



UnitedHealthcare Connected for MyCare Ohio

Physician, Health Care Professional, Facility and Ancillary

providermanual

Table of Contents

• Chapter 1: Introduction	5
• Welcome	5
• Background	5
• Contacting UnitedHealthcare Connected	5
• UnitedHealthcare Connected Network	6
• Participating Providers	6
• Quick Reference Guide	7
• Chapter 2: Covered Services for Medicare/Medicaid Members	8
• Understanding Our Covered Services	8
• Our Plan Does Not Allow Providers to Charge You for Services	8
• About the Benefits Chart	8
• Preventive Visits	9
• Preventive Services and Screenings	10
• Other Services	12
• Accessing Services When the Member is Away From Home or Outside of the Service Area	25
• Benefits Not Covered by the Plan	25
• Covered Services for Medicaid Only	25
• Services That DO NOT Require an Okay	27
• Services That Do Require an Okay	27
• Services That MAY Require an Okay	28
• Non-Covered Services	28
• Chapter 3: Provider Responsibilities	29
• General Provider Responsibilities	29
• Member Eligibility and Enrollment	29
• Member ID Card	30
• Chapter 4: Long Term Services and Support	31
• Long Term Services and Support (LTSS)	31
• Primary Care Provider Member Assignment	34
• Verifying Member Enrollment	34
• Coordinating 24-Hour Coverage	34

• Chapter 5: Claims Process/Coordination of Benefits/Claims	35
• Claims Submission Requirements	35
• Balance Billing	36
• Chapter 6: Medical Management, Quality Improvement and Utilization Review Programs	37
• Referrals and Prior Authorization	37
• Primary Care Provider Referral Responsibilities	38
• Specialist Referral Guidelines	38
• Services Requiring Prior Authorization	38
• Requesting Prior Authorization	38
• Denial of Requests for Prior Authorization	39
• Pre-Admission Authorization	39
• Concurrent Hospital Review	39
• Discharge Planning	39
• Outpatient Services Review	39
• Second Medical or Surgical Opinion	39
• Medical Criteria	40
• Care Management	40
• Evidence Based Medicine/Clinical Practice Guidelines	41
• Provider Responsibility With Termination of Services-Notification of Medicare Non-Coverage	41
• Chapter 7: Provider Performance Standards and Compliance Obligation	43
• Provider Evaluation	43
• Provider Compliance to Standards of Care	43
• Compliance Process	43
• Laws Regarding Federal Funds	44
• Marketing	44
• Sanctions Under Federal Health Programs and State Law	44
• Selection and Retention of Participating Providers	44
• Notification of Members of Provider Termination	44

• Chapter 8: Medical Records	45
• Medical Record Review	45
• Standards for Medical Records	45
• Confidentiality of Member Information	45
• Member Record Retention	45
• Chapter 9: Reporting Obligations	46
• Cooperation in Meeting the Centers for Medicaid and Medicare Services (CMS) Requirements	46
• Certification of Diagnostic Data	46
• Risk Adjustment Data	46
• Chapter 10: Initial Decisions, Appeals and Grievances	47
• Initial Decisions	47
• Appeals and Grievances	47
• Resolving Appeals	47
• Resolving Grievances	48
• Further Appeal Rights	48
• Chapter 11: Members' Rights and Responsibilities	49
• Timely Quality Care	49
• Treatment With Dignity and Respect	49
• Member Satisfaction	49
• Member Responsibilities	49
• Services Provided in a Culturally Competent Manner	50
• Member Complaints/Grievances	50
• Chapter 12: Access to Care/Appointment Availability	51
• Member Access to Health Care Guidelines	51
• Provider Availability	51
• Physician Office Confidentiality Statement	51
• Transfer and Termination of Members From Participating Physician's Panel	51
• Closing of Provider Panel	51
• Prohibition Against Discrimination	51
• Chapter 13: Compliance	52
• Integrity and Compliance	52
• Fraud and Abuse	52
• Resolving Disputes	54



• Chapter 14: Prescription Benefits	55
• Network Pharmacies	55
• Formulary	55
• Drug Management Programs (Utilization Management)	56
• Chapter 15: Behavioral Health	57
• Screening for Behavioral Health Problems	57
• Role of the Behavioral Health Unit	57
• Behavioral Health Emergencies	57
• Referrals for Behavioral Health Services	57
• Behavioral Health Guidelines and Standards	57
• Appendix	58
• Glossary of Terms	61

Chapter 1: Introduction

Welcome

Welcome to UnitedHealthcare Connected for MyCare Ohio (Medicare-Medicaid Plan). UnitedHealthcare Connected is offered by the UnitedHealthcare Community Plan of Ohio. We recognize that quality providers are the key to delivering quality health care to members. In order to better assist providers, UnitedHealthcare Connected for MyCare Ohio has provided this manual as a resource to answer questions regarding care for enrolled members.

Our goal is to assist providers in ensuring that our members receive the highest quality health care. This provider manual explains the policies and procedures of the UnitedHealthcare Connected network. We hope it provides you and your office staff with helpful information and guide you in making the best decisions for your patients.

Background

UnitedHealthcare Connected for MyCare Ohio serves members who are dually eligible for Medicare and Medicaid within the UnitedHealthcare Connected Service area. Members of UnitedHealthcare Connected must be eligible and enrolled in Medicare Part A, Medicare Part B, and Ohio Medicaid.

UnitedHealthcare Connected is currently available in Columbiana, Cuyahoga, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, Trumbull and Wayne Counties.

Contacting UnitedHealthcare Connected for MyCare Ohio

UnitedHealthcare Connected for MyCare Ohio manages a comprehensive provider network. The network includes health care professionals such as primary care physicians, specialist physicians, medical facilities, allied health professionals, home and community based service providers and ancillary service providers.

UnitedHealthcare Connected for MyCare Ohio offers several options to support providers who require assistance.

Provider Service Center

This is the primary point of contact for providers who require assistance. The Provider Service Center is staffed with Provider Service Representatives trained specifically for UnitedHealthcare Connected for MyCare Ohio. The Provider Service Center can assist you with questions on benefits, eligibility, claims resolution, forms required to report specific services, billing questions, etc.



They can be reached at **800-600-9007**, 8 a.m. to 5 p.m., Monday through Friday to meet your needs. The Provider Service Center works closely with all UnitedHealthcare Connected departments. Provider Services: **800-600-9007**

UnitedHealthcareOnline.com

The web-based provider portal offers the convenience of online support 24 hours a day, 7 days a week. This site was developed specifically with the providers in mind allowing for personal support. On the Provider Portal, providers can verify member eligibility, check claim status, submit claims, request an adjustment, review a remittance advice, submit prior authorization requests or review a member roster.



To access the Provider website, go to **UnitedHealthcareOnline.com > For Healthcare Professionals > Claims and Member Information**. Follow the instructions for obtaining a user ID. You will receive your user ID and password within 48 hours.

UnitedHealthcare Connected for MyCare Ohio Roster

Primary Care Physicians can get a roster of all assigned members on the provider portal. Primary Care Physicians should use this to determine if they are responsible for providing primary care to a particular member.



Rosters can be viewed electronically on the provider portal at **UnitedHealthcareOnline.com**.

UnitedHealthcare Connected for MyCare Ohio

UnitedHealthcare Connected for MyCare Ohio maintains and monitors a network of Participating Providers including physicians, hospitals, skilled and non-skilled nursing facilities, ancillary providers, home and community-based providers and other health care providers through which members obtain covered services.

Members using UnitedHealthcare Connected for MyCare Ohio must choose a Primary Care Physician to coordinate their care. Primary Care Physicians are the basis of the managed care philosophy. UnitedHealthcare Connected for MyCare Ohio works with contracted Primary Care Physicians who help manage the health care needs of members and arrange for medically necessary covered medical services. Providers may, at any time, advocate on behalf of the member without restriction in order to ensure the best care possible for the member. To ensure coordination of care, members must coordinate with their Primary Care Physicians before seeking care from a specialist, except in the case of specified services (such as women's routine preventive health services, routine dental, routine vision, and behavioral health). Contracted health care professionals are required to coordinate member care within the UnitedHealthcare Connected provider network. If possible, all member referrals should be directed to UnitedHealthcare Connected contracted providers. Referrals outside of the network are permitted, but only with prior authorization from UnitedHealthcare Connected.

The referral and prior authorization procedures explained in this manual are particularly important to the UnitedHealthcare Connected program. Understanding and adhering to these procedures are essential for successful participation as a UnitedHealthcare Connected provider.

Occasionally UnitedHealthcare Connected will distribute communication documents on administrative issues and general information of interest regarding UnitedHealthcare Connected to you and your office staff. It is very important that you and/or your office staff read the newsletters and other special mailings and retain them with this provider manual, so you can incorporate the changes into your practice.

Participating Providers

Primary Care Physicians

UnitedHealthcare Connected contracts with certain physicians/providers that members may choose to coordinate their health care needs. These physicians/providers are known as Primary Care Physicians/Providers. The Primary Care Physician is responsible for providing or requesting authorization for covered services for members of UnitedHealthcare Connected. Primary Care Physicians are generally physicians of internal medicine, pediatrics, family practice or general practice. However, they may also be other provider types, who accept and assume primary care provider roles and responsibilities. All members must select a Primary Care Physician when they enroll in UnitedHealthcare Connected and may change their designated Primary Care Physician once a month. If you don't select a primary care physician, UnitedHealthcare may assign one to you.

Specialists

A specialist is any licensed Participating Provider who provides specialty medical services to members. A Primary Care Physician may refer a member to a specialist as medically necessary.

Quick Reference Guide

Resource	Uses	Contact Information
UnitedHealthcareOnline.com	Verify member eligibility, check claim status, submit claims, request adjustment, review remits, review member rosters, submit requests for prior authorizations.	UnitedHealthcareOnline.com
Provider Service Center	8 a.m. to 5 p.m., 5 days a week Verify eligibility, claim inquiries, benefit questions, form requests.	800-600-9007
Member Services	Available 24/7 Verify network primary care physicians and pharmacies and receive information about drug formulary matters.	877-542-9236 TTY 711
Prior Authorization – Medical	Notify us of medical services that need prior authorization.	800-366-7304
Prior Authorization – Pharmacy	Notify us of pharmacy services that need prior authorization.	800-711-4555

Chapter 2: Covered Services for Medicare/Medicaid Members

Understanding Our Covered Services

This chapter tells you what services UnitedHealthcare Connected covers, how to access services, and if there are any limits on services. You can also learn about services that are not covered.

Because members get assistance from Medicaid, they generally pay nothing for the covered services explained in this chapter as long as they follow the plan's rules. However, members may be responsible for paying a "patient liability" for nursing facility or waiver services that are covered through their Medicaid benefit. The County Department of Job and Family Services will determine if a member's income and certain expenses require you to have a patient liability.

Our Plan Does Not Allow Providers to Charge You for Services

Except as indicated above, you are not allowed to bill a member for covered services. As a provider, we pay you directly.

About the Benefits Chart

The following Benefits Chart is a general list of services the plan covers. It lists preventive services first and then categories of other services in alphabetical order. It also explains the covered services, how to access the services, and if there are any limits or restrictions on the services.

We will cover the services listed in the Benefits Chart only when the following rules are met:

- Your Medicare and Medicaid covered services must be provided according to the rules set by Medicare and Ohio Medicaid.
- The services (including medical care, services, supplies, equipment, and drugs) must be a plan benefit and must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition.
 - If UnitedHealthcare Connected makes a decision that a service is not medically necessary or not covered, a member or someone authorized to act on your behalf may file an appeal.

- Members must get their care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider.
- Members have a primary care provider (PCP) or a care team that is providing and managing your care.
- Some of the services listed in the Benefits Chart are covered only if the provider or other network provider gets approval from us first. This is called prior authorization. Also, some of the services listed in the Benefits Chart are covered only if the provider or other network provider writes an order or a prescription for you to receive the service.

Members do not pay anything for the services listed in the Benefits Chart, as long as they meet the coverage requirements described above. The only exception is if a member has a patient liability for nursing facility services or waiver services as determined by the County Department of Job and Family Services.

