealthcare Long Term Care Medicaid Covered Level of Benefits 6
  - Exclusions 6
  - Post Stabilization, Emergency and Urgently Needed Services 6
  - Behavioral Health 7
  - Questions or Concerns 7

- **Chapter 5: Enrollment** 8
  - Enrollment Eligibility 8
  - Enrollee Orientation 9
  - Disenrollment 9
  - Notification Requirements 12
  - Provider Education 12

- **Chapter 6: Credentialing and Re-credentialing** 13
  - Credentialing 13
  - Adverse Credentialing Determination Appeals 13
  - Termination 13
  - Provider Complaint Process 14
  - Arbitration 14
  - Data Collection 14
  - Protect Confidentiality of Enrollee Data 14
• County Services Contact Telephone Numbers 14
• Toll Free Provider Help Line 14

**Chapter 7: Health Services and Quality Improvement Programs** 15
• Care Management Model 15
• Other Provider and Subcontractor Responsibilities 15
• Initial Assessment 15
• Enrollee Records 15
• Access to Care Standards 16
• Clinical Practice Guideline References 16
• Quality Improvement Enhancement 17
• Enrollee Bill of Rights 17
• Sanctions 18
• Surveys 18

**Chapter 8: Billing and Payment** 19
• Billing and Claims 19
• Electronic Claim Submission 19
• Paper Claim Submission 19
• Payment Information 19
• Enrollee Payment Liability 19
• Common Claim Administration Issues 20
• Claim Completion Requirements 20
• Claims Paid and/or Denied in Error 21
• Claim Denials 21
• Overpayment 21
• Durable Medical Equipment (DME) Billing 21
• Filling Corrected Claims 21
• Provider Claims Appeals 21
• Adjustment Request Form 22
• How to Bill a UB04 23
• How to Bill a HCFA 1500 24
• Claim Submission Address 25
• Claims Forms Used 26
• Provider Remittance Advice 27
• Provider Risk Arrangements 29
• Coordination of Benefits 29
• Chapter 9: Appeals and Grievances 30
  • Enrollee Appeals and Grievances 30

• Chapter 10: Fraud and Abuse 33
  • Fraud and Abuse Reporting 33

• Chapter 11: Comments 34
  • Comments 34
Purpose of Administrative Manual

UnitedHealthcare welcomes you as a participating provider. You play a key role as we pursue our commitment to improve the health and well-being of the enrollees we serve.

The purpose of the Administrative Manual is to serve as a resource and reference guide for participating providers. The manual contains information regarding covered services and quality improvement programs, billing and claim procedures, and ID cards and eligibility verification. Please share it with others in your office or organization.

The information contained is current as of the date it was published, and may be modified by UnitedHealthcare at any time. This manual was designed so that updates and changes from time to time can be done efficiently. If a section is updated or enhancements to the content are made, you will be provided with the material to replace the respective section.

In addition, information is available online at UnitedHealthcareOnline.com or UHCCommunityPlan.com

For your ease, we have included a “Comments” section at the end of this manual for you to provide feedback or make recommendations.

Overview

What is Medicaid?
The medical assistance program authorized by Title XIX of the Social Security Act, 42U.S.C. §1396 et seq., and regulations thereunder, as administered in the State of Florida by the Agency under s. 409.901 et seq., F.S.

What is UnitedHealthcare LTC Medicaid Managed Care?
Managed care is when health care organizations manage how their enrollees receive health care services. Managed Care Organizations will work with different providers to offer quality health care services to enrollees.

The goals of Florida Long-Term Care Managed Care are to provide:

- Coordinated long-term care across different health care settings
- A choice of the best long-term care plan for their needs
- Long-term care plans with the ability to offer more services
- Access to cost-effective community-based long-term care services

Enrollees enrolled in LTC Medicaid Managed Care will have their services/care managed through the Managed Care Health Plan. UnitedHealthcare works with different providers to offer quality health care services and to ensure enrollees have access to covered services.

The goals of the Long Term Care Managed Care Plan are to provide coordinated long-term care services across different health care settings and to provide enrollee access to cost-effective community-based long-term care services.

The Long Term Care Managed Care Plan will not change Medicare benefits.

Provides for service provision that allows at-risk individuals to remain at home and improve their quality of life.

This section of your manual provides helpful information you will need to support the care manager and enrollee in coordination of services as determined by the individual enrollee care plan. Unless there is a discrepancy, the information contained in this section does not replace the information contained in other sections of this manual, but highlights information pertinent to the Long Term Care Managed Care Plan.

How the UnitedHealthcare Long Term Care Medicaid Managed Care Plan Works:
UnitedHealthcare operates under a contract with the state of Florida Agency for Health Care Administration (AHCA). UnitedHealthcare is committed to support and coordinates all Medicaid-covered benefits for eligible enrollees using a plan of care that is intended to support the enrollee in remaining in the community. Should the enrollee require facility care, the plan of care is developed to provide the enrollee with every opportunity to improve quality of life, and when, or if possible, allow for a successful transition back into the community. This model utilizes covered benefits, enhanced benefits, community resources, caregiver/family support systems and primary health care providers to meet the overall care needs of the enrollee. UnitedHealthcare is also required to comply with any new Medicaid coverage decisions.
UnitedHealthcare Long Term Care Medicaid Managed Care Plan Provider Relationship:
The success of UnitedHealthcare depends on strong relationships with its providers. We encourage enrollees to work with their care manager to coordinate their care and help them access their covered benefits. If the enrollee uses a non-contracted provider, the services will not be covered unless services are authorized by the care manager. A Medicare beneficiary can access any Medicare-approved provider without authorization.

The Enrollee and UnitedHealthcare:
Only Medicaid recipients who meet eligibility requirements and are living in a region with authorized Managed Care Plans are eligible to enroll and receive services from the Long Term Care Medicaid Managed Care Plan. Each recipient will have a choice of Managed Care Plans and may select any authorized Managed Care Plan unless the Managed Care Plan is restricted by this contract to a specific population that does not include the recipient.

AHCA or its agent will be responsible for enrollment, including enrollment into the UnitedHealthcare Long Term Care Managed Care Plan, disenrollment and outreach and education activities. UnitedHealthcare will coordinate with the agency and its agent as necessary for all enrollment and disenrollment functions.

UnitedHealthcare will accept Medicaid recipients without restriction and in the order in which they enroll. UnitedHealthcare will not discriminate on the basis of religion, gender, race, color, age or national origin, health status, pre-existing condition or need for health care services and will not use any policy or practice that has the effect of such discrimination.

Medicaid-Only Beneficiaries:
Each enrollee has an assigned care manager who works with the enrollee’s health care providers and authorized representatives to develop and coordinate the Plan of Care. A Medicare beneficiary can access any Medicare-approved provider without authorization.

UnitedHealthcare and its contracted providers will treat all enrollees with dignity and respect and will recognize the enrollee’s right to privacy, regardless of race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment.

Cultural Competency Plan:
UnitedHealthcare believes in and supports the ability of individuals and systems to provide services effectively to people of various cultures, races, ethnic background and religions in a manner that recognizes values, affirms and respects the worth of individuals and respects and protects their dignity.

Please visit UnitedHealthcareOnline.com for a more complete description of the Cultural Competency Plan. You may request at no charge a copy of the Plan’s Cultural Competency Plan by calling 800-791-9233.

Send request in writing to:
UnitedHealthcare Community Plan
LTC Medicaid Managed Care Plan
3100 SW 145th Avenue -- 2nd Floor
Miramar, FL 33027
Chapter 2: How to Reach

Contacts

<table>
<thead>
<tr>
<th>Administrative Office</th>
<th>800-791-9233</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations Administrative Office</td>
<td>800-791-9233 or email: <a href="mailto:fl_ltc_network@uhc.com">fl_ltc_network@uhc.com</a></td>
</tr>
<tr>
<td>Customer Service</td>
<td>Customer service representatives are available between 8 a.m. and 7 p.m. EST, Monday through Friday at 800-791-9233 or TTY 771 for the hearing impaired.</td>
</tr>
<tr>
<td>Plan Address</td>
<td>UnitedHealthcare Community Plan Long-Term Care Medicaid Managed Care (FL0504) 3100 SW 145th Avenue -- 2nd Floor Miramar, FL 33027</td>
</tr>
<tr>
<td>Claims Submission</td>
<td>P.O. Box 31362, Salt Lake City, UT 84131-0362</td>
</tr>
<tr>
<td>Address</td>
<td>Or electronically Payer ID 87726</td>
</tr>
</tbody>
</table>

Provider Relations
Contact your Provider Relations Department for questions regarding:

- Changes in provider information, including name, address, telephone number or Federal Tax Identification number
- If you open or close an office
- If you have reached capacity and you are no longer accepting new enrollees. Please provide the effective date and date anticipated for accepting new enrollees.
- Contract administration/implementation issues
- Credentialing and re-credentialing
- Reimbursement, payment or coding questions
- Specific information about UnitedHealthcare’s policies and procedures
- Training for billing and claim submission

Provider Relations can be reached by telephone at 800-791-9233 or by email at fl_ltc_network@uhc.com.

UnitedHealthcare Online
UnitedHealthcareOnline.com: Forms, bulletins, eligibility and claim status look-up; and online claim submission.

Community Plans Online
Chapter 3: Enrollee Identification

Enrollee Identification

Each UnitedHealthcare enrollee receives an identification (ID) card to present to providers when seeking health care services. See below for a sample enrollee ID card.

This card identifies the enrollee as a UnitedHealthcare Long Term Care Managed Care Program enrollee. Medicaid will not be responsible for claims for this enrollee while they continue to be enrolled in UnitedHealthcare. During that time, all claims need to be submitted to UnitedHealthcare.

Medicaid recipients receive a gold plastic, Medicaid ID card issued by the state of Florida. This card will allow providers instant access to Medicaid recipient eligibility information.

Enrollee ID Card

Sample of UnitedHealthcare Long-Term Care Medicaid Managed Care Identification Card
Chapter 4: Benefits

Covered Services

UnitedHealthcare Long Term Care Managed Care covers all Medicaid-covered services as well as additional benefits. New coverage decisions are communicated to contracted providers via written notification. A general list of covered services is included below. All services must be provided in accordance with professionally recognized standards of care.

List of Covered Benefits

Services are coordinated by the care manager.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Health Care</td>
<td>Home Accessibility Adaptation</td>
</tr>
<tr>
<td>Adult Companion Care</td>
<td>Home Delivered Meals</td>
</tr>
<tr>
<td>***Assisted Living Services</td>
<td>Homemaker</td>
</tr>
<tr>
<td>***Assistive Care Services (Adult Family Care Home only)</td>
<td>Hospice</td>
</tr>
<tr>
<td>Attenant Care</td>
<td>*Intermittent and Skilled Nursing</td>
</tr>
<tr>
<td>*Behavioral Management</td>
<td>**Medical Equipment</td>
</tr>
<tr>
<td>Caregiver Training</td>
<td>Medication Administration</td>
</tr>
<tr>
<td>Comprehensive Medication Management</td>
<td>Medication Management</td>
</tr>
<tr>
<td>**Consumable Medical Supplies</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td></td>
<td>**Medical Equipment</td>
</tr>
<tr>
<td></td>
<td>Respite Care</td>
</tr>
<tr>
<td></td>
<td>Respiratory Therapy</td>
</tr>
<tr>
<td></td>
<td>Speech Therapy</td>
</tr>
<tr>
<td></td>
<td>Respiratory Therapy</td>
</tr>
<tr>
<td></td>
<td>Speech Therapy</td>
</tr>
<tr>
<td></td>
<td>Transport, Non-Emergency</td>
</tr>
</tbody>
</table>

*Behavioral Management and Intermittent – Skilled nursing care provided through contracted network. Hospice is provided through hospice provider network. Case manager will coordinate enrollee services.

**Medical equipment and consumable medical supplies coordinated by care manager through contracted providers. Provider bills per contract based on item and appropriate coding.

***Assisted Living Facilities and Adult Family Care Homes must meet Home Like Environment Criteria as set by AHCA. Characteristics are: Choice of private or semi-private room; Choice of roommate; Ability to lock door of living unit; Access to telephone and length of use; Flexible eating schedule and; Participate in facility and community activities, with the ability to have; Unlimited visitation and the ability to; Maintain a personal sleeping schedule and to; Prepare and have snacks as desired.

All providers will support the enrollee’s community inclusion and integration by working with the managed care organization’s case manager and the enrollee to facilitate the enrollee’s personal goals and access to community activities.

List of Enhanced Benefits

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over-The-Counter (OTC) Medicines and Products</td>
<td>Enrollee and Caregiver Support</td>
</tr>
<tr>
<td></td>
<td>Dental (Preventative Care)</td>
</tr>
</tbody>
</table>

*Behavioral Management and Intermittent – Skilled nursing care provided through contracted network. Hospice is provided through hospice provider network. Case manager will coordinate enrollee services.

**Medical equipment and consumable medical supplies coordinated by care manager through contracted providers. Provider bills per contract based on item and appropriate coding.

***Assisted Living Facilities and Adult Family Care Homes must meet Home Like Environment Criteria as set by AHCA. Characteristics are: Choice of private or semi-private room; Choice of roommate; Ability to lock door of living unit; Access to telephone and length of use; Flexible eating schedule and; Participate in facility and community activities, with the ability to have; Unlimited visitation and the ability to; Maintain a personal sleeping schedule and to; Prepare and have snacks as desired.
UnitedHealthcare Long Term Care Medicaid Covered Level of Benefits

UnitedHealthcare Long Term Care covered benefits are available to enrollees only if they receive services from a UnitedHealthcare contracted provider. If the enrollee receives services from a non-contracted provider, UnitedHealthcare will provide an opportunity for the non-contracted to become contracted. If the provider chooses to remain non-contracted, then the care manager will work with the enrollee and our contracted providers to transition services. All services require case management authorization. Medicare enrollees can access any Medicare-approved provider without authorization.

Exclusions

Certain services and/or service categories are excluded from coverage under UnitedHealthcare. The UnitedHealthcare Long Term Care Medicaid Managed Care Plan Evidence of Coverage (EOC) lists many of the excluded services. For a complete list of exclusions, contact Provider Relations at the number found on the “How to Reach Us” page of this section. In addition to the specific excluded services, UnitedHealthcare may deny coverage if:

• The service is not medically necessary; or
• The service is not a Medicaid-covered benefit.

Post-Stabilization, Emergency and Urgently Needed Services

Post-Stabilization Care Services – Covered services related to an emergency medical condition that are provided after a enrollee is stabilized in order to maintain, improve or resolve the enrollee’s condition pursuant to 42 CFR 422.113.

Urgent Care – Services for conditions, which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain) or substantially restrict a enrollee’s activity (e.g., infectious illnesses, influenza, respiratory ailments).

Emergency Services and Care – Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If such a condition exists, emergency services and care include the care or treatment necessary to relieve or eliminate the emergency medical condition within the service capability of the facility.

UnitedHealthcare will ensure that enrollees are notified of their rights and responsibilities how to obtain care and what to do in an emergency or urgent medical situation.

In the event of an emergency, the enrollee should seek immediate care or call 911 for assistance. Prior authorization is not required, and UnitedHealthcare may not deny payment if a physician or health care provider instructs a enrollee to seek emergency services.

UnitedHealthcare provides coverage, within the scope of covered benefits, for the treatment of an emergency medical condition, which is defined by AHCA as a condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, which possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

Post-stabilization care is covered if:

• Prior authorized by UnitedHealthcare;
• UnitedHealthcare did not respond to the request by the physician or health care provider of post-stabilization services for prior authorization within one hour after UnitedHealthcare was asked to approve post-stabilization care; or
• UnitedHealthcare could not be reached for prior authorization despite reasonable efforts.

Such automatic approval of post-stabilization care continues to be covered until UnitedHealthcare has responded to the request and arranged for discharge or transfer.

Enrollees are encouraged to notify UnitedHealthcare as soon as possible after receiving post-stabilization, emergency or urgently needed health services. The UnitedHealthcare contracted providers are required to notify UnitedHealthcare if a enrollee is admitted to the hospital.
Behavioral Health

Optum Health Behavioral Solutions, a subsidiary of UnitedHealth Group, provides the mental health services for UnitedHealthcare Substance Abuse Treatment if coordinated through United Optum Health; however the services are covered through Medicaid and DCF.

Enrollees and/or their care managers can arrange these services by calling 800-582-8220.

Questions or Concerns

Should you have any questions, you may contact the customer service line at 800-791-9233 for further clarification of covered benefits.
Enrollment Eligibility

Eligibility requirements are determined by the Department of Elder Affairs’ CARES Unit and compliance is essential. The following guidelines are used to determine UnitedHealthcare Long Term Medicaid Managed Care enrollee eligibility:

Enrollee Eligibility Mandatory

Eligible recipients age 18 or older in any of the following programs or eligibility categories are required to enroll in a Managed Care Plan if they have been determined by CARES to meet the nursing facility level of care:

- Temporary Assistance to Needy Families (TANF);
- SSI (Aged, Blind and Disabled);
- Institutional Care;
- Hospice; and
- Aged/Disabled Adult waiver.

Individuals who age out of Children’s Medical Services and meet the following criteria for the Aged/Disabled Adult waiver:

- Received care from Children’s Medical Services prior to turning age 21;
- Age 21 and older;
- Cognitively intact;
- Medically complex; and
- Technologically dependent.
- Assisted Living waiver;
- Nursing Home Diversion waiver;
- Channeling waiver;
- Low-income families and children;
- MEDS (SOBRA) for children born after 9/30/83 (age 18-20);
- MEDS AD (SOBRA) for aged and disabled;
- Protected Medicaid (aged and disabled);
- Dually Eligible (Medicare and Medicaid);
- Individuals enrolled in the Frail/Elderly Program component of UnitedHealthcare HMO; and
- Medicaid Pending for Long Term Care Managed Care HCBS waiver services.

Enrollee Eligibility Voluntary

Eligible recipients 18 years or older in any of the following eligibility categories may, but are not required to, enroll in a Managed Care Plan if they have been determined by CARES to meet the nursing facility level of care:

A. Traumatic Brain and Spinal Cord Injury waiver;
B. Project AIDS Care (PAC) waiver;
C. Adult Cystic Fibrosis waiver;
D. Program of All-Inclusive Care for the Elderly (PACE) plan enrollees;
E. Familial Dysautonomia waiver;
F. Model waiver (age 18-20);
G. Medicaid for the Aged and Disabled (MEDS AD) – Sixth Omnibus Budget Reconciliation Act (SOBRA) for aged and disabled – enrolled in Developmental Disabilities (DD) waiver;
H. Recipients with other creditable coverage excluding Medicare; and
I. Recipients on DD HCBS Wait-list.

Enrollee Eligibility Excluded

Recipients in any eligibility category not listed in sub-items A.1. or A.2. above are excluded from enrollment in a Managed Care Plan. This includes, but is not limited to, recipients in the following eligibility categories:

- Supplemental Security Income (SSI) (enrolled in a DD waiver);
- Presumptive Newborns (PEN);
- Foster care;
- Institutional Care – Transfer of Assets;
- MediKids;
- MEDS (SOBRA) for children born after 9/30/83 (under age 18);
- MEDS (SOBRA) for pregnant women;
- Presumptively eligible pregnant women;
- Medically needy;
- Refugee assistance;
- Family planning waiver;
- Women enrolled through the Breast and Cervical Cancer Program;
Chapter 5. Enrollment

- Emergency shelter/Department of Juvenile Justice (DJJ) residential;
- Emergency assistance for aliens;
- Qualified Individual (QI) 1;
- Qualified Medicare beneficiary (QMB);
- Special low-income beneficiaries (SLMB);
- Working disabled (19);
- I Budget waiver (developmental disabilities waiver); and
- Developmental Disabilities (DD) waivers (Tiers 1-4).