The Benefits Chart

Preventive Visits

Services covered by our plan	Limitations and expectations
<p>Annual checkup</p> <p>This is a visit to make or update a prevention plan based on your current risk factors. Annual checkups are covered once every 12 months.</p> <p>Note: Members cannot have their first annual checkup within 12 months of their “Welcome to Medicare” preventive visit. They will be covered for annual checkups after they have had Part B for 12 months. Members do not need to have had a “Welcome to Medicare”</p>	
<p>“Welcome to Medicare” visit</p> <p>If a member has been in Medicare Part B for 12 months or less, they can get a one-time “Welcome to Medicare” preventive visit. When a member makes their appointment, they tell the provider they want to schedule their “Welcome to Medicare” preventive visit. This visit includes:</p> <ul style="list-style-type: none"> • a review of a member’s health, • education and counseling about the preventive services a member needs (including screenings and shots), and • referrals for other care if it is needed. 	
<p>Well child check-up (also known as Healthchek)</p> <p>Healthchek is Ohio’s early and periodic screening, diagnostic, and treatment (EPSDT) benefit for everyone in Medicaid from birth to under 21 years of age. Healthchek covers medical, vision, dental, hearing, nutritional, development, and mental health exams. It also includes immunizations, health education, and laboratory tests.</p>	

Preventative Services and Screenings

Services covered by our plan	Limitations and expectations
<p>Abdominal aortic aneurysm screening</p> <p>The plan covers abdominal aortic aneurysm ultrasound screenings if you are at risk.</p>	
<p>Alcohol misuse screening and counseling</p> <p>The plan covers alcohol-misuse screenings for adults. This includes pregnant women. If a member screens positive for alcohol misuse, they can get face-to-face counseling sessions with a qualified primary care provider or practitioner.</p>	
<p>Bone Mass measurements</p> <p>The plan covers certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. The plan will also cover a doctor looking at and commenting on the results.</p>	
<p>Breast cancer screening</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Women under the age of 35 who are at high risk for developing breast cancer may also be eligible for mammograms • Annual clinical breast exams 	
<p>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</p> <p>The plan covers visits with a primary care provider to help lower your risk for heart disease. During this visit, a provider may:</p> <ul style="list-style-type: none"> • discuss aspirin use, • check a member’s blood pressure, or • give a member tips to make sure they are eating well. 	
<p>Cardiovascular (heart) disease testing</p> <p>The plan covers blood tests to check for cardiovascular disease. These blood tests also check for defects due to high risk of heart disease.</p>	
<p>Cervical and vaginal cancer screening</p> <p>The plan covers pap tests and pelvic exams annually for all women.</p>	

Services covered by our plan	Limitations and expectations
<p>Colorectal cancer screening</p> <p>For people 50 and older or at high risk of colorectal cancer, the plan covers:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema) • Fecal occult blood test • Screening colonoscopy <p>For people not at high risk of colorectal cancer, the plan will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).</p>	
<p>Counseling to stop smoking or tobacco use</p> <p>The plan covers tobacco cessation counseling.</p> <p>As a preventive service, the plan covers counseling on attempts to quit by your PCP as well as the Tobacco Quitline.</p> <p>You can call 800-QUITNOW or 800-784-8669 at any time.</p>	
<p>Depression screening</p> <p>The plan covers depression screening.</p>	
<p>Diabetes screening</p> <p>The plan covers diabetes screening (includes fasting glucose tests). Provider should speak to the member if they have any history of the following: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, family history of diabetes, or history of high blood sugar (glucose).</p>	
<p>HIV screening</p> <p>The plan covers HIV screening exams for people who ask for an HIV screening test or are at increased risk for HIV infection.</p>	
<p>Immunizations</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Vaccines for children under age 21 • Pneumonia vaccine • Flu shots, once a year, in the fall or winter • Hepatitis B vaccine if a member is at high or intermediate risk of getting hepatitis B • Other vaccines if a member is at risk and they meet Medicare Part B or Medicaid coverage rules • Other vaccines that meet the Medicare Part D coverage rules. 	
<p>Obesity screening and therapy to keep weight down</p> <p>The plan covers counseling to help members lose weight. Members should talk to their primary care provider to find out more.</p>	<p>Members must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan.</p>

Services covered by our plan	Limitations and expectations
<p>Prostate cancer screening</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • A digital rectal exam • A prostate specific antigen (PSA) test 	
<p>Sexually transmitted infections (STIs) screening and counseling</p> <p>The plan covers screenings for sexually transmitted infections, including but not limited to chlamydia, gonorrhea, syphilis, and hepatitis B.</p> <p>The plan also covers face-to-face, high-intensity behavioral counseling sessions for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long.</p>	<p>A primary care provider must order the tests.</p> <p>The plan covers these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.</p>

Other Services

Services covered by our plan	Limitations and expectations
<p>Ambulance and wheelchair van services</p> <p>Covered emergency ambulance transport services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take a member to the nearest place that can give them care. A member's condition must be serious enough that other ways of getting to a place of care could risk their life, or if they are pregnant, their unborn baby's life or health.</p> <p>In cases that are not emergencies, ambulance or wheelchair van transport services are covered when medically necessary.</p>	<p>Prior authorization is required for ambulance services in cases that are not emergencies.</p>
<p>Chiropractic services</p> <p>The plan covers:</p> <ul style="list-style-type: none"> • Diagnostic X-rays • Adjustments of the spine to correct alignment 	<p>Prior authorization is needed after 15 visits for those under 21. For members over age 21 the calendar year limit is 15 visits.</p>
<p>Dental services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Oral exam once every six months • Preventive services including prophylaxis, fluoride, sealants, and space maintainers • Routine radiographs/diagnostic imaging • Comprehensive dental services including non-routine diagnostic, restorative, endodontic, periodontic, prosthodontic, orthodontic, and surgery services 	

Services covered by our plan	Limitations and expectations
<p>Diabetic services</p> <p>The plan covers the following services for all people who have diabetes (whether they use insulin or not):</p> <ul style="list-style-type: none"> • Training to manage your diabetes, in some cases • Supplies to monitor your blood glucose, including: <ul style="list-style-type: none"> – Blood glucose monitors and test strips – Lancet devices and lancets – Glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease: <ul style="list-style-type: none"> – One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, or – One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) <p>The plan also covers fitting the therapeutic custom-molded shoes or depth shoes. The plan covers training to help members manage their diabetes at ADA</p>	
<p>Durable medical equipment and related supplies</p> <p>Covered durable medical equipment includes, but is not limited to, the following:</p> <ul style="list-style-type: none"> • Wheelchairs • Oxygen and respiratory therapy equipment • Canes, crutches, and walkers • IV infusion pumps • Hospital beds • Commodes • Nebulizers • Incontinence garments • Enteral nutritional products • Ostomy and urological supplies • Surgical dressings and related supplies • Incontinence garments <p>The plan may also cover learning how to use, modify, or repair an item. The member's Care Team will work with the member to decide if these other items and services are right for them and will be in their Individualized Care Plan.</p> <p>We will cover all durable medical equipment that Medicare and Medicaid usually cover. If our supplier in the area does not carry a particular brand or maker, the member may ask them if they can special-order it.</p>	<p>Prior authorization may be needed.</p>

Services covered by our plan	Limitations and expectations
<p>Emergency care (see also “urgently needed care”)</p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> • given by a provider trained to give emergency services, and • needed to treat a medical emergency. <p>A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:</p> <ul style="list-style-type: none"> • placing the person’s health in serious risk; or • serious harm to bodily functions; or • serious dysfunction of any bodily organ or part; or • in the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur: <ul style="list-style-type: none"> – There is not enough time to safely transfer the member to another hospital before delivery. – The transfer may pose a threat to the health or safety of the member or unborn child. <p>In an emergency, a member should call 911 or go to the nearest emergency room (ER) or other appropriate setting.</p> <p>If you are not sure if you need to go to the ER, a member should call their PCP or the 24-hour toll-free nurse advice line. The PCP or the nurse advice line can give the member advice on what they should do.</p> <p>This coverage is within the U.S. and its territories only.</p>	<p>If a member gets emergency care at an out-of-network hospital and need inpatient care after the member’s emergency is stabilized, we will work with the doctor who wants you to stay to do what is best for you. The doctor needs to call us right away (within 24 hours).</p>
<p>Family planning services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Family planning exam and medical treatment • Family planning lab and diagnostic tests • Family planning methods (birth control pills, patch, ring, IUD, injections, implants) • Family planning supplies (condom, sponge, foam, film, diaphragm, cap) • Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions • Treatment for sexually transmitted infections (STIs) • Treatment for AIDS and other HIV-related conditions • Voluntary sterilization (a member must be age 21 or older, and they must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that the member signs the form and the date of surgery.) • Screening, diagnosis and counseling for genetic anomalies and/or hereditary metabolic disorders <p>Note: The member can get family planning services from a network or out-of-network qualified family planning provider (for example Planned Parenthood) listed in the Provider and Pharmacy Directory. The member can also get family planning services from a network certified nurse midwife, obstetrician, gynecologist, or PCP.</p>	

Services covered by our plan	Limitations and expectations
<p>Federally Qualified Health Centers</p> <p>The plan covers the following services at Federally Qualified Health Centers:</p> <ul style="list-style-type: none"> • Office visits for primary care and specialists services • Physical therapy services • Speech pathology and audiology services • Dental services • Podiatry services • Optometric and/or optician services • Chiropractic services • Transportation services • Mental health services <p>Note: Members can get services from a network or out-of-network Federally Qualified Health Center.</p>	
<p>Health Products Catalog</p> <p>Members can earn up to \$200 in credits they can use to get every-day products from our health products catalog, such as toothbrushes, bandages, cough medicine, thermometers and more.</p> <p>Members can earn \$100 in credits for completing their Health Risk Assessment. Earn another \$100 for seeing their PCP at an Annual Wellness Visit.</p>	
<p>Hearing services and supplies</p> <p>The plan covers the following:</p> <ul style="list-style-type: none"> • Hearing and balance tests to determine the need for treatment (covered as outpatient care when a member gets them from a physician, audiologist, or other qualified provider) • Hearing aids, batteries, and accessories (including repair and/or replacement) <ul style="list-style-type: none"> – Conventional hearing aids are covered once every 4 years – Digital/programmable hearing aids are covered once every 5 years 	<p>Prior authorization is needed.</p>

Services covered by our plan	Limitations and expectations
<p>Home and community-based waiver services</p> <p>The plan covers the following home and community-based waiver services:</p> <ul style="list-style-type: none"> • Adult day health services • Alternative meals service • Assisted living services • Choices home care attendant • Chore services • Community transition • Emergency response services • Enhanced community living services • Home care attendant • Home delivered meals • Home medical equipment and supplemental adaptive and assistive devices • Home modification, maintenance, and repair • Homemaker services • Independent living assistance • Nutritional consultation • Out of home respite services • Personal care services • Pest control • Social work counseling • Waiver nursing services • Waiver transportation 	<p>These services are available only if the member’s need for long-term care has been determined by Ohio Medicaid.</p> <p>The member may be responsible for paying a patient liability for waiver services. The County Department of Job and Family Services will determine if the member’s income and certain expenses require them to have a patient liability.</p>
<p>Home health services</p> <p>The plan covers the following services provided by a home health agency:</p> <ul style="list-style-type: none"> • Home health aide and/or nursing services • Physical therapy, occupational therapy, and speech therapy • Private duty nursing (may also be provided by an independent provider) • Home infusion therapy for the administration of medications, nutrients, or other solutions intravenously or internally • Medical and social services • Medical equipment and supplies 	<p>Before members receive home health services, a doctor must certify that they need home health services and will order home health services to be provided by a home health agency.</p> <p>Prior authorization is needed.</p>