In addition, regardless of eligibility category, the following recipients are excluded from enrollment in a Managed Care Plan:

- Recipients residing in residential commitment facilities operated through DJJ or mental-health facilities;
- Recipients residing in DD centers including Sunland and Tacachale;
- Children receiving services in a prescribed pediatric extended care center (PPEC);
- Children with chronic conditions enrolled in the Children’s Medical Services Network; and
- Recipients in the Health Insurance Premium Payment (HIPP) program.

Enrollee Orientation

Once the UnitedHealthcare Long Term Care Medicaid Managed Care enrollment application is processed, each new enrollee receives a letter stating the effective date of coverage and a packet of information about the program.

The following documents are provided to new enrollees:

- Welcome Letter
- Enrollee Handbook
- Enrollee ID Card
- Provider Directory
- HIPAA Privacy Notice

UnitedHealthcare will contact new enrollees via telephone and conduct a Health Risk Assessment. Within five days of enrollment UnitedHealthcare will contact the enrollee and develop a plan of care.

The enrollee orientation is completed during a visit to the enrollee by the assigned care manager and includes the following topics:

- The role of the enrollee’s primary care practitioner (PCP)
- How to access long-term care services
- Behavioral and substance-abuse services
- How to access urgent care and emergency care
- Use of non-contracted providers and practitioners
- Filing a grievance or appeal
- Enrollee rights and responsibilities
- Enrollee right to self-determination
- The care manager’s role with the enrollee and his or her PCP
- How to dis-enroll voluntarily
- Customer service number and use

Disenrollment

General Provisions

A. UnitedHealthcare Long Term Care Medicaid Managed Care program will ensure that it does not restrict the enrollee’s right to dis-enroll voluntarily in any way.

B. UnitedHealthcare or its agents will not provide or assist in the completion of a disenrollment request or assist the agency’s contracted enrollment broker in the disenrollment process.

C. UnitedHealthcare will ensure that enrollees who are dis-enrolled and wish to file an appeal have the opportunity to do so. All enrollees shall be afforded the right to file an appeal on disenrollment except for the following reasons:

- Moving out of the region;
- Loss of Medicaid eligibility;
- Determination that a enrollee is in an excluded population; and
- Enrollee death.

D. A enrollee subject to open enrollment may submit to AHCA or its agent a request to dis-enroll. This may be done without cause during the 90-calendar day change period following the date of the enrollee’s initial enrollment with UnitedHealthcare, or the date AHCA or its agent sends the enrollee notice of the enrollment, whichever is later. A enrollee may request disenrollment without cause every 12 months thereafter during the annual open enrollment period. Those not subject to open enrollment may dis-enroll at any time.
Chapter 5. Enrollment

E. The effective date of an approved disenrollment will be the last calendar day of the month in which disenrollment was made effective by AHCA or its agent. In no case will disenrollment be later than the first calendar day of the second month following the month in which the enrollee or UnitedHealthcare files the disenrollment request. If AHCA or its agent fails to make a disenrollment determination within this time frame, the disenrollment is considered approved as of the date AHCA’s action was required.

F. On the first day of the month after receiving notice from FMMIS that the enrollee has moved to another region, AHCA will automatically dis-enroll the enrollee from UnitedHealthcare and treat the enrollee as if the enrollee is a new Medicaid-eligible enrollee able to choose another provider pursuant to the AHCA’s enrollment process.

When Disenrollment Can Occur
A enrollee may request disenrollment at any time. AHCA or the enrollment broker performs disenrollment as follows:

- For cause, at any time
- Without cause, for enrollees subject to open enrollment, at the following times:
  - During the 90 days following the enrollee’s initial enrollment, or the date AHCA or its agent sends the enrollee notice of the enrollment, whichever is later;
  - At least every 12 months;
  - If the temporary loss of Medicaid eligibility has caused the enrollee to miss the open enrollment period;
  - When AHCA or its agent grants the enrollee the right to terminate enrollment without cause (done on a case-by-case basis); or
  - During the 30 days after the enrollee is referred for hospice services in order to enroll in another managed care plan to access the enrollee’s choice of hospice provider.
- Without cause, for enrollees not subject to open enrollment, at any time.

Cause for Disenrollment

A. A mandatory enrollee may request disenrollment from UnitedHealthcare for cause at any time. Such request will be submitted to AHCA or its agent.

B. The following reasons constitute cause for disenrollment from UnitedHealthcare:

- The enrollee does not live in a region where UnitedHealthcare is authorized to provide services, as indicated in FMMIS.
- The provider is no longer with UnitedHealthcare.
- The enrollee is excluded from enrollment.
- A substantiated marketing or community outreach violation has occurred.
- The enrollee is prevented from participating in the development of his or her treatment plan/plan of care. The enrollee has an active relationship with a provider who is not on UnitedHealthcare’s panel, but is on the panel of another managed care plan. “Active relationship” is defined as having received services from the provider within the six months preceding the disenrollment request.
- The enrollee is in the wrong managed care plan as determined by AHCA.
- The managed care plan no longer participates in the region.
- The state has imposed intermediate sanctions upon UnitedHealthcare.
- The enrollee needs related services to be performed concurrently, but not all related services are available within UnitedHealthcare’s network, or the enrollee’s PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.
- UnitedHealthcare does not, because of moral or religious objections, cover the service the enrollee seeks.
- The enrollee missed open enrollment due to a temporary loss of eligibility, defined as 60 days or less for long-term care enrollees and 180 days or less for MMA enrollees.
- Other reasons per 42 CFR 438.56(d)(2) and s. 409.969(2), F.S., including, but not limited to: poor quality of care; lack of access to services covered under the contract; service access impairments due to significant changes in the geographic location of services; an unreasonable delay or denial of service; lack of access to providers experienced in dealing with the enrollee’s health care needs; or fraudulent enrollment.

C. Voluntary enrollees may dis-enroll from UnitedHealthcare at any time.
Chapter 5. Enrollment

Involuntary Disenrollment Requests

A. With proper written documentation, the following are acceptable reasons for which UnitedHealthcare may submit involuntary disenrollment requests to AHCA or its agent:

- Fraudulent use of the enrollee ID card. In such cases UnitedHealthcare will report the event to MPI.
- The enrollee's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the UnitedHealthcare Plan seriously impairs our ability to furnish services to either the enrollee or other enrollees.
  - This section does not apply to enrollees with medical or mental health diagnoses if the enrollee’s behavior is attributable to the diagnoses.
- An involuntary disenrollment request related to enrollee behavior must include documentation that UnitedHealthcare:
  - Provided the enrollee at least one (a) oral warning and at least one (b) written warning of the full implications of the enrollee’s actions;
  - Attempted to educate the enrollee regarding rights and responsibilities;
  - Offered assistance through care coordination/case management that would enable the enrollee to comply; and
  - Determined that the enrollee's behavior is not related to the enrollee’s medical or mental health condition.
- Falsification of prescriptions by a enrollee. In such cases the managed care plan shall report the event to MPI.

B. UnitedHealthcare will promptly submit such disenrollment requests to AHCA. In no event will UnitedHealthcare submit a disenrollment request at such a date as would cause the disenrollment to be effective later than 45 calendar days after the Plan’s receipt of the reason for involuntary disenrollment. UnitedHealthcare will ensure that involuntary disenrollment documents are maintained in an identifiable enrollee record.

C. All requests will be reviewed on a case-by-case basis and subject to the sole discretion of AHCA. Any request not approved is final and not subject to UnitedHealthcare dispute or appeal.

D. UnitedHealthcare will not request disenrollment of a enrollee due to:

- Health diagnosis;
- Adverse changes in an enrollee’s health status;
- Utilization of medical services;
- Diminished mental capacity;
- Pre-existing medical condition;
- Uncooperative or disruptive behavior resulting from the enrollee’s special needs; or
- Attempt to exercise rights under UnitedHealthcare's grievance system.

E. When UnitedHealthcare requests an involuntary disenrollment, it will notify the enrollee in writing that UnitedHealthcare is requesting disenrollment, the reason for the request, and an explanation that UnitedHealthcare is requesting that the enrollee be dis-enrolled in the next contract month, or earlier if necessary. Until the enrollee is dis-enrolled, the managed care plan shall be responsible for the provision of services to that enrollee.
Chapter 5. Enrollment

Notification Requirements

<table>
<thead>
<tr>
<th>Procedures and Services</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Admissions (Hospital, &amp; SNF)</td>
<td>All in-patient admissions (except maternity), including acute hospital, rehabilitation facilities, and skilled nursing facilities.</td>
</tr>
<tr>
<td>Out-of-Network Services</td>
<td>Referrals to physicians, health care professionals and hospitals that are not contracted with UnitedHealthcare.</td>
</tr>
<tr>
<td>Home and Community-Based Services</td>
<td>All home-based services, including nursing, respiratory therapy, IV infusion services, hospice services, physical, speech and occupational therapies and social work.</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)/Supplies (DMS)</td>
<td>All DME/DMS services must be coordinated with the care manager.</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Mental health services must be coordinated with the care manager.</td>
</tr>
<tr>
<td>Therapy Services</td>
<td>Any physical therapy (PT), occupational therapy (OT), and/or speech pathology therapy (ST) services.</td>
</tr>
</tbody>
</table>

This list does not signify coverage for benefits. If you have questions about a enrollee's benefit coverage, please call customer service at 800-791-9233.

Provider Education

Please review your Provider Manual in detail. Should you have any questions, you may reach a Provider Relations Advocate at 800-791-9233 or by email at fl_ltc_network@uhc.com.

Provider education regarding the Long Term Medicaid Managed Care Plan and claims submission process will be made available to all new and current providers through monthly webcast training. The Network Provider Relations Advocate will notify you of the times and how to access the trainings during your initial on-boarding process. For current providers, invites to ongoing webcast opportunities will be provided by mail and/or email.

Education on claims submission will also be made available on-site at designated locations and times throughout the year to assist you with claims submission issues. You will be notified in writing and provided opportunity to sign up for those sessions.
Credentialeding

UnitedHealthcare is responsible for the credentialing and re-credentialeding of the provider network. All providers must successfully meet AHCA and UnitedHealthcare standards for network participation.

Requirements include all of the below: (Compliance with all credentialing requirements if required every three years unless indicated with **. The ** documents are required annually.)

- Completed provider application;
- W9;
- **A copy of your current medical license for medical providers, or occupational or facility license as applicable to provider type, or authority to do business;
- No revocation, moratorium or suspension of your state license by AHCA or the Department of Health, if applicable;
- **No sanctions imposed on the provider by Medicare or Medicaid (validated by OIG and/or EPLS report);
- No record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.;
- A satisfactory level II background check pursuant to s. 409.907, F.S., for all treating providers not currently enrolled in Medicaid’s fee-for-service program;
  - AHCA-approved Attestation to compliance
  - As defined by UnitedHealthcare, you will need to submit a roster listing of all staff who qualify as direct providers (face-to-face contact and have access to enrollee information) as it relates to enrollees enrolled in the UnitedHealthcare Long Term Care Medicaid Managed Care Plan. The roster will be utilized to confirm staff compliance by accessing the AHCA background screening portal.
- Professional Liability Claims History (Requires Loss/Run Report);
- Liability insurance;
- **Occupational License or Tax Receipt;
- Medicaid ID number; (providers do not have to be a participating provider in the Florida Medicaid program; however, you must be eligible for participation. If AHCA determines that you are not eligible to participate in the Medicaid program then you are considered ineligible to participate in the Long Term Care Medicaid Managed Care Plan. The Medicaid number is assigned for encounter data reporting purposes only. If you do not have a Medicaid number, the plan can apply for one on your behalf.
- Tax ID number;
- NPI number (transportation, emergency response system, environmental adaptation and pest control providers are excluded);
- Disclosure of ownership;
- Debarment letter;
- Work history; and
- Attestation to abuse/neglect/exploitation training.

The credentialing process is considered complete when the credentialing committee approves the credentialing application. The provider will be issued a UnitedHealthcare number once the credentialing process has been completed.

Adverse Credentialing Determination Appeals

All providers must meet UnitedHealthcare’s protocols for continued participation in UnitedHealthcare. Providers receive written notice of such protocols in the contract between the provider and UnitedHealthcare (provider contract), in UnitedHealthcare’s credentialing policies and procedures, and in other communication vehicles from time to time. If UnitedHealthcare makes an adverse determination regarding a provider’s continued participation, the provider will be notified of such decision in writing and given an opportunity to initiate a formal appeal.

Termination

You must give us notice to terminate as outlined in your contract with us and your active enrollees will be notified of that termination. We will also notify AHCA of the termination. In addition to all termination procedures listed in your contract, AHCA or UnitedHealthcare may request immediate termination of your contract if, after notice of non-compliance, you fail to come into compliance with the contract. You will have no additional right to appeal this termination outside the standard rights on termination.
Provider Complaint Process

Should you have a concern, complaint, inquiry, you may contact us through the Provider Toll-Free line at 800-791-9233 or by email at fl_ltc_network@uhc.com.

A Provider Relations representative will look into your issue and try to resolve it through informal discussions. If the outcome is not in your favor, you will be notified in writing within 30 days. If you disagree with the outcome of this discussion, an arbitration proceeding may be filed as described below and in your contract agreement. If your concern or complaint relates to a matter, which is generally administered by certain United Healthcare procedures, such as the credentialing or care-management process, we will follow the procedures set forth in those departments to resolve the concern or complaint. After following those procedures, if one of us remains dissatisfied, an arbitration proceeding may be filed as described below and in your agreement. If we have a concern or complaint about our agreement with you, we will send you a letter containing the details. If we can’t resolve the complaint through informal discussions with you, an arbitration proceeding may be filed as described below and in our agreement.

These processes may also be found at: UnitedHealthcareOnline.com and UHCCommunityPlan.com.

Arbitration

UnitedHealthcare will conduct any arbitration proceeding under your agreement under the auspices of the American Arbitration Association, as further described in our agreement. For more information on the American Arbitration Association guidelines, visit their website at www.adr.org. In the event that a customer has authorized you to appeal coverage determination on their behalf, that appeal will follow the appropriate government regulatory process governing customer appeals outlined in this manual.

Data Collection

UnitedHealthcare is required to maintain a health information system that collects, analyzes and integrates all data necessary to compile, evaluate and report certain statistical data related to costs, utilization and quality, and such other matters as AHCA may require from time to time. As a UnitedHealthcare contracted provider, you are required to submit all data necessary to fulfill these obligations in a timely manner. Providers are required to certify in writing at the time of submission to UnitedHealthcare or its designee, that all data including, but not limited to, encounter data and other information that AHCA may specify, is truthful, reliable, accurate and complete.

UnitedHealthcare is authorized to take whatever steps are necessary to ensure that the provider is recognized by the state Medicaid program, including its choice counseling/enrollment broker contractor(s) as a participating provider of the health plan and that the provider’s submission of encounter data is accepted by the Florida MMIS and/or the state’s encounter data warehouse.

Protect Confidentiality of Enrollee Data

UnitedHealthcare enrollees have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates that need that information to fulfill our obligations and to facilitate improvements to our enrollees’ health care experience. We require our affiliates and business partners to protect privacy and abide by privacy law. If an enrollee requests specific medical record information, we will refer the enrollee to you as the holder of the medical records. UnitedHealthcare requires that all providers comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for privacy and protection of enrollee data.

County Services Contact

Telephone Numbers

- To Report Domestic Violence, call 800-500-1119
- To Reach the Statewide Consumer Call Center, call 888-419-3456
- To Report Health Care Fraud, call 866-966-7226 or 850-414-3990.
- To reach your local Medicaid office, call 305-593-3000
- Healthy Mothers-Healthy Babies, call 954-765-0550
- Pregnancy Prevention Education, call 305-324-2400

Toll-Free Provider Help Line

- Provider Toll-Free Help Line, 800-791-9233
Care Management Model

The care management model is a clinically grounded, mission-driven model that focuses on optimizing the health and well-being of the UnitedHealthcare enrollee and builds upon existing community relationships. The following principles guide the direction and focus of care-management activities:

- Enrollees are at the center of all care decisions.
- Care and services should be provided in a variety of settings at differing levels of intensity.
- Care-management activities must emphasize the provision of the right services, at the right time, in the right place, for the right reason, and at the right cost.
- Care management guidelines and practices are built from evidence-based practices.

This unique innovative model utilizes advanced technology to improve communications and streamline day-to-day operations. The model incorporates health-risk screening, medical/social assessment, care planning and ongoing service-plan monitoring to identify and address enrollee needs. This model is founded upon principles for the care of geriatric, chronically ill and frail individuals.

Care managers (CM) will interface with the PCP, specialist, enrollee, and authorized representative on an ongoing basis. The CM will develop and implement the care plan in collaboration with the enrollee's care team, for example, scheduling appointments or arranging for home and community-based services (HCBS).

Other Provider and Subcontractor Responsibilities

Providers are required to comply with all sections of the contract agreement between UnitedHealthcare and the subcontractor. Requirements include but are not limited to:

- Provider credentialing requirements;
- Make available to all authorized state and federal oversight agencies and their agents to any and all administrative, financial, documentation records and data relating to the delivery of items or services for which Medicaid monies are expended. Access shall be during normal business hours except under special circumstances when AHCA and the Florida attorney general shall have after-hours admission;
- Adherence to the False Claim Act;
- Eligible for participation in the Medicaid Program, however, you are not required to participate in the Medicaid program as a provider. All providers will be assigned a Medicaid ID number for the purpose of reporting encounter data to AHCA;
- Adequate record system for recording services, charges, dates, and all other commonly accepted information elements for services rendered;
- HIPAA privacy and security provisions; and
- Cooperate with the care manager in providing services established in the enrollee care plan.

Initial Assessment

All UnitedHealthcare Long Term Care Medicaid Managed Care enrollees will receive initial and ongoing face-to-face care management assessments.

The care manager will develop and implement an individualized care plan for enrollees requiring services, review the enrollee's progress and adjust the care plan as necessary to ensure that the enrollee continues to receive an appropriate level of care. The care manager documents all of the orientation; health assessments, reassessment, and care plan findings in UnitedHealthcare’s care management system software program.

Enrollee Records

UnitedHealthcare will make use of the usual and customary protocols within the provider community by utilizing the enrollee records maintained by providers. These records will include enrollee’s diagnoses, medical conditions, medications, scheduled appointments, progress notes and services/treatments provided on behalf of the enrollee.

Confidentiality and accuracy of an enrollee’s record must be maintained at all times. UnitedHealthcare requires that all providers comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for privacy and protection of enrollee data. The privacy of any information that identifies a particular enrollee must be safeguarded. Information from or copies of an enrollee’s record may only be released to authorized individuals. Providers must ensure that unauthorized individuals cannot gain access to or alter an enrollee's record. Original records may only be released in accordance with state laws, court
orders or subpoenas, and timely access by enrollees to the information that pertains to them must be ensured. Additionally, providers and UnitedHealthcare must abide by all federal and state laws regarding confidentiality and disclosure of all enrollee records and information.

All records must be maintained for six years. Additionally, there must be prominent documentation in the record demonstrating whether or not a enrollee has executed an advance directive. UnitedHealthcare, AHCA, and any federal or state agency, and their designees, must have access to enrollee records.

Every enrollee must have an individual record which meets the following standards:

• Identifying information on the enrollee, including name, identification number, date of birth, sex, and legal guardianship (if applicable);
• The record is legible and maintained in detail;
• All entries are dated and signed;
• Reflect the primary language spoken by the enrollee
• Identify enrollees needing communication assistance in the delivery of care services;
• Contain documentation that the enrollee was provided written information concerning the enrollee’s rights regarding advanced directives (written instructions for living will or power of attorney), and whether or not the enrollee has executed an advance directive.
• The provider shall not, as a condition of treatment/services, require the enrollee to execute or waive an advance directive in accordance with section 765.110, F.S.
• Screening for domestic abuse and/or violence will be noted with an indication of referral to an appropriate agency is required, when appropriate.