Services covered by our plan	Limitations and expectations
<p>Hospice care</p> <p>A member can get care from any hospice program certified by Medicare. The member's hospice doctor can be a network provider or an out-of-network provider.</p> <p>The plan will cover the following:</p> <ul style="list-style-type: none"> • Drugs to treat symptoms and pain • Short-term respite care • Home care • Nursing facility care <p><i>For hospice services and services covered by Medicare Part A or B that relate to the member's terminal illness:</i></p> <ul style="list-style-type: none"> • The hospice provider will bill Medicare for the member's services. Medicare will cover hospice services and any Medicare Part A or B services. The member pays nothing for these services. <p><i>For services covered by Medicare Part A or B that are not related to the member's terminal illness (except for emergency care or urgently needed care):</i></p> <ul style="list-style-type: none"> • The provider will bill Medicare for the member's services. Medicare will cover the services covered by Medicare Part A or B. The member pays nothing for these services. <p><i>For services covered by UnitedHealthcare Connected but not covered by Medicare Part A or B:</i></p> <ul style="list-style-type: none"> • UnitedHealthcare Connected will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to the member's terminal illness. Unless the member is required to pay a patient liability for nursing facility services, the member pays nothing for these services. <p>Note: Except for emergency/urgent care, if the member needs non-hospice care, they should call their care manager to arrange the services. Non-hospice care is care that is not related to the member's terminal illness.</p> <p>Our plan covers hospice consultation services for a terminally ill person who has not chosen the hospice benefit.</p>	<p>If a member wants hospice services in a nursing facility, they may be required to use a network nursing facility. Also, a member may be responsible for paying a patient liability for nursing facility services, after the Medicare nursing facility benefit is used. The County Department of Job and Family Services will determine if the member's income and certain expenses require the member to have a patient liability.</p> <p>Prior authorization is needed.</p>
<p>Inpatient behavioral health services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Inpatient psychiatric care in a private or public free-standing psychiatric hospital or general hospital <ul style="list-style-type: none"> – For members 22-64 years of age in a freestanding psychiatric hospital with more than 16 beds, there is a 190-day lifetime limit • Inpatient detoxification care 	<p>Prior authorization is needed.</p>

Services covered by our plan	Limitations and expectations
<p>Inpatient hospital care</p> <p>The plan covers the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if it is medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units, such as intensive care or coronary care units • Drugs and medications • Lab tests • X-rays and other radiology services • Needed surgical and medical supplies • Appliances, such as wheelchairs for use in the hospital • Operating and recovery room services • Physical, occupational, and speech therapy • Inpatient substance abuse services • Blood, including storage and administration beginning with the first pint • Physician/provider services • In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral <p>If the member needs a transplant, a Medicare-approved transplant center will review their case and decide whether they are a candidate for a transplant.</p>	<p>Note: To be an inpatient, the provider must write an order to admit the member formally as an inpatient of the hospital. Even if the member stays in the hospital overnight, they might still be considered an outpatient. This is called an “Outpatient Observation” stay. If a member is not sure If they’re an inpatient or outpatient, they should ask their doctor or the hospital staff.</p> <p>Prior authorization is needed.</p>
<p>Kidney disease services and supplies</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help the member make good decisions about their care • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area • Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for the member and anyone helping them with their home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on the member’s home dialysis, to help in emergencies, and to check their dialysis equipment and water supply <p>Note: The member’s Medicare Part B drug benefit covers some drugs for dialysis.</p>	

Services covered by our plan	Limitations and expectations
<p>Medical nutrition therapy</p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by a member’s doctor.</p> <p>The plan covers three hours of one-on-one counseling services during the member’s first year that they receive medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We cover two hours of one-on-one counseling services each year after that. Under the member’s Medicaid coverage, the plan covers counseling on medical nutrition by the member’s PCP.</p>	<p>The member may be able to get counseling if they do not have diabetes or kidney disease.</p>
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Medicare. UnitedHealthcare Connected covers the following drugs:</p> <ul style="list-style-type: none"> • Drugs members don’t usually give themselves and are injected or infused while they are getting doctor, hospital outpatient, or ambulatory surgery center services • Drugs members take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors members give themselves by injection if they have hemophilia • Immunosuppressive drugs, if the member was enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected. These drugs are paid for if the member is homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug themself • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases 	<p>Prior authorization may be needed.</p>
<p>Members Matter Representative</p> <p>The Members Matter Representative is a part of a team who welcomes new members to our plan, performs Health Risk Assessments and coordinates member’s identified needs with the care management department. Members Matter offers the member additional resources outside of Member Services for enhanced care coordination, enhanced access to preventive and specialized care, case management, expanded member services and education with minimal disruption to members’ established relationships with providers and existing care treatment plans. Members can receive support in accessing the health plan benefits and community resources.</p>	

Services covered by our plan	Limitations and expectations
<p>Mental health and substance abuse services at addiction treatment centers</p> <p>The plan covers the following services at addiction treatment centers:</p> <ul style="list-style-type: none"> • Ambulatory detoxification • Assessment • Case management • Counseling • Crisis intervention • Intensive outpatient • Alcohol/drug screening analysis/lab urinalysis • Medical/somatic • Methadone administration • Office administered medications for addiction including vivitrol and buprenorphine induction <p>See “Inpatient behavioral health services” and “Outpatient mental health care” for additional information.</p>	<p>Prior authorization is needed for ambulatory detoxification, case management, intensive outpatient and methadone administration.</p>
<p>Mental health and substance abuse services at community mental health centers</p> <p>The plan covers the following services at certified community mental health centers:</p> <ul style="list-style-type: none"> • Mental health assessment/diagnostic psychiatric interview <ul style="list-style-type: none"> – Limited to 4 hours for non-physician assessment and 2 hours for physician interview per year • Community psychiatric supportive treatment (CPST) services • Counseling and therapy <ul style="list-style-type: none"> – Limited to 52 hours of combined individual/group therapy per year • Crisis intervention • Pharmacological management <ul style="list-style-type: none"> – Limited to 24 hours per year • Pre-hospital admission screening • Certain office administered injectable antipsychotic medications • Partial hospitalization <ul style="list-style-type: none"> – Partial hospitalization is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care the member gets in your doctor’s or therapist’s office. It can help keep you from having to stay in the hospital. <p>See “Inpatient behavioral health services” and “Outpatient mental health care” for additional information.</p>	<p>Prior authorization needed for Community Psychiatric Support Treatment service (CPST) and Partial hospitalization.</p>

Services covered by our plan	Limitations and expectations
<p>Nursing and skilled nursing facility care</p> <p>The plan covers the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • A semi-private room, or a private room if it is medically needed • Meals, including special diets • Nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs the member gets as part of their plan of care, including substances that are naturally in the body, such as blood-clotting factors • Blood, including storage and administration beginning with the first pint of blood • Medical and surgical supplies given by nursing facilities • Lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • Appliances, such as wheelchairs, usually given by nursing facilities • Physician/provider services <p>Members will usually get their care from network facilities. However, they may be able to get their care from a facility not in our network. The member can get Medicaid nursing facility care from the following place if it accepts our plan's amounts for payment:</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you lived on the day you became a UnitedHealthcare Connected member <p>The member can get Medicare nursing facility care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where the member lived before they went to the hospital (as long as it provides nursing facility care) • A nursing facility where the member's spouse lives at the time you leave the hospital 	<p>The member may be responsible for paying a patient liability for room and board costs for nursing facility services. The County Department of Job and Family Services will determine if the member's income and certain expenses require them to have a patient liability.</p> <p>Note that patient liability does not apply to Medicare-covered days in a nursing facility.</p> <p>Prior authorization is needed. 3-day inpatient hospital stay is waived.</p>
<p>Outpatient mental health care</p> <p>The plan covers mental health services provided by:</p> <ul style="list-style-type: none"> • a state-licensed psychiatrist or doctor, • a clinical psychologist, • a clinical social worker, • a clinical nurse specialist, • a nurse practitioner, • a physician assistant, or • any other qualified mental health care professional as allowed under applicable state laws. <p>The plan covers the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Clinic services and general hospital outpatient psychiatric services • Day treatment • Psychosocial rehab services 	

Services covered by our plan	Limitations and expectations
<p>Outpatient services</p> <p>The plan covers services the member gets in an outpatient setting for diagnosis or treatment of an illness or injury.</p> <p>The following are examples of covered services:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • The plan covers outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers • Chemotherapy • Labs and diagnostic tests (for example urinalysis) • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • Imaging (for example X-rays, CTs, MRIs) • Radiation (radium and isotope) therapy, including technician materials and supplies • Blood, including storage and administration beginning with the first pint • Medical supplies, such as splints and casts • Some screenings and preventive services • Some drugs that you can't give yourself 	<p>Prior authorization may be needed.</p>
<p>Physician/provider services, including doctor's office visits and services by nurse practitioners and nurse midwives</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Health care or surgery services given in places such as a physician's office, certified ambulatory surgical center, or hospital outpatient department • Consultation, diagnosis, and treatment by a specialist • Some telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner for patients in rural areas or other places approved by Medicare • Second opinion by another network provider, if available, before a medical procedure • Non-routine dental care. Covered services are limited to: <ul style="list-style-type: none"> – surgery of the jaw or related structures, – setting fractures of the jaw or facial bones, – pulling teeth before radiation treatments of neoplastic cancer, or – services that would be covered when provided by a physician. 	
<p>Podiatry services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Diagnosis and medical or surgical treatment of injuries and diseases of the foot, the muscles and tendons of the leg governing the foot, and superficial lesions of the hand other than those associated with trauma • Routine foot care for members with conditions affecting the legs, such as diabetes 	

Services covered by our plan	Limitations and expectations
<p>Prosthetic devices and related supplies</p> <p><i>Prosthetic devices</i> replace all or part of a body part or function. The following are examples of covered prosthetic devices:</p> <ul style="list-style-type: none"> • Colostomy bags and supplies related to colostomy care • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) • Dental devices <p>The plan also covers some supplies related to prosthetic devices and the repair or replacement of prosthetic devices.</p> <p>The plan offers some coverage after cataract removal or cataract surgery. See “Vision Care” later in this section for details.</p>	
<p>Rehabilitation services</p> <ul style="list-style-type: none"> • Outpatient rehabilitation services <ul style="list-style-type: none"> – The plan covers physical therapy, occupational therapy, and speech therapy. – The member can get outpatient rehabilitation services from hospital outpatient departments, independent therapist/chiropractor/ psychologist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. • Cardiac (heart) rehabilitation services <ul style="list-style-type: none"> – The plan covers cardiac rehabilitation services such as exercise, education, and counseling for certain conditions. – The plan also covers intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. • Pulmonary rehabilitation services <ul style="list-style-type: none"> – The plan covers pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive 	<p>Rehabilitation services are covered with a doctor’s order.</p> <p>Prior authorization may be needed for some services.</p>
<p>Rural Health Clinics</p> <p>The plan covers the following services at Rural Health Clinics:</p> <ul style="list-style-type: none"> • Office visits for primary care and specialists services • Clinical psychologist • Clinical social worker for the diagnosis and treatment of mental illness • Visiting nurse services in certain situations <p>Note: The member can get services from a network or out-of-network Rural Health Clinic.</p>	

Services covered by our plan	Limitations and expectations
<p>Transportation for non-emergency services (see also “Ambulance and wheelchair van services”)</p> <p>Necessary taxi and chaircar transport for medical reasons, within 50 miles.</p> <p>If a member <u>must</u> travel 30 miles or more from their home to receive covered health care services, UnitedHealthcare Connected will provide transportation to and from the provider’s office. This does not count towards the member’s annual trip limit.</p> <ul style="list-style-type: none"> – In addition to the transportation assistance that UnitedHealthcare Connected provides, they can still get help with transportation for certain services through the Non-Emergency Transportation (NET) program. 	<p>Reservations are required and the member must also have a scheduled appointment (except in the case of urgent/emergent care)</p>
<p>Urgently needed care</p> <p><i>Urgently needed care</i> is care given to treat:</p> <ul style="list-style-type: none"> • a non-emergency, or • a sudden medical illness, or • an injury, or • a condition that needs care right away. <p>If a member requires urgently needed care, they should first try to get it from a network provider. However, they can use out-of-network providers when they cannot get to a network provider.</p> <p>Coverage is within the U.S. and its territories only.</p>	
<p>Vision care</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • One comprehensive eye exam, complete frame, and pair of lenses (contact lenses, if medically necessary) are covered per 12-month period. • Vision training • Services for the diagnosis and treatment of diseases and injuries of the eye, including but not limited to: <ul style="list-style-type: none"> – Treatment for age-related macular degeneration – One glaucoma screening each year for members under the age of 20 or age 50 and older, members with a family history of glaucoma, and members with diabetes – One pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If the member has two separate cataract surgeries, they must get one pair of glasses after each surgery. The member cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) The plan will also cover corrective lenses, and frames, and replacements if the member needs them after a cataract removal without a lens implant. 	<p>Choice of glasses or retail allowance of \$125 toward any type of contact lenses every 12 months; Eye exams every 12 months.</p>

Accessing Services When the Member is Away From Home or Outside of the Service Area

If a member is away from home or outside of our service area and need medical care, they should contact their PCP's office or NurseLine for assistance. Remember, if it's an emergency they should go to the nearest ER or call 911. Members can also get urgent care services from an out-of-network provider if a network provider is not available where you are. Both emergency and urgent care services are only available within the U.S. and its territories.