**Access to Care Standards**

UnitedHealthcare Long Term Care Medicaid Managed Care is offered in a defined service area approved by the state of Florida Agency for Health Care Administration. Within the service area, UnitedHealthcare must offer a uniform benefit package and maintain a network of contracted providers to meet access standards. UnitedHealthcare must ensure that all covered services are available and accessible through UnitedHealthcare, and available 24 hours a day, seven days a week. UnitedHealthcare complies with the LTC provider qualifications and Network Adequacy Requirements established by AHCA in development of its provider network for the Long Term Care Managed Care plan.

UnitedHealthcare ensures that the hours of operation of contracted providers do not discriminate against the enrollee, and that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

Providers are contractually bound to provide appropriate assistance to enrollees that may have a limited English proficiency or reading skills. If the provider is unable to accommodate the enrollee, the provider must contact UnitedHealthcare for assistance by calling the Customer Service number in the ‘How to Reach Us’ section in this manual. A translation service using Language Line is available at the request of the enrollee or the provider.

**Meeting the needs of our enrollees out of network:** (Requires care management approval):

When an enrollee has service needs that cannot be met by in-network providers, UnitedHealthcare initiates a Letter of Agreement (LOA) with a provider so that service requirements can be met by out-of-network resources.

**Short-Term Intervention:** If contracted provider is not able to meet enrollee service requirements, we will use out-of-network providers through a LOA to ensure enrollee needs are met. Out-of-network providers are reimbursed at an in-network rate. Prior to implementation of the LOA process, we validate a provider’s licensure status and good standing with the state.

**Long-Term Intervention:** If a provider meets credentialing requirements, they can become a participating network provider (e.g., in-network), thereby expanding network options for services.

**Clinical Practice Guideline References**

Page 26 of 50 Document Number: LTC-B-N-8/13-8/31/18-227

As part of our quality improvement process, UnitedHealthcare adopts clinical practice guidelines that are based on valid and reliable clinical evidence. UnitedHealthcare reviews and updates the guidelines periodically as appropriate. Special emphasis is placed on the following conditions:

• Asthma
• Chronic obstructive pulmonary disease (COPD)
• Congestive heart failure (CHF)
• Diabetes
• Depression
• Human immunodeficiency virus (HIV)
• Pressure ulcers
Chapter 7. Health Services and Quality Improvement Programs

**Quality Improvement Enhancement**

The Quality Improvement program and committee monitors:

- Quality and appropriateness of care provided to enrollees including, but not limited to, review of quality of care and service concerns, grievances, enrollee rights, adverse events, enrollee safety and utilization review processes;
- Monitoring and evaluation of network quality including, but not limited to, credentialing and re-credentialing processes;
- Performance improvement projects;
- Performance measurement;
- Problem resolution and improvement approach and strategy;
- Annual program evaluation;
- Metrics for monitoring the quality and performance of participating providers related to their continued participation in the network;
- Approval of policies and procedures;
- Define and implement improvements in processes that enhance clinical efficiency, provide effective utilization and focus on improved outcome management achieving the highest level of success; and
- Define interventions that will best help manage the care and enrollee outcomes.

**Enrollee Bill of Rights**

The state must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Long Term Care Medicaid Managed Care plan and its providers or AHCA treat the enrollee.

We tell our customers they have the following rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you. These rights and responsibilities are reprinted from our customer handbook.

**Customers have the right to:**

- Receive information about UnitedHealthcare, our services and network providers in accordance with federal and state regulations;
- To be treated with respect and with due consideration for his or her dignity and privacy by UnitedHealthcare personnel, network physicians, and health care professionals as well as privacy and confidentiality for treatments, tests or procedures received;
- Voice concerns about the service and care they receive as well as register complaints and appeals concerning their health plan or the care provided to them and receive timely responses to their concerns;
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee’s condition and ability to understand, regardless of cost or benefit coverage;
- Participate with their doctor and other caregivers in decisions about their health care, including the right to refuse treatment;
- Be informed of, and refuse to participate in, any experimental treatment;
- Have coverage decisions and claims processed according to regulatory standards;
- Choose an advance directive to designate the kind of care they wish to receive should they be unable to express their wishes;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and
- Request and receive a copy of his or her records, and request that they be amended or corrected.

**Customers have the responsibility to:**

- Know and confirm their benefits before receiving services;
- Contact an appropriate health care professional when they have a medical need or concern;
- Show their identification card before receiving health care services;
- Verify that the provider they receive service from is in the UnitedHealthcare Long Term Care network;
- If applicable, pay any necessary copayment at the time they receive treatment;
- Provide information needed for their care;
- Follow the agreed upon instructions and guidelines of physicians and health care professionals; and
- Notify Customer Service of a change in address, family status or other coverage information.

UnitedHealthcare Long Term Care enrollees receive a complete list of their enrollee rights and responsibilities in their Enrollee Information Guide.
Sanctions

Upon written notification from AHCA – by letter or the lists published by the OIG and GAO – of a provider’s exclusion from original Medicare or Medicaid, UnitedHealthcare will send a letter to the provider stating the provider will be removed from the UnitedHealthcare list of contracted providers as of a given date. Except for post-stabilization, emergency and urgently needed care, no payments will be made to the provider after the exclusionary effective date. Enrollees are notified that the provider is no longer contracted and are advised to select a new provider.

Enrollees with claims pending for items or services from an excluded provider, or enrollees submitting claims for items or services from an excluded physician or provider for the first time will receive a letter notifying the enrollee of the following:

- The enrollee is accessing a sanctioned provider.
- Payments to a Medicare-Medicaid-excluded provider are prohibited.
- Payments will not be made for items or services rendered after the date of exclusion or after notification to the enrollee (whichever date is later).

Providers are also prohibited from employing or contracting with an individual who is excluded from participation in Medicaid, or with an entity that employs or contracts with such an individual, for the provision of services, utilization review, medical social work or administrative services.

Upon reinstatement by AHCA, the provider is responsible for notifying UnitedHealthcare and applying for reinstatement.

Surveys

AHCA requires an annual enrollee satisfaction survey. Enrollees will be polled to determine satisfaction with the care manager, customer service, network availability/service provision and enrollee materials. A survey or focus group may be conducted with enrollees that are non-English speaking, or have physical disabilities, or are part of a minority ethnic group.
Billing and Claims

When presenting a claim for payment to UnitedHealthcare, you are indicating an understanding that you have an affirmative duty to supervise the provision of, and be responsible for, the covered services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for UnitedHealthcare Long Term Care covered services determined medically necessary and that have actually been furnished to the recipient prior to submitting your claim.

At UnitedHealthcareOnline.com, you can:

• Check enrollee eligibility
• Check claims status
• Submit claims (HCFA 1500) electronically, for faster claims payment.

This website is a service provided free to participating network providers.

Electronic Claim Submission

In addition to UnitedHealthcareOnline.com, you can also submit electronic claims through the Electronic Data Interchange (EDI) using a claims clearinghouse.

For more information about EDI, contact your claims clearinghouse vendor or UnitedHealthcare at 800-842-1109.

Another option that is free for providers to use for the purpose of submitting claims is Office Ally: http://www.officeally.com/

For electronic claim submissions please use or have the clearinghouse use Payer ID 87726.

There may be costs associated with EDI submission. Please check with the clearinghouse for details.

Paper Claim Submission

For claims submitted via standard mail, claims should be completed on either a HCFA 1500 or UB04 claim form.

• Use a UB04 for facility or hospital claims
• Use a HCFA 1500 for physician and ancillary claims

Detailed directions for completing the HCFA 1500 and UB04 can be found in the Claims Submission Completion all required fields is included in the Claim Completion Requirements section.

Once the claims are completed accurately with all required information, mail paper claims to the claims address on the enrollee’s ID card, which is:

UnitedHealthcare
P.O. BOX 31362
Salt Lake City, UT 84131-0362

Please do not bill Medicaid directly.

Payment Information

It is UnitedHealthcare’s policy to encourage providers to submit claims for covered benefits as soon as possible and no later than the time frames set forth in your participation agreement.

Unless otherwise specified in your contract, UnitedHealthcare must receive all information necessary to process the claims no more than 90 days from the date of discharge from a facility; or 90 days from the date the services are rendered to the UnitedHealthcare Long Term Care enrollee. Any claims received after this time period may be rejected for payment, at UnitedHealthcare’s discretion.

UnitedHealthcare will pay claims for health services provided to an enrollee in accordance to the contractual agreement.

Enrollee Payment Liability

Participating providers must submit claims on the enrollee’s behalf and work directly with UnitedHealthcare for reimbursement. Enrollees should not be asked to submit claims for services rendered.

Providers cannot bill the enrollee for services provided if the provider fails to submit a claim. The enrollee cannot be balance billed for services covered under the contractual agreement at a pre-determined contracted rate.
If a claim is filed within the time period allowed under Medicaid the service is UnitedHealthcare’s liability, the claim must be paid by UnitedHealthcare even if the contract between AHCA and UnitedHealthcare is no longer in effect; or if the enrollee has dis-enrolled from UnitedHealthcare, provided that the enrollee was enrolled and effective at the time that the service(s) were rendered and that the service was a covered benefit through the UnitedHealthcare Long Term Care Plan.

Common Claim Administration Issues

Should you submit two identical claims for the same service on the same date (for the same enrollee), one will be denied as an “exact duplicate.”

The correct UnitedHealthcare enrollee ID number should be legible and included on the claim.

For HCFA 1500 claims, only valid procedure codes should be used. Consult your contract agreement payment appendix for approved codes to be provided for submitting claims for services provided.

For UB04 claims, only valid revenue codes must be used. Consult your contract agreement payment appendix for approved codes to be provided for submitting claims for services provided.

Claim Completion Requirements

Patient information required for each claim:

- Enrollee’s 16-digit UnitedHealthcare At-Home identification number (unique for each enrollee);
- Enrollee’s name – enter the enrollee’s last name, first name and middle initial, if any as shown on enrollee’s UnitedHealthcare ID card;
- Enrollee’s address;
- Enrollee’s birth date and sex;
- Enrollee’s authorization (signature on file); and
- Other health insurance coverage, if applicable.

Provider information required on each claim:

- Name of provider providing service;
- If applicable, must include provider DBA name;
- Seven-digit UnitedHealthcare number for provider who renders the service (unique for each provider);
- If applicable, name of the referring physician;
- Federal Tax ID Number; and
- Provider signature/date – for HCFA 1500 claims.

Service information required on each claim:

- Itemization of services;
- Date(s) of service;
- CPT/Revenue codes or HCPCS procedure code;
- ICD-10-CM diagnosis code and description specified to the fourth and fifth digit;
- Procedure code modifiers when applicable;
- Charges/total charges;
- Days or units;
- Service location – for HCFA 1500 claims; and
- Standard CMS site codes are required to indicate where services were rendered.

Guidelines for submitting claims:

- Claims should be submitted for only one enrollee and one provider per claim form.
- For HCFA 1500 claims, multiple visits rendered by a provider over several days should be itemized, by date of service. (See section on – How to Bill HCFA 1500.)
- For UB04 see section on – How to Bill UB04
- Modifiers are located at the beginning of each major section of CPT. The modifiers provide a means by which the definition of a particular service can be modified to better describe the circumstances of the service. When appropriate, the two-digit modifier should be used immediately following the five-digit procedure code. (Do not insert a space or a dash.)
Examples of reasons why claims would be returned:
Original claim submittals will be returned for any of the following reasons:

- Enrollee’s UnitedHealthcare ID number is invalid for date of service and/or missing
- Enrollee’s UnitedHealthcare At-Home ID number does not match enrollee name
- Bill type is missing
- ICD-10 diagnosis code is invalid and/or missing the fourth and fifth digit
- Revenue or CPT code is invalid and/or missing
- Claim was not submitted on appropriate form (i.e., HCFA 1500 or UB04)
- Date span for services requiring authorization does not match dates authorized

Claims Paid and/or Denied in Error
Claims receiving partial/incorrect payments or inappropriate denials must be resubmitted using the Adjustment Request Form. Failure to use the Adjustment Request Form may cause a delay in adjusting the claim.

Claims Denials
Claims denied for any inaccurate or missing information will be noted on the Provider Remittance Advice, see section for Remittance Advice included in this manual. The denied claims will be listed with a denial code. The denial code will identify the error that must be corrected prior to resubmitting the claim. The claim must be resubmitted noting Corrected Claim in the comments section to assure the claim will be reprocessed appropriately. For questions concerning the resubmission of claims, contact your local Provider Relations Advocate. Reference the ‘How to Reach Us Page’ for information on how to reach the Provider Relations Advocate.

Provider Claims Appeals
If you disagree with a claim payment determination, send a letter of appeal to the claim office at:

UnitedHealthcare
P.O. Box 31364
Salt Lake City, UT 84131

Your appeal must be submitted to us within 12 months from the date of payment shown on the EOB or PRA. If you are appealing a claim that was denied because filing was not timely, for:

- Electronic claims: include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim.

Paper claims: include a copy of a screen print from your accounting software to show the date you submitted the claim.

Providers are reimbursed according to their LTC contracted rates. If you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed as described in your agreement.

Overpayment

- If you receive an overpayment from UnitedHealthcare, you can return the original UnitedHealth Group/UnitedHealthcare check by mailing it to the local UnitedHealthcare office c/o Operations Manager with the reason for the return (See ‘How to Reach Us’ section).
- To properly credit any returned check or refund check please include a copy of the PRA with your correspondence.
- If you wish to mail a refund check to UnitedHealthcare on your own check stock paper, please mail it to:

UnitedHealth Group Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0804

Durable Medical Equipment (DME) Billing
Prior authorization is required for all DME products. If you are a supplier of DME products, please verify the appropriate billing source for your products. It is your responsibility to identify the skill level of the enrollee before the provision of services. This knowledge of the level of care provided will assure the appropriate party is billed for the services.

Filing Corrected Claims
1. If you are submitting corrected claims by mail: Complete the Adjustment Request Form below and submit the completed form along with required documentation to:

UnitedHealthcare
P.O. BOX 31362
Salt Lake City, UT 84131-0362

2. If you are submitting corrected claims online: Complete the required UnitedHealthcare Claim Reconsideration Request Form. Check the appropriate reason for submission and attach required documents.

Go to UnitedHealthcareOnline.com. Click on Claims and Payments > Choose 'Claim Reconsideration' > Log in to complete the process.
Single Paper Claim Reconsideration Request Form

This form is to be completed by physicians, hospitals or other health care professionals for paper Claim Reconsideration Requests for our members.

- Please submit a separate Claim Reconsideration Request form for each request.

**NOTE**
- No new claims should be submitted with this form.
- Do not use this form for formal appeals or disputes. Continue to use your standard appeals process for formal appeals or disputes.

Please refer to the attached Claim Reconsideration Reference Guide, your provider administrative manual or our provider website for additional details including where to send paper Claim Reconsideration Requests. You may verify the member’s address using the eligibility search function on the website listed on the member’s health care ID card.

- [ ] Physician
- [ ] Hospital
- [ ] Other Health Care Professional (Lab, Durable Medical Equipment (DME), etc.)

### Member Information

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Control / Claim #</th>
<th>Date of Service</th>
<th>Billed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Last Name</td>
<td>First Name</td>
<td>MI</td>
<td></td>
</tr>
<tr>
<td>Street Address</td>
<td>State</td>
<td>Zip</td>
<td></td>
</tr>
</tbody>
</table>

### Patient Information

<table>
<thead>
<tr>
<th>Patient Last Name</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

### Physician/Healthcare Professional Information

Tax Identification Number (TIN): ____________________________ Phone Number (with area code): ____________________________

Email Address: ____________________________

Physician or other Health Care Professional Name (as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB))

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

Facility/Group Name ____________________________ Contact Person ____________________________

Expected amount owed ____________________________ Contact Fax Number (with area code) ____________________________

### Reason for Request:

(More information on the definition reasons listed below and what documentation needs to be submitted can be found on the Claim Reconsideration Request definition sheet on UnitedHealthcareOnline.com)

- [ ] 1. Previously denied / closed as “Exceeds Filing Time”
- [ ] 2. Previously denied / closed for “Additional Information”
- [ ] 3. Previously denied / closed for “Coordination of Benefits” information
- [ ] 4. Resubmission of a corrected claim
- [ ] 5. Previously processed but rate applied incorrectly resulting in over/underpayment (Network Providers - check your fee schedules)
- [ ] 6. Resubmission of “Prior Notification Information”
- [ ] 7. Resubmission of a claim with “Bundled” services
- [ ] 8. Other (explain below)

Please include what you are expecting from UnitedHealthcare regarding this Claim Reconsideration Request to close this out in your practice management system, including dollar amount if possible.

Comments

### Required Attachments

- Copy of PRA or EOB
- Claim Form is **ONLY** required for Corrected Claims Submissions
- Other required attachments as listed above

You may have additional rights under individual state laws. Please review the provider website, your provider administrative guide or your provider agreement/contract if you need more information.

Doc#: PCA11850_20140312
How to Bill a UB04

This list contains the information required to process a claim on a UB04. Any missing/invalid data will result in the claim not being paid. Claim information must match authorization information.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Box Number</th>
<th>Description of Information to Provide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider's name and address</td>
<td>1</td>
<td>Name and billing address</td>
</tr>
<tr>
<td>Bill Type</td>
<td>4</td>
<td>3 digit type of bill</td>
</tr>
<tr>
<td>Federal Tax ID</td>
<td>5</td>
<td>Facility Federal Tax ID</td>
</tr>
<tr>
<td>Date of Service (start and end date)</td>
<td>6</td>
<td>From and to dates of services authorized</td>
</tr>
<tr>
<td>Enrollee Name</td>
<td>12</td>
<td>Enrollee's name</td>
</tr>
<tr>
<td>Enrollee Address</td>
<td>13</td>
<td>Nursing home address</td>
</tr>
<tr>
<td>Birth date</td>
<td>14</td>
<td>Enrollee's date of birth</td>
</tr>
<tr>
<td>Sex</td>
<td>15</td>
<td>Enrollee's gender</td>
</tr>
<tr>
<td>Revenue Code</td>
<td>42</td>
<td>Revenue Code as required by contract</td>
</tr>
<tr>
<td>Description</td>
<td>43</td>
<td>Write in Long Term Care or Respite # as authorized</td>
</tr>
<tr>
<td>HCPCS Rates</td>
<td>44</td>
<td>Rates as determined in contract</td>
</tr>
<tr>
<td>Service Date</td>
<td>45</td>
<td>Service dates</td>
</tr>
<tr>
<td>Service Units</td>
<td>46</td>
<td>The number of days at the specific level</td>
</tr>
<tr>
<td>Total Charges</td>
<td>47</td>
<td>Total dollars for service dates</td>
</tr>
<tr>
<td>Payer</td>
<td>50</td>
<td>UnitedHealthcare DO NOT BILL MEDICAID</td>
</tr>
<tr>
<td>Provider ID</td>
<td>51</td>
<td>Your UnitedHealthcare provider number</td>
</tr>
<tr>
<td>Enrollee ID</td>
<td>60</td>
<td>16-digit UnitedHealthcare At-Home Enrollee ID Number</td>
</tr>
<tr>
<td>Authorization number</td>
<td>63</td>
<td>Authorization number when required (optional)</td>
</tr>
<tr>
<td>Procedure Codes</td>
<td>67-81</td>
<td>ICD-10-CM diagnosis code and written diagnosis with fourth and fifth digit as required</td>
</tr>
<tr>
<td>Provider Name</td>
<td>82</td>
<td>Provider name and provider number</td>
</tr>
</tbody>
</table>
# How to Bill a HCFA 1500