Benefits Not Covered by the Plan

This section tells you what kinds of benefits are excluded by the plan. *Excluded* means that the plan does not cover these benefits.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not cover the excluded medical benefits listed in this section and Medicaid will not cover them either.

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan:**

- Services considered not "reasonable and necessary," according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically needed and Medicare covers it
- A private room in a hospital, except when it is medically needed
- Personal items in a member's room at a hospital or a nursing facility, such as a telephone or a television
- Inpatient hospital custodial care
- Full-time nursing care in your home

- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will cover reconstruction of a breast after a mastectomy and for treating the other breast to match it
- Chiropractic care, other than diagnostic X-rays and manual manipulation (adjustments) of the spine to correct alignment consistent with Medicare and Medicaid coverage guidelines
- Routine foot care, except for the limited coverage provided according to Medicare and Medicaid guidelines
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother
- Acupuncture
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- Infertility services for males or females
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies
- Paternity testing
- Naturopath services (the use of natural or alternative treatments)
- Services provided to veterans in Veterans Affairs (VA) facilities
- Services to find cause of death (autopsy)

Covered Services for Medicaid Only

Medicaid helps with medical costs for certain people with limited incomes and resources. Ohio Medicaid pays for Medicare premiums for certain people, and may also pay for Medicare deductibles, co-insurance and co-payments except for prescriptions. Medicaid covers long-term care services such as home and community-based "waiver" services, which includes assisted living services and long-term nursing home care. It also covers dental and vision services.

Because a member chose or was assigned to only receive Medicaid-covered services from our plan, Medicare will be the primary payer for most services. You can choose to receive both your Medicare and Medicaid benefits through UnitedHealthcare Connected so all of your services can be coordinated.

If a member must travel 30 miles or more from your home to receive covered health care services, UnitedHealthcare Connected will provide transportation to and from the provider's office. These services must be medically necessary and not available in your service area. A member must also have a scheduled appointment (except in the case of urgent/emergent care).

In addition to the transportation assistance that UnitedHealthcare Connected provides, members can still receive assistance with transportation for certain services through the local county department of job and family services Non-Emergency Transportation (NET) program.

If a member has been determined eligible and enrolled in a home and community-based waiver program, there are also waiver transportation benefits available to meet the member's needs.

As a UnitedHealthcare Connected member, they will continue to receive all medically-necessary Medicaid-covered services at no cost to the member. These services may or may not require an okay before the member receives the service. Please see the following charts to determine if the member's benefits require an okay.

- Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source
 - Prescription drugs (certain drugs not covered by Medicare Part D) (please see the following chart(s) for more information)
 - Services for children with medical handicaps (Title V)
 - Hearing services, including hearing aids
 - Vision (optical) services, including eyeglasses
 - Waiver services (please see the following chart(s) for more information)
 - Yearly well adult exams when Medicare does not cover these
- Ambulance transportation
 - Assisted living services
 - Dental services
 - Durable medical equipment and supplies
 - Family planning services and supplies
 - Free-standing birth center services at a free-standing birth center (please see the following chart(s) for more information)
 - Medicaid home health and private duty nursing services
 - Hospice care in a nursing facility (care for terminally ill, e.g., cancer patients)
 - Mental health and substance abuse services (please see the following chart(s) for more information)
 - Nursing facility and long-term care services and supports (please see the following chart(s) for more information)

Services That DO NOT Require an Okay

UnitedHealthcare Connected encourages members to work with their PCP to help coordinate access to these services. However, it is not required that the member see their PCP before they receive these services. Make sure the member shows both their Medicare and MyCare Ohio ID cards when getting any service.

Service	Coverage
Chemotherapy	Covered
Dental services	Routine exams and cleanings every six months. Some non-routine dental services may require an okay.
Eye exams, routine vision (optical) services, including eyeglasses*	1 exam and 1 pair of glasses or retail allowance of \$125 toward any type of contacts (must use the entire benefit at one time) every 12 months. Must be for vision correction and not for cosmetic reasons only. Additional replacements may require an okay.
Family planning services and supplies	Covered
Free-standing birth center services at a free-standing birth center	Covered
Mental health and substance abuse services	Covered – The behavioral health crisis line can be reached 24/7 at 877-542-9236 (TTY 711).
Physical exam required for employment or for participation in job training programs	Covered if the exam is not provided free of charge by another source.
Respite Services	Covered for SSI members between 18 and 21 years old who meet certain requirements.
Yearly Well adult Exams	Covered when Medicare does not cover these.

Services That DO Require an Okay

The provider must call UnitedHealthcare Connected's Utilization Management Department at 800-366-7304 to get approval before you can receive the following services. Make sure the member shows both their Medicare and MyCare Ohio ID cards when getting any service.

Service	Coverage
Assisted Living Services	Covered
Home and community-Based (Waiver) Services	Covered
Hospice care in a nursing facility (care for terminally ill, e.g., cancer patients)	Covered
Medicaid home health and private duty nursing services	Covered
Medically necessary plastic or cosmetic surgery	Covered
Nursing facility and Long-term care Services and Supports	Covered
Pain management procedures	Covered
Hearing services, including hearing aids	Covered

Services That MAY Require an Okay

Depending on the level of care needed, these services may require an okay before a member can receive them. Make sure the member shows both their Medicare and MyCare Ohio ID cards when getting any service.

Service	Coverage
Ambulance and ambulette transportation	Covered
Durable medical equipment	Covered
Outpatient surgeries	Covered
Prescription Drugs, including certain prescribed over-the-counter drugs	Covered Please refer to the List of Covered Drugs that can be found on our website www.myuhc.com/communityplan
Services for children with medical handicaps (Title v)	Covered

Non-Covered Services

While Medicare will be the primary payer for most services, UnitedHealthcare Connected will not pay for services or supplies received without following the directions in this provider manual. We will not make any payment for the following services that are not covered by Medicaid:

- Services determined by Medicare or another third party payer as not medically necessary
- Sexual or marriage counseling
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure

This is not a complete list of the services that are not covered by Medicaid or our plan.

- Abortions except in the case of a reported rape, incest or when medically necessary to save the life of the mother
- Acupuncture and biofeedback services
- All services or supplies that are not medically necessary
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid and not in accordance with customary standards of practice
- Infertility services for males or females, including reversal of voluntary sterilizations
- Inpatient treatment to stop using drugs and/or alcohol (inpatient detoxification services in a general hospital are covered)
- Paternity testing
- Plastic or cosmetic surgery that is not medically necessary
- Services for the treatment of obesity unless determined medically necessary
- Services to find cause of death (autopsy) or services related to forensic studies

Chapter 3: Provider Responsibilities

General Provider Responsibilities

UnitedHealthcare Connected contracted providers are responsible for:

- A. Verifying the enrollment and assignment of the member via UnitedHealthcare Connected roster, using the UnitedHealthcare of Ohio Provider Portal, or contacting Provider Service Center prior to the provision of covered services. Failure to verify member enrollment and assignment may result in claim denial.
- B. Rendering covered services to UnitedHealthcare Connected members in an appropriate, timely, and cost effective manner and in accordance with their specific contract, CMS requirements and Medicaid regulations.
- C. Maintaining all licenses, certifications, permits, or other prerequisites required by law to provide covered services, and submitting evidence that each is current and in good standing upon the request of UnitedHealthcare Connected.
- D. Rendering services to members who are diagnosed as being infected with the Human Immunodeficiency Virus (HIV) or having Acquired Immune Deficiency Syndrome (AIDS) in the same manner and to the same extent as other members, and under the compensation terms set forth in their contract.
- E. Meeting all applicable Americans with Disabilities Act (ADA) requirements when providing services to members with disabilities who may request special accommodations such as interpreters, alternative formats, or assistance with physical accessibility.
- F. Making a concerted effort to educate and instruct members about the proper utilization of the practitioner's office in lieu of hospital emergency rooms. The practitioner shall not refer or direct members to hospital emergency rooms for non-emergent medical services at any time.
- G. Abiding by the UnitedHealthcare Connected referral and prior authorization guidelines.
- H. Admitting members in need of hospitalization only to contracted hospitals unless: (1) prior authorization for admission to some other facility has been obtained from UnitedHealthcare Connected; or, (2) the member's condition is emergent and use of a contracted hospital is not feasible for medical reasons. The practitioner agrees to provide covered services to members while in a hospital as determined medically necessary by the practitioner or a medical director.
 - I. Using contracted hospitals, specialists, and ancillary providers. A member may be referred to a non-contracted practitioner or provider only if the medical services required are not available through a contracted practitioner or provider and if prior authorization is obtained.
 - J. Reporting all services provided to UnitedHealthcare Connected members in an accurate and timely manner.
 - K. Obtaining authorization for all hospital admissions.
 - L. Providing culturally competent care and services.
 - M. Complying with Health Insurance Portability and Accountability Act (HIPAA) provisions.
 - N. Adhering to Advance Directives (Patient Self Determination Act). The federal Patient Self- Determination Act requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult members (age 21 and older) written information about their right to have an advance directive. Advance directives are oral or written statements either outlining a member's choice for medical treatment or naming a person who should make choices if the member loses the ability to make decisions. Providers are required to maintain policies and procedures regarding advance directives and document in individual medical records whether or not they have executed an advanced directive. Information about advance directives is included in the UnitedHealthcare Connected Member Handbook.
 - O. Provider must establish standards for timeliness and in office waiting times that consider the immediacy of member needs and common waiting times for comparable services in the community.

Member Eligibility and Enrollment

Medicare and Medicaid beneficiaries who elect to become members of UnitedHealthcare Connected must meet the following qualifications:

1. Members must be entitled to Medicare Part A and be enrolled in Medicare Part B.
2. Members must be entitled and enrolled in Medicaid Title XIX benefits.
3. Members must reside in a UnitedHealthcare Connected Service Area: Columbiana, Cuyahoga, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, Trumbull and Wayne Counties

4. A Member must maintain a permanent residence within the Service Area, and must not reside outside the Service Area for more than 6 months.
5. Members of all ages who do not have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant) at time of application.

Each UnitedHealthcare Connected member will receive a UnitedHealthcare Connected identification (ID) card containing the member's name, member number, Primary Care Physician name, and information about their benefits. The UnitedHealthcare Connected ID membership card does not guarantee eligibility. It is for identification purposes only.

Member ID Cards

UnitedHealthcare
Community Plan

Connecting Medicare + Medicaid

Health Plan (80840) 911-87726-04
Member ID: 999999999

Member:
 SUBSCRIBER M BROWN SR
 MMIS: 999999999999
 PCP Name:
 DR. PROVIDER BROWN
 PCP Phone: (999)999-9999

Payer ID: 87726

Rx Bin: 610494
 Rx Grp: ACUOHMMP
 Rx PCN: 9999

UnitedHealthcare Connected for MyCare Ohio (Medicare-Medicaid Plan)
 H2531 PBP# 001

Printed: 05/25/11

In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

Website:	MyUHC.com/CommunityPlan	
Member Services:	1-877-542-9236	TTY 711
Behavioral Health Crisis:	1-877-542-9236	TTY 711
Care Management:	1-877-542-9236	TTY 711
24 Hour Nurse Advice:	1-800-542-8630	TTY 711
For Providers:	1-800-600-9007	
Send claims to:	PO Box 8207, Kingston, NY, 12402-8207	
Eligibility Verification:	1-800-600-9007	Claim Inquiry: 1-800-600-9007
Pharmacy Claims:	OptumRx, PO Box 29045, Hot Springs, AR 71903	
Pharmacy Help Desk:	1-877-889-6510	

UnitedHealthcare
Community Plan

Connecting Medicare + Medicaid

UnitedHealthcare[®] Connected[™] for MyCare Ohio (Medicare-Medicaid Plan)
 Health Plan (80840) 911-87726-04
Member ID: 999999999

Member:
 SUBSCRIBER M BROWN SR
 MMIS: 999999999999
 PCP Name:
 DR. PROVIDER BROWN
 PCP Phone: (999)999-9999

Payer ID: 87726

Rx Bin: 610097
 Rx Grp: MMPOH
 Rx PCN: 8500

H2531 PBP# 001

Printed: 05/25/11

In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

	MyUHC.com/CommunityPlan	
Member Services:	1-877-542-9236	TTY 711
Care Management:	1-877-542-9236	TTY 711
Behavioral Health Crisis:	1-877-542-9236	TTY 711
24 Hour Nurse Advice:	1-800-542-8630	TTY 1-800-855-2880
For Providers:	UnitedHealthcareOnline.com 1-800-600-9007	
Medical Claims:	PO Box 8207, Kingston, NY, 12402-8207	
Utilization Mngt.:	1-800-366-7304	BH Utilization Mngt.: 1-866-261-7692
Pharmacy Claims:	OptumRx, PO Box 29045, Hot Springs, AR 71903	
For Pharmacist:	1-877-889-6510	

Chapter 4: Long Term Services and Support

Long Term Services and Support (LTSS)

Members may be able to get long-term services and supports (LTSS) which are also called Medicaid “waiver services”. Long-term services and supports give assistance to help members 18 years or older, who are fully eligible for both Medicare and Medicaid, enrolled in MyCare Ohio and remain in the community instead of going to a nursing home or hospital. **Members must be eligible to receive these services as they are not available to all plan members.** If members are eligible for Waiver services, they will work with their Care Manager for coordinating their needs for Long Term Services and Supports.

The following Waiver services are available if member is eligible:

- Out of Home Respite
- Adult Day Health
- Home Medical Equipment & Supplemental Adaptive & Assistive Devices
- Waiver Transportation
- Chore Services
- Social Work Counseling
- Emergency Response
- Home Modification Maintenance & Repair
- Personal Care
- Homemaker
- Waiver Nursing
- Home Delivered Meals
- Alternative Meals
- Pest Control
- Assisted Living
- Home Care Attendant
- Choices Home Care Attendant
- Enhanced Community Living
- Nutritional Consultation
- Independent Living Assistance
- Community Transition

Transition Period

This period applies to individuals who were enrolled on any of the Ohio Medicaid waivers (PASSPORT, Choices, Assisted Living, Ohio Home Care, or Transitions Carve-Out) immediately prior to enrolling on the MyCare Ohio Waiver. In order to minimize service disruption, the members' existing service levels and providers will be maintained for a pre-determined amount of time, depending upon the type of service. The members' services and service providers will remain in place for a limited time, with some exceptions as follows.

Exceptions:

During the transition period, change from the existing provider can occur in the following circumstances:

1. The member requests a change,
2. The provider gives appropriate notice of intent to discontinue services to a member, or;
3. The provider performance issues are identified that affect an individual's health and welfare.

Transition Requirements

Transition Requirements	Waiver Consumers	Non-Waiver Consumers with LTC Needs (HH and PDN use)	NF Consumers AL Consumers	No LTC Need Consumers
Physician	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others
Pharmacy	90 day transition	90 day transition	90 day transition	90 day transition
Medicaid DME	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity
Scheduled Surgeries	Must honor specified provider	Must honor specified provider	Must honor specified provider	Must honor specified provider
Chemo/Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider	Must honor specified provider	Must honor specified provider	Must honor specified provider
Medicaid Vision and Dental	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered
Home Health and PDN	Maintain service at current level and with current providers at current Medicaid reimbursement rates. Changes may not occur unless: A significant change occurs as defined in OAC 5101:3-45-01; or Individuals expresses a desire to self-direct services; or after 365 days.	Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	For AL: Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	N/A

Transition Requirements	Waiver Consumers	Non-Waiver Consumers with LTC Needs (HH and PDN use)	NF Consumers AL Consumers	No LTC Need Consumers
Assisted Living Waiver Service			Provider maintained at current rate for the life of demonstration.	
Waiver Services-Direct Care <ul style="list-style-type: none"> • Personal Care • Waiver Nursing • Home Care Attendant • Choice Home Care Attendant • Out of Home Respite • Enhanced Community Living • Adult Day Health Services • Social Work Counseling • Independent Living Assistance 	<p>Maintain service at current level and with current providers at current Medicaid reimbursement rates. Changes may not occur unless:</p> <p>A significant change occurs as defined in OAC 5101:3-45-01; or Individuals expresses a desire to self-direct services; or after 365 days.</p>	N/A	N/A	N/A
Waiver Services-All other	Maintain service at current level for 365 days and existing service provider for 90 days. Plan initiated change in service provider can only occur after an in-home assessment and plan for the transition to a new provider.	N/A	N/A	N/A
Behavioral Health Services	Maintain service provider, level and rate documented in the BH plan of care at the time of enrollment for 365 days.	Maintain service provider, level and rate documented in the BH plan of care at the time of enrollment for 365 days.	Maintain service provider, level and rate documented in the BH plan of care at the time of enrollment for 365 days.	Maintain service provider, level and rate documented in the BH plan of care at the time of enrollment for 365 days.

End of Transition Period:

When the transition period ends, it does not necessarily mean that the member's services or providers will change. [UnitedHealthcare Connected] only has the option to make changes to the member's services after this period.

Prior to the conclusion of the transition period, the member's Waiver Services Coordinator will meet with them to review their waiver service plan and discuss any needed changes in services or providers. If a change in provider is required for any reason, the member will be provided with information regarding other available providers.

Members must be eligible to receive Long Term Services and Support (LTSS) and work with their Case Manager.



If you have further questions, please contact UnitedHealthcare Connected at icdsprovider@uhc.com. Members may contact Member Services at **800-396-1942 (TTY 800-947-6644)** for assistance.



Primary Care Provider Member Assignment

UnitedHealthcare Connected is responsible for managing the member's care on the date that the member is enrolled with the plan and until the member is disenrolled from UnitedHealthcare Connected. Members receive a letter notifying them of the name of their Primary Care Physician, office location, telephone number, and the opportunity to select a different Primary Care Physician should they prefer someone other than the Primary Care Physician assigned. If a member asks UnitedHealthcare Connected to change his/her Primary Care Physician at any other time, the change will be made effective the first day of the following month.

Verifying Member Enrollment

Once a member has been assigned to a Primary Care Physician, UnitedHealthcare Connected documents the assignment and provides each Primary Care Physician a roster indicating the members assigned to them. Rosters can be viewed electronically on UnitedHealthcareOnline.com. Primary Care Physicians should verify eligibility by using their rosters in conjunction with:

- Provider website: UnitedHealthcareOnline.com
- UnitedHealthcare Community Plan Provider Service Center (8:00 a.m. to : 5:00 p.m., five days a week) 800-600-9007
- Medicaid web-based eligibility verification system

At each office visit, your office staff should:

- Ask for the member's ID cards and have a copy of both sides in the member's office file.
- Determine if the member is covered by another health plan to record information for coordination of benefits purposes.
- Refer to the member's ID card for the appropriate telephone number to verify eligibility in the UnitedHealthcare Connected, deductible, coinsurance amounts, co-payments, and other benefit information.
- Primary Care Physicians office staff should check their UnitedHealthcare Connected Panel Listing to be sure the Primary Care Physician is the member's primary care physician. If the member's name is not listed, your office staff should contact UnitedHealthcare Connected Member Services to verify Primary Care Physician selection before the member is seen by the Participating Provider.

All providers should verify member eligibility prior to providing services.

Coordinating 24-Hour Coverage

Primary Care Physicians are expected to provide coverage for UnitedHealthcare Connected members 24 hours a day, 7 days a week. When a Primary Care Physician is unavailable to provide services, the Primary Care Physician must ensure that he or she has coverage from another Participating Provider. Hospital Emergency rooms or urgent care centers are not substitutes for covering Participating Providers. Participating Providers can contact the UnitedHealthcare Connected Member Services with questions regarding which providers participate in the UnitedHealthcare Connected network.

Chapter 5: Claims Process/Coordination of Benefits/Claims

Ohio providers contracted with Medicare and Medicaid lines of business, serving members enrolled with UnitedHealthcare Connected for Medicare and Medicaid benefits, will be able to take advantage of single-claim submission. Claims submitted to UnitedHealthcare Connected for dual-enrolled members will process first against Medicare benefits and then will automatically process against UnitedHealthcare Connected Medicaid benefits. Providers will not need to submit separate claims.

Claims Submission Requirements

UnitedHealthcare Connected requires that you initially submit your claim within your contracted deadline. Please consult your contract to determine your initial filing requirement. The timely filing limit is set at 180 days after the date of service.

A “clean claim” is defined in Ohio Revised Statutes as one that can be processed without obtaining additional information from the provider of service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim selected for medical review by UnitedHealthcare Connected.

Please mail your paper claims to:

UnitedHealthcare Connected
P.O. Box 8207
Kingston, NY 12402

For Electronic Submission of Claims

Please access UnitedHealthcareOnline.com and sign up for electronic claims submission. If you are already signed up to send claims electronically using 837P or 837I the payer ID is 87726.

Submission of CMS-1500 Form Drug Codes

Attach the current NDC (National Drug Code) 11-digit number for all claims submitted with drug codes. The NDC number must be entered in 24D field of the CMS-1500 Form or the LINo3 segment of the HIPAA 837 electronic form.

Please note this only applies to the Medicaid portion of the pharmacy claim. It does not apply to the Medicare portion of the pharmacy claim.

Practitioners

Participating Providers should submit claims to UnitedHealthcare Connected as soon as possible after service is rendered, using the standard CMS Claim Form or electronically as discussed below.

To expedite claims payment, identify the following items on your claims:

- Patient’s name, date of birth, address and ID number
- Name, signature, address and phone number of physician or physician performing the service, as in your contract document
- National Provider Identifier (NPI) number
- Physician’s tax ID number
- CPT-4 and HCPCS procedure codes with modifiers where appropriate
- ICD-9 diagnostic codes
- Revenue codes (UB-04 only)
- Date of service(s), place of service(s) and number of services (units) rendered
- Referring physician’s name (if applicable)
- Information about other insurance coverage, including job-related, auto or accident information, if available
- Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers
- Attach an anesthesia report for claims submitted with QS modifier
- Attach a description of the procedure/service provided for claims submitted with unlisted medical or surgical CPT codes or experimental or reconstructive services (if applicable)

UnitedHealthcare Connected will process electronic claims consistent with the requirements for standard transactions set forth at 45 CFR Part 162. Any electronic claims submitted to UnitedHealthcare Connected should comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements.

Hospitals

Hospitals should submit claims to the UnitedHealthcare Connected (MyCare Ohio) claims address as soon as possible after service is rendered, using the standard UB-92 Form or electronically using payer ID 87726

To expedite claims payment, identify the following items on your claims:

- Member name
- Member’s date of birth and sex

- Member's UnitedHealthcare Connected ID number
- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details
- Appropriate diagnosis, procedure and service codes
- Date of services (including admission and discharge date)
- Charge for each service
- Provider's ID number and locator code, if applicable
- Provider's Tax ID Number
- Name/address of Participating Provider

UnitedHealthcare Connected will process electronic claims consistent with the requirements for standard transactions set forth at 45 CFR Part 162. Any electronic claims submitted to UnitedHealthcare Connected should comply with HIPAA requirements.

Balance Billing

The balance billing amount is the difference between Medicare's and Medicaid's allowed charge and the provider's actual charge to the patient. Providers are prohibited from billing, charging or otherwise seeking payment from enrollees for covered services.

Services to members cannot be denied for failure to pay co-payments. If a member requests a service that is not covered by UnitedHealthcare Connected, providers should have the member sign a release form indicating understanding that the service is not covered by UnitedHealthcare Connected and the member is financially responsible for all applicable charges. This release must include the date of the service and the specific service being rendered.

The subcontractor may bill the member when the MCP has denied prior authorization or referral for the services and the following conditions are met:

1. The member was notified by the subcontractor of the financial liability in advance of service delivery.
2. The notification by the subcontractor was in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose.
3. The notification is dated and signed by the member.

Chapter 6: Medical Management, Quality Improvement and Utilization Review Programs

Ohio providers contracted with Medicare and Medicaid lines of business, serving members enrolled with UnitedHealthcare Connected (MyCare Ohio) for Medicare and Medicaid benefits, will be able to take advantage of single-claim submission. Claims submitted to UnitedHealthcare of Ohio for dual-enrolled members will process first against Medicare benefits, and then will automatically process against UnitedHealthcare Connected (MyCare Ohio) Medicaid benefits. Providers will not need to submit separate claims.

Medicaid Cost-Sharing Policy: UnitedHealthcare Connected members are eligible for both Medicaid and Medicare services. Claims for members will be paid according to the Medicare Cost Sharing Policy. UnitedHealthcare Connected will not be responsible for cost sharing should the payment from the primary payer be equal to or greater than what the provider would have received under Medicaid.