This list contains the minimum amount of information required to process a claim on a HCFA 1500. Any missing/invalid data will result in the claim not being paid. Claim information must match authorization information.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Box Number</th>
<th>Description of Information to Provide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured ID number</td>
<td>1a</td>
<td>16-Digit Enrollee ID Number</td>
</tr>
<tr>
<td>Name</td>
<td>2</td>
<td>Enrollee name</td>
</tr>
<tr>
<td>Enrollee's Birth Date</td>
<td>3</td>
<td>Date of birth and gender</td>
</tr>
<tr>
<td>Enrollee's Address</td>
<td>5</td>
<td>Enrollee's address</td>
</tr>
<tr>
<td>Origin of enrollee's condition</td>
<td>10</td>
<td>Please select appropriate response (For Electronic claims only)</td>
</tr>
<tr>
<td>Enrollee's Authorization</td>
<td>12,13</td>
<td>Enrollee's authorization (signature on file)</td>
</tr>
<tr>
<td>Name of Referring Physician</td>
<td>17,17a</td>
<td>Provider name and provider number</td>
</tr>
<tr>
<td>Outside lab</td>
<td>20</td>
<td>Please select if you are an outside lab provider Yes or No (For Electronic claims only)</td>
</tr>
<tr>
<td>ICD-10-CM</td>
<td>21-24 e</td>
<td>ICD-10-CM diagnosis codes and written diagnosis. Include the fourth and fifth digit specificity as appropriate</td>
</tr>
<tr>
<td>Itemization of Services</td>
<td>24</td>
<td>Itemize the services provided to enrollee</td>
</tr>
<tr>
<td>Items a, b</td>
<td></td>
<td>Dates of service</td>
</tr>
<tr>
<td>Items c</td>
<td></td>
<td>Type of service (For Electronic claims only)</td>
</tr>
<tr>
<td>Items d</td>
<td></td>
<td>CPT or HCPCS codes, with modifier when applicable</td>
</tr>
<tr>
<td>Items e</td>
<td></td>
<td>ICD-10-CM Diagnosis Code- specific to the procedure with fourth and fifth digit specificity as appropriate</td>
</tr>
<tr>
<td>Items f</td>
<td></td>
<td>Charges</td>
</tr>
<tr>
<td>Items g</td>
<td></td>
<td>Days or units</td>
</tr>
<tr>
<td>Federal Tax ID number</td>
<td>25</td>
<td>Federal Tax ID number must match W9 submitted</td>
</tr>
<tr>
<td>Enrollee account number</td>
<td>26</td>
<td>Enrollee account number or last name (For Electronic claims only)</td>
</tr>
<tr>
<td>Accept Medicare Assignment</td>
<td>27</td>
<td>If applicable, should be yes</td>
</tr>
<tr>
<td>Total Charges</td>
<td>28</td>
<td>Total charges from column 24f</td>
</tr>
<tr>
<td>Physician Signature/Date</td>
<td>31</td>
<td>Provider signature and date</td>
</tr>
<tr>
<td>Facility information</td>
<td>32</td>
<td>Address where services were rendered</td>
</tr>
<tr>
<td>Provider Name, Address and ID</td>
<td>33</td>
<td>Provider name, payment address and seven-digit UnitedHealthcare number</td>
</tr>
</tbody>
</table>
Claim Submission Address

All paper claims must be submitted to:
UnitedHealthcare
P.O. BOX 31362
Salt Lake City, UT 84131-0362

Do not submit claims to Medicaid:
Claims submitted to Medicaid are denied and returned to you, delaying payment for services.

All electronic claims may be submitted using:
EDI: Through a clearinghouse using payer ID 87726*
Web: UnitedHealthcareOnline.com (HCFA 1500 claims only)

*Please see Billing and Claims section for additional information concerning electronic submission of claims.

Claims Forms Used

Physician claims.................................HCFA 1500
Ancillary claims.................................HCFA 1500
Facility claims........................................UB04

Provider Remittance Advice

A Provider Remittance Advice (PRA) is a summary of payments made on all claims processed. This statement is called an Explanation of Benefits (EOB) when it is sent to the UnitedHealthcare Long Term Care Plan enrollee. (An EOB is a statement sent to a covered person by the health plan listing services provided, amount billed, and the payment made. It is not a bill).

A PRA is issued for each unique provider number for which a claim was paid/denied.

A PRA is included with each check sent to a provider.

The PRA provides the information needed to accurately post the payments received.

See the PRA sample that follows in the next three pages.

What information can be found on a PRA?
The PRA is an enrollee-by-enrollee accounting of the amount billed, the amount disallowed (if any), as well as the amount paid. An amount disallowed is a denial for portions of the claimed amount. (Examples of amount disallowed: not-covered benefits or amounts over the fee maximum.)

Enrollees are listed alphabetically by last name and identified by provider’s own in-house account number if this information was included on the original claim at the time of submission.

UnitedHealthcare sends payment to the address listed in UnitedHealthcare’s claim processing system. The claim form address must match either the place of service or the billing address listed in UnitedHealthcare’s claims processing system in order for the claim to be processed in a timely manner.

Remittance Advice Key

1. CHECK DATE: The date the check was issued
2. CHECK NO: The number of the check that was generated
3. AMOUNT: The total amount of the check
4. TAX ID NO: Provider’s Federal Tax Identification number
5. PROVIDER/ALT PAYEE: The mailing name and address for the provider of alternate payee
6. PROV NO: 7-digit number identifying the provider
7. NAME: The name of the provider who performed the services
8. MEMBER: The name of the member receiving services
9. NUMBER: The 16 digit number for the member receiving services
10. ACCOUNT NO: Member’s account number assigned by the provider and submitted on the claim
11. ADJUSTMENT: The word “Adjustment” is displayed on a separate line above the claim number if the claim was modified from the original. In addition to the word “Adjustment”, the original payment date is displayed if the claim was paid on a previous check write
12. PCP NAME/NO: The member’s Primary Care Physician name and number displays when applicable
13. CLAIM NO: The audit number assigned to the claim
14. DOS: Date of service - date the service was performed
15. PROC: The code identifying the procedure/service provided
16. U: The number of units for each detail line
17. CLAIMED: The total amount claimed for the procedure performed
18. COPAY: Amount that the member is required to pay for services
19. DEDUCT: Amount of deductible specified under the member’s contract
20. **INELIG MEM:** Services that are not covered by the member’s policy and are member responsibility *(These are generally services not covered by Medicare)*

21. **INELIG PROV:** Services that are not covered and are the provider responsibility

22. **CODES:** Reason codes that define any claim adjustments, disallows or denials. The code explanations are listed on the last page or end of the PRA.

23. **DISCOUNT:** Amount of discount defined within a provider’s contract *(Difference between claimed amount and contract rate – YOU MUST WRITE THIS OFF)*

24. **AMOUNT PAID:** Net amount paid to the provider for services after all deductions have been taken

25. **CLAIM TOTAL:** The total dollars paid on the claim
**Provider Remittance Advice**

UNITEDHEALTHCAREINSURANCECOMPANY  
P.O. Box 1459  
Minneapolis, MN 55440-1459  
a member of the United HealthCare Corporation family of services

Sample Provider Medical Clinic  
123 Main Street  
Anytown, MN 55555

**UNITEDHEALTHCAREINSURANCECOMPANY**  
P.O. Box 1459  
Minneapolis, MN 55440-1459

**Sample Provider Medical Clinic**  
123 Main Street  
Anytown, MN 55555

**Member:** Doe, Jane  
**Number:** 10003-300030003-00  
**Account No.:** 403  
**UPIN No.:** Plz Submit

**ICD-10 DIAG.**  
**43401 PCP NO.**

<table>
<thead>
<tr>
<th>DOS</th>
<th>PROC</th>
<th>U</th>
<th>CLAIMED COPAY</th>
<th>DEDUCT</th>
<th>Inelig-mem</th>
<th>Inelig-prov</th>
<th>Code</th>
<th>Discount</th>
<th>Withhold</th>
<th>Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/17/97</td>
<td>99312</td>
<td>01</td>
<td>100.00</td>
<td>20.00</td>
<td>35.73</td>
<td>32</td>
<td>9.64</td>
<td>34.63</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CLAIM TOTAL:**  
100.00  
20.00  
35.73  
34.63

**The Above Totals are included in Check#7779299**

**Ref #: 0858**  
**MSP B10.001**

**CHECK NO.: 7779295**  
**AMOUNT:** $34.63

**TAXID NO.: 460789999**

**PROVNO. 01-99999**  
**NAME:** Sample Provider Medical Clinic  
**UPIN NO.:** Plz Submit  
**Plz Submit**

**CHECK DATE:** 05/13/1997  
**Ref #: 0858**  
**MSP B10.001**  
**CHECK NO.: 7779295**  
**AMOUNT:** $34.63  
**TAXID NO.: 460789999**

**PROVNO. 01-99999**  
**NAME:** Sample Provider Medical Clinic  
**UPIN NO.:** Plz Submit  
**Plz Submit**

**CHECK DATE:** 05/13/1997  
**Ref #: 0858**  
**MSP B10.001**  
**CHECK NO.: 7779295**  
**AMOUNT:** $34.63  
**TAXID NO.: 460789999**
### PROVIDER REMITTANCE ADVICE

<table>
<thead>
<tr>
<th>CODE DESCRIPTIONS</th>
<th>CHECK DATE</th>
<th>REF #</th>
<th>MSP BR1500</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVNO. 01-99999</td>
<td>01/23/1997</td>
<td>1126</td>
<td>BR1500</td>
</tr>
</tbody>
</table>

| NAME | GERIATRIC PHYSICIANS ASSOCIATES, Inc. |

**INELIGIBLE EXPLANATION CODES**

32  CHARGES EXCEED FEE SCHEDULE
Provider Risk Arrangements

UnitedHealthcare is required to disclose their provider incentive arrangements to AHCA on request. The purpose of this disclosure is to allow AHCA to monitor those entities that hold their providers at “substantial financial risk.”

In addition, UnitedHealthcare is required to disclose to current and potential enrollees upon request information regarding provider incentive arrangements. Disclosed information will describe the Plan’s arrangements in general, but will not disclose incentive arrangements specific to any provider.