Cost Sharing for UnitedHealthcare Connected Members
Providers will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any UnitedHealthcare Connected member who is eligible for both Medicare and Medicaid, or his or her representative, or the UnitedHealthcare Connected organization for Medicare Part A and B cost sharing (e.g., co-pays, deductibles, coinsurance) when the state is responsible for paying such amounts. Provider will either: (a) accept payment made by or on behalf of the UnitedHealthcare Connected organization as payment in full; or (b) bill the appropriate state source for such cost sharing amount.

Provider Claims Dispute: Stated as “**Administrative Appeals by Practitioner**” on Provider Remit

If after a provider is not able to resolve a claim denial through Provider Service Center, the provider may challenge the claim denial or adjudication by filing a formal claim dispute.

UnitedHealthcare Connected Policy requires that the dispute, with required documentation, must be received within 60 days of the original denial notice. Failure to meet the timely request of a claims dispute is deemed a waiver of all rights to further administrative review.

A claim dispute must be in writing and state with particularity the factual and legal basis and the relief requested, along with any supporting documents (e.g., claim, remit, medical review sheet, medical records, correspondence, etc.). Particularity usually means a chronology of pertinent events and a statement as to why the provider believes the action by UnitedHealthcare Connected was incorrect.

UnitedHealthcare Connected seeks to improve the quality of care provided to its members. Thus, UnitedHealthcare Connected encourages Provider participation in health promotion and disease prevention programs. Providers are encouraged to work with UnitedHealthcare Connected in its efforts to promote healthy lifestyles through member education and information sharing. UnitedHealthcare Connected seeks to accomplish the following objectives through its Quality Improvement and Medical Management Programs:

Participating Providers must comply and cooperate with all UnitedHealthcare Connected medical management policies and procedures and in UnitedHealthcare Connected quality assurance and performance improvement programs.

Referrals and Prior Authorization

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

The referral and prior authorization procedure are particularly important to the UnitedHealthcare Connected managed care program. Understanding and adhering to these procedures is essential for successful participation as a UnitedHealthcare Connected provider. Prior authorization is one of the tools used by UnitedHealthcare Connected to monitor the medical necessity and cost-effectiveness of the health care members receive. Contracted and non-contracted health professionals, hospitals, and other providers are required to comply with UnitedHealthcare Connected prior authorization policies and procedures. Non-compliance may result in delay or denial of reimbursement. Because the Primary Care Physician coordinates most services provided to a member, it is typically the Primary Care Physician who initiates requests for prior authorization; however, specialists and ancillary providers may also request prior authorization for services within their specialty areas.

Unless another department or unit has been specifically designated to authorize a service, requests for prior authorization are routed through the prior authorization department where Nurses and Medical Directors are available.



Requests are made by telephone to Provider Service Center at **800-600-9007** or via the Provider Portal at **UnitedHealthcareOnline.com**.



Primary Care Provider Referral Responsibilities

If a member self-refers, or the Primary Care Physician is making a referral to a specialist, the Primary Care Physician should check the UnitedHealthcare Connected Provider Directory to ensure the specialist is a Contracted Provider in the UnitedHealthcare Connected network.

The Primary Care Physician should provide the specialist with the following clinical information:

- Members name
- Referring Primary Care Physician
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results
- Pertinent past medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific request of the specialist

Specialist Referral Guidelines

Primary Care Physicians may refer UnitedHealthcare Connected members to contracted network specialists. To ensure coordination of care, if a member desires to receive care from a different specialist, the Primary Care Physician should try to coordinate specialty referrals within the list of contracted network specialists. UnitedHealthcare Connected should be contacted for assistance in locating contracted providers within a specialty field. Primary Care Physicians need prior authorization approval to refer members outside of the contracted network.

Primary Care Physicians are authorized to make referrals, using a UnitedHealthcare Connected- specified referral form, to specialists within the guidelines of UnitedHealthcare Connected Prior Authorization List. Members are encouraged to coordinate primary and specialty care services through their designated Primary Care Physician. Members have the ability to self-refer to a contracted network specialist without a written referral from a designated Primary Care Physician.

Services Requiring Prior Authorization

The presence or absence of a procedure or service on the list below does not define whether or not coverage or benefits exist for that procedure or service. The new authorization requirements do not change or otherwise affect current requirements for outpatient prescription drug benefits or behavioral health benefits.

Requesting Prior Authorization

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

1. Requests for prior authorization are to be directed to UnitedHealthcare Connected prior authorization department or to their Care Manager
 - Contact the Provider Service Center if you are interested in using the Internet-based prior authorization system, iExchange for inpatient prior authorization notification.
2. All requests for prior authorization require:
 - A valid member ID number
 - Name of referring physician
 - The current applicable CPT, ICD-9, and HCPCS codes for the services being requested
 - The designated place of service
3. The Primary Care Physician is responsible for initiating and coordinating requests for prior authorization. However, UnitedHealthcare Connected recognizes that specialists, ancillary providers, and facilities may need to request prior authorization for additional services in their specialty area and will process these requests as necessary.
4. Non-contracted providers must obtain prior authorization from UnitedHealthcare Connected before rendering any non-emergent services. Failure to do so will result in claims being denied

The prior authorization department, under the direction of licensed nurses and medical directors, documents and evaluates requests for authorization, including:

- Verification that the member is enrolled with UnitedHealthcare Connected at the time of the request for authorization and on each date of service
- Verification that the requested service is a covered benefit for the member
- Assessment of the requested service's medical necessity and appropriateness
- UnitedHealthcare Connected medical review criteria based on CMS/Medicaid program requirements, applicable policies and procedures, contracts, and law
- Verification that the service is being provided by a contracted provider and in the appropriate setting
- Verification of other insurance for coordination of benefits

The prior authorization department is also responsible for receiving and documenting facility notifications of inpatient admissions and emergency room treatment.

Requests for elective services generally need review and approval by a medical director and frequently require additional documentation.

Denial of Requests for Prior Authorization

Denials of authorization requests occur only after a UnitedHealthcare Connected Medical Director has reviewed the request. A UnitedHealthcare Connected Medical Director is always available to speak to a provider and review a request.

If a prior authorization request is denied, often times it is due to a lack of medical documentation. Providers are encouraged to call or submit additional information for reconsideration. If additional information is requested and not received within 5 business days, then the request is denied.

Pre-Admission Authorization

For coordination of care, Primary Care Physicians or the admitting hospital facilities should notify UnitedHealthcare Connected if they are admitting a UnitedHealthcare Connected member to a hospital or other inpatient facility.

To notify UnitedHealthcare Connected of an admission, the admitting hospital should call UnitedHealthcare Connected at 866-604-3267 and provide the following information:

- Notifying Primary Care Physician or hospital
- Name of admitting Primary Care Physician
- Member's name, sex, and UnitedHealthcare Connected ID number
- Admitting facility
- Primary diagnosis
- Reason for admission
- Date of admission

Concurrent Hospital Review

UnitedHealthcare Connected will review all member hospitalizations within 48 business hours of admission to confirm that the hospitalization and/or procedures were medically necessary. Reviewers will assess the usage of ancillary resources, service and level of care according to professionally recognized standards of care. Concurrent hospital reviews will validate the medical necessity for continued stay.

Discharge Planning

UnitedHealthcare Connected will assist Participating Providers and hospitals in the inpatient discharge planning process implemented in accordance with requirements under the Medicare Advantage Program. At the time of admission and during the hospitalization, the UnitedHealthcare Connected Medical Management staff may discuss discharge planning with the Participating Provider, member, and family.

Outpatient Services Review

Outpatient review involves the retrospective evaluation of outpatient procedures and therapies to determine medical necessity and appropriateness. Outpatient treatment plans for members with complex or chronic conditions may be developed.

Second Medical or Surgical Opinion

A member may request a second opinion if:

- The member disputes reasonableness decision
- The member disputes necessity of procedure decision
- The member does not respond to medical treatment after a reasonable amount of time

To receive a second opinion, a member should first contact his or her Primary Care Physician to request a referral. If the member does not wish to discuss their request directly with the Primary Care Physician, he or she may call UnitedHealthcare

Connected for assistance. Members may obtain a second opinion from a Participating Provider within the UnitedHealthcare Connected network.

Medical Criteria

Qualified professionals who are members of the UnitedHealthcare Connected Quality Improvement Committees and the Board of Directors will approve the medical criteria used to review medical practices and determine medical necessity. UnitedHealthcare Connected currently uses nationally recognized criteria, such as Diagnostic Related Groups Criteria and Milliman USA Health Care Management Guidelines™, to guide the prior authorization, concurrent review and retrospective review processes. These criteria are used and accepted nationally as clinical decision support criteria.



For more information or to receive a copy of these guidelines, please contact the Provider Service Center at **800-600-9007**.

UnitedHealthcare Connected may develop recommendations or clinical guidelines for the treatment of specific diagnoses, or for the utilization of specific drugs. These guidelines will be communicated to Participating Providers through the UnitedHealthcare Practice Matters newsletters.

UnitedHealthcare Connected has established the Quality and Utilization Management Peer Review Committee to allow physicians to provide guidance on medical policy, quality assurance and improvement programs and medical management procedures. Participating Providers may recommend specific clinical guidelines to be used for a specific diagnosis. These requests should be supported with current medical research and or data and submitted to the UnitedHealthcare Connected Quality and Utilization Management Peer Review Committee.

A goal of the Quality and Utilization Management Peer Review Committee is to ensure that practice guidelines and utilization management guidelines:

- Are based on reasonable medical evidence or a consensus of health care professionals in the particular field
- Consider the needs of the enrolled population
- Are developed in consultation with participating physicians
- Are reviewed and updated periodically

The guidelines will be communicated to providers, and, as appropriate, to members decisions with respect to utilization management, member education, coverage of services, and other areas in which the guidelines apply will be consistent with the guidelines.

If you would like to propose a topic to be considered for discussion with UnitedHealthcare Connected Quality and Utilization Management Peer Review Committee, please contact a UnitedHealthcare Connected Medical Director.

Care Management

UnitedHealthcare Connected will assist in managing the care of members with acute or chronic conditions that can benefit from care coordination and assistance. UnitedHealthcare Connected providers shall assist and cooperate with UnitedHealthcare Connected care management programs. UnitedHealthcare Connected care management programs include but are not limited to:

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

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

- Members who are recipients of services provided through the Ohio Department of Health Services Children's Rehabilitative Services program
- Members who are recipients of services provided through the Ohio Department of Health Services/ Division of Behavioral Health-contracted Regional Behavioral Health Authorities
- Members diagnosed with HIV/AIDS
- Members diagnosed with End Stage Renal Disease receiving dialysis

- **Organ Transplantation** – A Transplant Nurse Care Coordinator coordinates provider requests for authorization of organ transplants. The Transplant Care Manager works cooperatively with the Medicaid Office of Medical Management, contracted providers, and internal UnitedHealthcare Connected departments to coordinate the delivery of services included in the transplantation process.

- **Emergency Department** – (ED) Care Coordination Program assists members with multiple ED visits to obtain necessary and appropriate medical and specialty care. Members over utilizing the ED may or may not be demonstrating drug seeking behavior(s).
- **HIV+/AIDS** – This program is offered in conjunction with the Medicaid guidelines for managing HIV/AIDS members’ treatment regimens. The Medicaid guidelines also require that any member receiving antiretroviral therapy be assigned to a UnitedHealthcare Connected HIV/AIDS Nurse Care Coordinator. Physicians are to contact the department whenever a member is diagnosed with HIV or AIDS or whenever an HIV/AIDS-diagnosed member is noncompliant. The HIV/AIDS Nurse Care Coordinator will assist in coordinating care for these members.
- **Chronic Pain** – Provider requests for assistance with members with chronic pain and related drug seeking behavior and/or emergency department abuse are managed by the Specialty Care Coordination Department.



Providers may refer candidates for care management by contacting a UnitedHealthcare Personal Care Specialist at **888-303-6163**.

Evidence Based Medicine/Clinical Practice Guidelines

Disease management programs for asthma, congestive heart failure and diabetes are offered within the medical case management department. These programs utilize nationally recognized clinical practice guidelines and the practitioner’s treatment plan as a basis to educate members and coordinate preventative services.

UnitedHealthcare Connected promotes the use of evidence-based clinical practice guidelines to improve the health of its members and provide a standardized basis for measuring and comparing outcomes. Outcomes are compared with the standards of care defined in the evidence based clinical practice guidelines for these diseases.

The UnitedHealthcare Connected care management department supports education for UnitedHealthcare Connected staff, practitioners, providers and members. UnitedHealthcare Connected reinforces and supports the implementation of clinical practice guidelines by providing training programs for providers and their staff on how best to integrate practice guidelines into everyday physician practice patterns.

UnitedHealthcare Connected provides individual practitioners feedback regarding their performance as well as information regarding the overall network performance as related to the guidelines. Evidence-based clinical practice guidelines are reviewed and revised on an annual basis and approved through the Medical Management and Quality Management processes.



Clinical practice guidelines can be accessed by providers on the UnitedHealthcare Connected Provider Portal **UnitedHealthcareOnline.com** or at **guidelines.gov**. Providers may also call the Provider Service Center at **800-600-9007** to request a hard copy of these guidelines.

Provider Responsibility With Termination of Services-Notification of Medicare Non-Coverage

Skilled Nursing Facility (SNF), Home C Health Agency (HHA), and Comprehensive Outpatient Rehabilitation Facility (CORF) Notification Requirements.

There are several components outlined in this process regarding your role as a Participating UnitedHealthcare SNF, HHA, or CORF provider. **The Notice of Medicare Non-Coverage (NOMNC)** is a short, straightforward notice that simply informs the patient of the date that coverage of services is going to end and describes what should be done if the patient wants to appeal the decision or needs more information.

CMS has developed a single, standardized NOMNC that is designed to make notice delivery as simple and burden-free as possible for the provider. The NOMNC essentially includes only three variable fields (patient name, ID/Medicare number and last day of coverage) that the provider must fill in.

When to Deliver the NOMNC

Based on the determination by UnitedHealthcare of when services should end, the SNF, HHA, or CORF is responsible for delivering the NOMNC no later than two days before the end of coverage. If services are expected to be fewer than two days, the NOMNC should be delivered upon admission. If there is more than a two-day span between services (e.g., in the home health setting), the NOMNC should be issued on the next to last time services are furnished. We encourage SNF, HHA, and CORF providers to work with UnitedHealthcare so that these notices can be delivered as soon as the service termination date is known. A provider need not agree with the decision that covered services should end, but it still has a responsibility under its Medicare provider agreement to carry out this function.

How to Deliver the NOMNC

SNF, HHA, and CORF providers must carry out “valid delivery” of the NOMNC. This means that the member (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by telephone if personal delivery is not immediately available. In this case, the authorized representative must be informed of the contents of the notice, the call must be documented and the notice must be mailed to the representative.

Expedited Review Process

If the enrollee decides to appeal the end of coverage, he or she must contact the Quality Improvement Organization (QIO) by no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review.



The QIO for Ohio is MetaStar. A member may contact MetaStar at **800-362-2320**.

The QIO will inform UnitedHealthcare and the provider of the request for a review and UnitedHealthcare is responsible for providing the QIO and enrollee with a detailed explanation of why coverage is ending.

UnitedHealthcare may need to present additional information needed for the QIO to make a decision. Providers should cooperate with UnitedHealthcare’s requests for assistance in getting needed information. Based on the expedited time frames, the QIO decision should take place by close of business of the day coverage is to end.

Exclusions from NOMNC Delivery Requirements

Providers are not required to deliver the NOMNC if coverage is being terminated for any of the following reasons:

1. The member’s benefit is exhausted;
2. Denial of an admission to an SNF, HHA or CORF;
3. Denial of non-Medicare covered services; or
4. A reduction or termination of services that do not end the skilled stay.

When a Detailed Explanation of Non-Coverage (DENC) will be Issued:

UnitedHealthcare will issue a DENC explaining why services are no longer medically necessary to the member and provide a copy to the QIO no later than close of business (typically 4:30 p.m.) the day of the QIO’s notification that the member requested an appeal, or the day before coverage ends, whichever is later.

Where to locate the UnitedHealthcare NOMNC form:

A copy of the UnitedHealthcare NOMNC can be found in the Appendix Section of this manual or on the UnitedHealthcare web site at UHCCommunityPlan.com on the ‘Resources’ page.

More Information

Further information on this process, including the required notices and related CMS instructions, can be found on the CMS web site at [cms.hhs.gov/ BNI/09_MAEDNotices.asp#TopOfPage](http://cms.hhs.gov/BNI/09_MAEDNotices.asp#TopOfPage). (Also, the regulations are at 42 CFR 422.624, 422.626 and 489.27, and Chapter 13 of the Medicare Managed Care Manual.)



<http://www.cms.hhs.gov/MMCAG/Downloads/NOMNC.pdf>

<http://www.cms.hhs.gov/MMCAG/downloads/NOMNCInstructions.pdf>

<http://www.cms.hhs.gov/MMCAG/Downloads/DENC.pdf>

<http://www.cms.hhs.gov/MMCAG/Downloads/DENCInstructions.pdf>

Chapter 7: Provider Performance Standards and Compliance Obligations

Provider Evaluation

When evaluating the performance of a Participating Provider, UnitedHealthcare Connected (MyCare Ohio) will review at a minimum the following areas:

- **Quality of Care** - measured by clinical data related to the appropriateness of member care and member outcomes.
- **Efficiency of Care** - measured by clinical and financial data related to a member's health care costs.
- **Member Satisfaction** - measured by the members' reports regarding accessibility, quality of health care, Member-Participating Provider relations, and the comfort of the practice setting.
- **Administrative Requirements** - measured by the Participating Provider's methods and systems for keeping records and transmitting information.
- **Participation in Clinical Standards** - measured by the Participating Provider's involvement with panels used to monitor quality of care standards.

Provider Compliance to Standards of Care

UnitedHealthcare Connected Participating Providers must comply with all applicable laws and licensing requirements. In addition, Participating Providers must furnish covered services in a manner consistent with standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. Participating Providers must also comply with UnitedHealthcare Connected standards, which include but are not limited to:

- Guidelines established by the Federal Center for Disease Control (or any successor entity)
- All federal, state, and local laws regarding the conduct of their profession
- Participating Providers must also comply with UnitedHealthcare Connected policies and procedures regarding the following:
 - Participation on committees and clinical task forces to improve the quality and cost of care
 - Prior authorization requirements and time frames
 - Participating Provider credentialing requirements
 - Referral policies
 - Care Management Program referrals

- Appropriate release of inpatient and outpatient utilization and outcomes information
- Accessibility of member medical record information to fulfill the business and clinical needs of UnitedHealthcare Connected
- Cooperating with efforts to assure appropriate levels of care
- Maintaining a collegial and professional relationship with UnitedHealthcare Connected personnel and fellow Participating Providers
- Providing equal access and treatment to all Medicare and Medicaid members

Compliance Process

The following types of non-compliance issues are key areas of concern:

- Out-of-network referrals/utilization without prior authorization by UnitedHealthcare Connected
- Failure to pre-notify UnitedHealthcare Connected of admissions
- Member complaints/grievances that are determined against the provider
- Under utilization, over utilization, or inappropriate referrals
- Inappropriate billing practices
- Non-supportive actions and/or attitude Participating Provider noncompliance is tracked, on a calendar year basis. Using an educational approach, the compliance process is composed of four phases, each with a documented educational component. Corrective actions will be taken

Participating Providers acting within the lawful scope of practice are encouraged to advise patients who are members of UnitedHealthcare Connected about:

1. The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options.
2. The risks, benefits, and consequences of treatment or non-treatment.

3. The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.
4. The importance of preventive changes at no cost to the member. Such actions shall not be considered non-supportive of UnitedHealthcare Connected.

Laws Regarding Federal Funds

Payments that Participating Providers receive for furnishing services to UnitedHealthcare Connected members are, in whole or part, from Federal funds. Therefore, Participating Providers and any of their subcontractors must comply with certain laws that are applicable to individuals and entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

Marketing

Participating providers may not develop and use any materials that market UnitedHealthcare Connected without the prior approval of UnitedHealthcare Connected in compliance with Medicare Advantage requirements.

Sanctions Under Federal Health Programs and State Law

Participating Providers must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other Federal Health Care Programs are employed or subcontracted by the Participating Provider.

Participating Providers must disclose to UnitedHealthcare Connected whether the Participating Provider or any staff member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of Ohio, the federal government, or any public insurer. Participating Providers must notify UnitedHealthcare Connected immediately if any such sanction is imposed on Participating Provider, a staff member or subcontractor.

Selection and Retention of Participating Providers

UnitedHealthcare Connected is responsible for arranging covered services that are provided to thousands of members through a comprehensive provider network of independent practitioners and facilities that contract with UnitedHealthcare of Ohio. The network includes health care professionals such as primary care physicians, specialist physicians, medical facilities, allied health professionals, and ancillary service providers.

UnitedHealthcare Connected's network has been carefully developed to include those contracted health care professionals who meet certain criteria such as availability, geographic service area, specialty, hospital privileges, quality of care, and acceptance of UnitedHealthcare Connected managed care principles and financial considerations.

UnitedHealthcare Connected continuously reviews and evaluates Participating Provider information and recredentials Participating Providers every three years. The credentialing guidelines are subject to change based on industry requirements and UnitedHealthcare Connected standards.

Notification of Members of Provider Termination

If the subcontractor involved is a Primary Care Physician, the MCP must notify, in writing, all members who use the subcontractor as a Primary Care Physician.

The MCP shall send the notice at least 45 calendar days prior to the effective date of the deletion to members who use the subcontractor as a Primary Care Physician. If the MCP receives less than 45 days prior notice, the MCP shall issue the notice within one working day of the MCP becoming aware of the Primary Care Physician's deletion.

Chapter 8: Medical Records

Medical Record Review

A UnitedHealthcare Connected representative may visit the Participating Provider's office to review the medical records of UnitedHealthcare Connected members to obtain information regarding medical necessity and quality of care. Medical records and clinical documentation will be evaluated based on the Standards for Medical Records listed below. The Quality and Utilization Management Subcommittee, the Provider Affairs Subcommittee and the Quality Management Oversight Committee will review the medical record results up to quarterly. The results will be used in the re-credentialing process.

Standards for Medical Records

Participating Providers must have a system in place for maintaining medical records that conform to regulatory standards. Each medical encounter whether direct or indirect must be comprehensively documented in the members' medical chart. Each medical record chart must have documented at a minimum:

- Member name
- Member identification number
- Member age
- Member sex
- Member date of birth
- Date of service
- Allergies and any adverse reaction
- Past medical history
- Chief complaint/purpose of visit
- Subjective findings
- Objective findings, including diagnostic test results
- Diagnosis/assessment/impression
- Plan, including services, treatments, procedures and/or medications ordered; recommendation and rationale
- Name of Participating Provider including signature and initials
- Instructions to member
- Evidence of follow-up with indication that test results and/or consultation was reviewed by Primary Care Physician and abnormal findings discussed with member/legal guardian
- Health risk assessment and preventative measures

In addition, Participating Providers must document in a prominent part of the member's current medical record whether or not the member has executed an advance directive.

Advance directives are written instructions such as a living will or durable power of attorney for health care relating to the provision of health care when an adult is incapacitated

Confidentiality of Member Information

Participating Providers must comply with all state and Federal laws concerning confidentiality of health and other information about members. Participating Providers must have policies and procedures regarding use and disclosure of health information that comply with applicable laws.

Member Record Retention

Participating Providers must retain records in accordance with OAC.

Chapter 9: Reporting Obligations

Cooperation in Meeting the Centers for Medicaid and Medicare Services (CMS) Requirements

UnitedHealthcare Connected must provide to CMS information that is necessary for CMS to administer and evaluate the UnitedHealthcare Connected program and to establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare and Medicaid services. Such information includes plan quality and performance indicators such as disenrollment rates; information on member satisfaction; and information on health outcomes. Participating Providers must cooperate with UnitedHealthcare Connected in its data reporting obligations by providing to UnitedHealthcare Connected any information that it needs to meet its obligations.

Certification of Diagnostic Data

UnitedHealthcare Connected is specifically required to submit to CMS data necessary to characterize the context and purposes of each encounter between a member and a provider, supplier, physician, or other practitioner (encounter data). Participating Providers that furnish diagnostic data to assist UnitedHealthcare Connected in meeting its reporting obligations to CMS must certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

Risk Adjustment Data

Providers are encouraged to comprehensively code all members' diagnoses to the highest level of specificity possible. All members' medical encounters must be submitted to UnitedHealthcare Connected.

Chapter 10: Initial Decisions, Appeals and Grievances

Initial Decisions

The “initial decision” is the first decision UnitedHealthcare Connected makes regarding coverage or payment for care. In some instances, a Participating Provider, acting on behalf of UnitedHealthcare Connected may make an initial decision regarding whether a service will be covered.