Your cooperation is necessary for UnitedHealthcare to comply with these AHCA requirements. Please respond promptly to our requests for information as required.

Coordination of Benefits

UnitedHealthcare is the primary payer, except in case of:

- Enrollees who have Medicare benefits
- Workers’ compensation insurance
- Black lung benefits
- Automobile medical insurance
- No fault insurance
- Any liability insurance
- All other insurance coverage determined to be primary payer source for covered benefits

The enrollee may receive a request from UnitedHealthcare for information about other insurance he/she may have. If the enrollee has other insurance, UnitedHealthcare may require that the enrollee assist in obtaining payment and/or payment information from the other insurer. Deductibles and copayments will not be applied to balances remaining after the primary carrier’s payment. In no event will payment exceed 100 percent of billed charges or possible amount required by state regulation, after the primary carrier and UnitedHealthcare have reached final claim disposition.
Chapter 9: Appeals and Grievances

Enrollee Appeals and Grievances

Grievance Process

If an enrollee has a concern or question regarding care or coverage under the plan, he/she should contact the Customer Service department at the toll-free number on the back of their identification card, Monday through Friday. A Customer Service representative will answer questions or concerns. The representative will try to resolve the problem. If the Customer Service representative does not resolve the problem to the enrollee’s satisfaction, he/she has the right to file a grievance.

The enrollee may file a grievance in writing or by phone. It must be filed within one year from the date of the concern. It may be filed by you, with the enrollee’s written consent. A grievance may be filed about such things as the quality of the care the enrollee receives from the Plan or a provider, rudeness from a Plan employee or a provider’s employee, a lack of respect for their rights by the Plan or a provider or anything else the enrollee may be dissatisfied with.

To file, you or the enrollee may call Customer Service at 800-791-9233 or TDD 771

Or write to:

Appeals and Grievances
National Service Center
P.O. Box 25557
Tampa, Florida 33622-5557

Or fax to: 877-275-6030 (Office hours from 8 a.m. to 5 p.m., Monday through Friday)

The Plan will send the enrollee a letter when the Plan receives the grievance. The Plan will send a decision letter usually within 60 days of receiving the request. In some cases, the Plan may need to ask for more information. Then it may take up to 90 days to issue a resolution letter.

It will not take longer than 90 days. If the enrollee wants a Grievance Committee Hearing, he/she or their provider, with the enrollee’s written permission, may ask for it within 90 days after they receive the Plan’s decision.

If the enrollee needs assistance in filing his/her grievance or need the help of an interpreter, they may call the Customer Service number: Toll-free 800-791-9233 or the TDD 771

The interpreter services are free.

If the enrollee needs more time to get information, he/she may get up to 14 days more. If the Plan needs more time, it will tell the enrollee why in writing.

The enrollee may also ask for a Medicaid Fair Hearing. The enrollee or his/her provider with the enrollee’s written permission, may ask for a hearing. To ask for a hearing write to:

Office of Appeals Hearings
1317 Winewood Boulevard, Building 5 # 203
Tallahassee, Florida 32399-0700

If the enrollee does not agree with UnitedHealthcare’s decision and he/she has not had a Medicaid Fair Hearing, they may ask for review by the Beneficiary Assistance Program (BAP). The enrollee has 365 days after the decision to ask for a review.

To ask for a review he/she may call: 850-412-4502

Or write to:

Agency for Health Care Administration
Bureau of Managed Health Care
2727 Mahan Drive, Building 1, # 339
Tallahassee, Florida 32308

Appeals Process

If UnitedHealthcare decides to reduce, put on hold or stop a service the enrollee is receiving he/she will get a written “Notice of Action” at least 10 days before the action takes place. If the enrollee does not agree, they may file an appeal. Or, they may have their provider file with the enrollee’s written consent.

Standard Appeal

A Standard Appeal asks UnitedHealthcare Medicaid Long Term Care Plan to review a decision about the enrollee’s care. The enrollee must file an appeal within 30 days after he/she gets notice of action. If the enrollee does not get a written notice from UnitedHealthcare, the enrollee has one year to file an appeal.

The enrollee can ask their doctor, a family enrollee or friend to file the appeal for them. If someone helps the enrollee file an appeal, that person must be the enrollee’s “authorized representative.”
Chapter 9. Appeals and Grievances

To file an appeal, the enrollee or representative may fax a letter to: 877-275-6030 (Office hours from 8 a.m. to 5 p.m., Monday through Friday)

Or mail to:
Appeals and Grievances
National Service Center
P.O. Box 25557
Tampa, Florida 33622-5557

Or call 1-800-791-9233 or TDD 1-888-685-8480

The enrollee may also ask for a Medicaid Fair Hearing. The enrollee or his/her provider may ask with the enrollee’s written consent. To ask for a hearing the enrollee may write to:
Office of Appeals Hearings
1317 Winewood Boulevard, Building 5 # 203
Tallahassee, Florida 32399-0700

If the enrollee does not agree with UnitedHealthcare’ s decision and he/she did not have a Medicaid Fair Hearing, he/she may ask for review by the Beneficiary Assistance Program (BAP). The enrollee has 365 days after the decision to ask for a review. To ask for a review, the enrollee may:

Call 850-412-4502 or 888-419-3456 (toll-free)

Or write to:
Agency for Health Care Administration
Bureau of Managed Health Care
2727 Mahan Drive, Building 1, # 339
Tallahassee, Florida 32308

If the enrollee calls, he/she must also send the appeal in writing. The review begins the day the Plan receives the request. The Plan will send a written notice to the enrollee within five days. UnitedHealthcare has 45 days to look at the case. The Plan will send the enrollee a letter with the decision, explaining how the Plan made our decision.

The Plan indicates the laws or health plan policies reviewed to decide the case. Before the Plan makes a decision, the enrollee and/or the person helping the enrollee with the appeal can give information to UnitedHealthcare. The new information can be in writing or in person. The enrollee and his/her representative may look at the case file. The enrollee’s estate representative may review the file after the enrollee’s death. The file may have medical records or other papers. The enrollee can review his/her file any time while the Plan is reviewing the appeal.

If the enrollee needs more time to get information, he/she may have it. The enrollee or the plan can request up to 14 calendar days. If the Plan asks for more time, it will send a letter informing the enrollee why the Plan needs the extra time. The enrollee may also ask for a Medicaid Fair Hearing while waiting for a decision from UnitedHealthcare or within 90 days of the notice of action. The enrollee or a provider acting on the enrollee’s behalf and with the enrollee’s written consent may request a hearing.

To request a Medicaid Fair Hearing, the enrollee should send a letter to:
Office Appeals Hearings
1317 Winewood Boulevard, Building 5 # 203
Tallahassee, Florida 32399-0700

A enrollee may continue to receive services while waiting for the Plan’s decision if all of the following apply:
- The appeal is filed on or before the effective date of the “action”;
- The appeal is related to reduction, suspension or termination of previously authorized services;
- The services were ordered by an authorized provider;
- The authorization has not ended, and
- The enrollee requested the services to continue.

The enrollee’s services may continue until one of the following happens:
- The enrollee decides not to continue the appeal.
- Ten days have passed or 15 if the request is sent by mail, from the date of the Notice of Action and the enrollee has requested a Medicaid Fair Hearing but did not request continuation of services.
- The time covered by the authorization is ended or the limitations on the services are met.

The enrollee may have to pay for the continued services if the final decision from the Medicaid Fair Hearing is against them.

If the Medicaid Fair Hearing agrees with the enrollee, UnitedHealthcare will pay for the services received while waiting for the decision.

If the Medicaid Fair Hearing decision agrees with the enrollee and he/she did not continue to get the services while waiting for the decision, UnitedHealthcare will issue an authorization for the services to restart as soon as possible and the Plan will pay for the services.
Chapter 9. Appeals and Grievances

If the enrollee does not agree with UnitedHealthcare’s decision and he/she did not have a Medicaid Fair Hearing, the enrollee may request a review by the Beneficiary Assistance Program (BAP).

He/she has 365 days from the decision date to ask for a review. To ask for a review, the enrollee may call;

Call 850-412-4502 or 888-419-3456 (toll-free)

Or write to:
Agency for Health Care Administration
Bureau of Managed Health Care
2727 Mahan Drive, Building 1, # 339
Tallahassee, Florida 32308

If the decision from UnitedHealthcare, the Medicaid Fair Hearing or the Subscriber Panel is in the enrollee’s favor and the services were not continued during the reviews, UnitedHealthcare will start the services and pay for them.

**Expedited Appeal**

An enrollee or their representative, with the enrollee’s written consent, can request an Expedited Appeal. Expedited Appeals are for health care services, not denied claims.

To ask for an Expedited Appeal, the enrollee or their representative may call: **800-595-9532**.

The new information can be in writing or in person. The Plan will send a written decision within 72 hours.

If the enrollee needs more time to get information, he/she may ask for up to 14 more days. If the plan asks for more time, the Plan will let the enrollee know why in writing.

If the Plan determines that taking more time to decide an appeal will be harmful to the enrollee, the Plan will notify the enrollee of the decision by phone and in writing within two days.
Chapter 10: Fraud and Abuse

Fraud and Abuse Reporting

To support suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hot-line toll-free at 888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form which is available online at: https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

If you report suspected Fraud and your report results in a fine, penalty or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General’s Fraud Award Program (toll-free 866-866-7226 or 850-414-3990). The reward may be up to 25 percent of the amount recovered, or a maximum of $500,000 per case (Florida Statutes Chapter 409.9203). You can talk to the Attorney General’s office about keeping your identity confidential and protected.
Chapter 11: Comments

Comments

UnitedHealthcare welcomes your comments and suggestions about this manual. If you need information about the material covered in this manual or expansion on topics not addressed or if you find incorrect or inaccurate information, please complete this form, and mail to:

UnitedHealthcare Community Plan
Provider Relations
3100 SW 145th Avenue -- 2nd Floor
Miramar, FL 33027

Comments and Recommendations

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please provide the following information so we can contact you if we need to clarify your request.

Name:____________________________________________________________________

Address:_________________________________________________________________

Phone:___________________________________________________________________