- If a member asks us to pay for medical care the member has already received, this is a request for an “initial decision” about payment for care.
- If a member or Participating Provider acting on behalf of a member, asks for preauthorization for treatment, this is a request for an “initial decision” about whether the treatment is covered by UnitedHealthcare Connected.
- If a member asks for a specific type of medical treatment from a Participating Provider, this is a request for an initial decision about whether the treatment the member wants is covered by UnitedHealthcare Connected.

UnitedHealthcare Connected will generally make decisions regarding payment for care that members have already received within 30 days.

A decision about whether UnitedHealthcare Connected will cover medical care can be a standard decision that is made within the standard time frame (typically within 14 days) or it can be an expedited decision that is made more quickly (typically within 72 hours).

A member can ask for an expedited decision only if the member or any physician believes that waiting for a standard decision could seriously harm the member’s health or ability to function. The member or a physician can request an expedited decision. If a physician requests an expedited decision, or supports a member in asking for one, and the physician indicates that waiting for a standard decision could seriously harm the member’s health or ability to function, UnitedHealthcare Connected will automatically provide an expedited decision.

At each patient encounter with a UnitedHealthcare Connected member, the Participating Provider must notify the member of his or her right to receive, upon request, a detailed written notice from UnitedHealthcare Connected regarding the member’s services. The Participating Provider’s notification must provide the member with the information necessary to contact UnitedHealthcare Connected and must comply with any other requirements specified by CMS. If a member requests UnitedHealthcare Connected to provide a detailed notice of

a Participating Provider’s decision to deny a service in whole or part, UnitedHealthcare Connected must give the member a written notice of the determination.

If UnitedHealthcare Connected does not make a decision within the time frame and does not notify the member regarding why the time frame must be extended, the member can treat the failure to respond as a denial and may appeal, as set forth below.

Appeals and Grievances

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. Appeals and grievances are the two different types of complaints they can make. All Participating Providers must cooperate in the Medicare and Medicaid Appeals and Grievances process.

- An appeal is the type of complaint a member makes when the member wants UnitedHealthcare Connected to reconsider and change an initial decision (by UnitedHealthcare Connected or a Participating Physician) about what services are necessary or covered or what UnitedHealthcare Connected will pay for a service.
- A grievance is the type of complaint a member makes regarding any other type of problem with UnitedHealthcare Connected or a Participating Provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the Participating Provider’s facilities are grievances. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (refer to Appeal).

Resolving Appeals

A member may appeal an adverse initial decision by UnitedHealthcare Connected or a Participating Provider concerning authorization for, or termination of coverage of, a health care service. A member may also appeal an adverse initial decision by UnitedHealthcare Connected concerning payment for a health care service. The plan must review and resolve each appeal as expeditiously as the member’s health condition requires but the resolution timeframe must not exceed 15 calendar days from the receipt of the appeal unless the resolution timeframe is extended as outlined in paragraph (F) of this rule.

Participating Providers must also cooperate with UnitedHealthcare Connected and members in providing necessary information to resolve the appeals within the required time frames. Participating Providers must provide the pertinent medical records and any other relevant information to UnitedHealthcare Connected. In some instances, Participating Providers must provide the records and information very quickly in order to allow UnitedHealthcare Connected to make an expedited decision.

If the normal time period for an appeal could result in serious harm to the member's health or ability to function, the member or the member's physician can request an expedited appeal. Such appeal is generally resolved within 72 hours unless it is in the member's interest to extend this time period. If a physician requests the expedited appeal and indicates that the normal time period for an appeal could result in serious harm to the member's health or ability to function, we will automatically expedite the appeal.

Special Types

A special type of appeal applies only to hospital discharges. If the member thinks UnitedHealthcare Connected coverage of a hospital stay is ending too soon, the member can appeal directly and immediately to the Quality Improvement Professional Research Organization, Inc. However, such an appeal must be requested no later than noon on the first working day after the day the member gets notice that UnitedHealthcare Connected coverage of the stay is ending. If the member misses this deadline, the member can request an expedited appeal from UnitedHealthcare Connected.

Another special type of appeal applies only to a member dispute regarding when coverage will end for skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility services (CORF). SNFs, HHAs and CORFs are responsible for providing members with a written notice at least 2 days before their services are scheduled to end. If the member thinks his/her coverage is ending too soon, the member can appeal directly and immediately to the Quality Improvement Professional Research Organization, Inc. If the member gets the notice 2 days before coverage ends, the member must request an appeal to Quality Improvement Professional Research Organization, Inc. no later than noon of the day after the member gets the notice. If the member gets the notice more than 2 days before coverage ends, then the member must make the request no later than noon the day before the date that coverage ends. If the member misses the deadline for appealing to Quality Improvement Professional Research Organization, Inc., the member can request an expedited appeal from UnitedHealthcare Connected.

Resolving Grievances

If an UnitedHealthcare Connected member has a grievance about UnitedHealthcare Connected, a Provider or any other issue; Participating Providers should instruct the member to contact UnitedHealthcare Connected Member Services. The phone number may be located on the back of the member's ID card.

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

UnitedHealthcare Connected will send a received letter within 5 days of receiving your grievance request. A final decision will be made as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint.

Further Appeal Rights

If UnitedHealthcare Connected denies the members appeal in whole or part, it will forward the appeal to an Independent Review Entity (IRE) that has a contract with the federal government and is not part of UnitedHealthcare Connected. This organization will review the appeal and, if the appeal involves authorization for health care service, make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision within 60 days.

If the IRE issues an adverse decision and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ). If the member is not satisfied with the ALJ's decision, the member may request review by the Department Appeal Board (DAB). If the Department Appeal Board (DAB) refuses to hear the case or issues an adverse decision, the member may be able to appeal to a District Court of the United States.

Chapter 11: Members' Rights and Responsibilities

UnitedHealthcare Connected members have the right to timely, high-quality care, and treatment with dignity and respect. Participating Providers must respect the rights of all UnitedHealthcare Connected members. Specifically, UnitedHealthcare Connected members have been informed that they have the following rights:

Timely Quality Care

- Choice of a qualified Contracting Primary Care Physician and contracting hospital
- Candid discussion of appropriate or Medically Necessary treatment options for their condition, regardless of cost or benefit coverage
- Timely access to their Primary Care Physician and Recommendations to Specialists when Medically Necessary
- To receive Emergency Services when the member, as a prudent layperson, acting reasonably would believe that an Emergency Medical Condition exists
- To actively participate in decisions regarding their health and treatment options
- To receive urgently needed services when traveling outside UnitedHealthcare Connected's service area or in UnitedHealthcare Connected's service area when unusual or extenuating circumstances prevent the member from obtaining care from a Participating Provider
- To request the number of grievances and appeals and dispositions in aggregate
- To request information regarding physician compensation
- To request information regarding the financial condition of UnitedHealthcare Connected

Treatment With Dignity and Respect

- To be treated with dignity and respect and to have their right to privacy recognized
- To exercise these rights regardless of the member's race, physical or mental ability, 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 for care
- To confidential treatment of all communications and records pertaining to the member's care

- To access, copy and/or request amendment to the member's medical records consistent with the terms of HIPAA
- To extend their rights to any person who may have legal responsibility to make decisions on the member's behalf regarding the member's medical care
- To refuse treatment or leave a medical facility, even against the advice of physicians (providing the member accepts the responsibility and consequences of the decision)
- To complete an advance directive, living will or other directive to the member's medical providers

Member Satisfaction

UnitedHealthcare Connected periodically surveys members to measure overall customer satisfaction as well as satisfaction with the care received from Participating Providers. Survey information is reviewed by UnitedHealthcare Connected and results are shared with the Participating Providers.

The Centers for Medicare and Medicaid Services (CMS) conducts annual surveys of members to measure their overall customer satisfaction as well as satisfaction with the care received from Participating Providers. Surveys results are available upon request.

Member Responsibilities

Member responsibilities include:

- Reading and following the Evidence of Coverage (EOC)
- Treating all UnitedHealthcare Connected staff and health care providers with respect and dignity
- Protecting their Medicaid/Medicare ID card and showing it before obtaining services
- Knowing the name of their Primary Care Physician
- Seeing their Primary Care Physician for their healthcare needs
- Using the emergency room for life threatening care only and going to their Primary Care Physician or urgent care center for all other treatment
- Following their doctor's instructions and treatment plan and telling the doctor if the explanations are not clear
- Making an appointment before they visit their Primary Care Physician or any other UnitedHealthcare Connected health care provider

- Arriving on time for appointments
- Calling the office at least 1 day in advance if they must cancel an appointment
- Being honest and direct with their Primary Care Physician, including giving the Primary Care Physician the member's health history as well as their child's
- Telling their UnitedHealthcare Connected support coordinator if they have changes in address, family size, or eligibility for enrollment
- Tell UnitedHealthcare of Ohio if they have other insurance
- Give a copy of their living will to their Primary Care Physician

Services Provided in a Culturally Competent Manner

UnitedHealthcare Connected is obligated to ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Participating Providers must cooperate with UnitedHealthcare Connected in meeting this obligation.

Member Complaints/Grievances

UnitedHealthcare Connected tracks all complaints and grievances to identify areas of improvement for UnitedHealthcare Connected. This information is reviewed in the Quality Improvement Committee, Service Improvement Subcommittee and reported to the UnitedHealthcare Connected Board of Directors. Please refer to section for members appeal and grievances rights.

Chapter 12: Access to Care/Appointment Availability

Member Access to Health Care Guidelines

The following appointment availability goals should be used to ensure timely access to medical care and behavioral health care:

- Routine Follow-Up or Preventative Care – within 30 days
- Routine/Symptomatic – within 7 days
- Non-Urgent Care – within 1 week
- Urgently Needed Services – within 24 hours
- Emergency – Immediately

Adherence to member access guidelines will be monitored through the office site visits, long-term care visits and the tracking of complaints/grievances related to access and/or discrimination. Variations from the policy will be reviewed by the Network Management for educational and/or counseling opportunities and tracked for Participating Provider re-credentialing.

All Participating Providers and hospitals will treat all UnitedHealthcare Connected members with equal dignity and consideration as their non-UnitedHealthcare Connected patients.

Provider Availability

Primary Care Physicians shall provide coverage 24 hours a day, 7 days a week. When a Participating Provider is unavailable to provide services, he or she must ensure that another Participating Provider is available.

The member should normally be seen within 30 minutes of a scheduled appointment or be informed of the reason for delay (e.g., emergency cases) and be provided with an alternative appointment.

After hours access shall be provided to assure a response to emergency phone calls within 30 minutes, response to urgent phone calls within 1 hour. Individuals who believe they have an Emergency Medical Condition should be directed to immediately seek emergency services.

Physician Office Confidentiality Statement

UnitedHealthcare Connected members have the right to privacy and confidentiality regarding their health care records and information in accordance with the UnitedHealthcare Connected program. Participating Providers and each staff member will sign an Employee Confidentiality Statement to be placed in the staff member's personnel file.

Transfer and Termination of Members From Participating Physician's Panel

UnitedHealthcare Connected will determine reasonable cause for a transfer based on written documentation submitted by the Participating Provider. Participating Providers may not transfer a member to another Participating Provider due to the costs associated with the member's Covered Services.

Participating Providers may request termination of a member due to fraud, disruption of medical services, or repeated failure to make the required reimbursements for services.

Closing of Provider Panel

When closing a practice to new UnitedHealthcare Connected members or other new patients, Participating Providers are expected to:

- Give UnitedHealthcare Connected prior written notice that the practice will be closing to new members as of the specified date.
- Keep the practice open to UnitedHealthcare Connected members who were members before the practice closed.
- Uniformly close the practice to all new patients including private payers, commercial or governmental insurers.
- Give UnitedHealthcare Connected prior written notice of the reopening of the practice, including a specified effective date.

Prohibition Against Discrimination

Neither UnitedHealthcare Connected or Participating Providers may deny, limit, or condition the coverage or furnishing of services to members on the basis of any factor that is related to health status, including, but not limited to the following:

1. Medical condition including mental as well as physical illness
2. Claims experience
3. Receipt of health care
4. Medical history
5. Genetic information
6. Evidence of insurability including conditions arising out of acts of domestic violence
7. Disability

Chapter 13: Compliance

Integrity and Compliance

Introduction

UnitedHealthcare is dedicated to conducting business honestly and ethically with members, providers, suppliers, and governmental officials and agencies. The need to make sound, ethical decisions as we interact with physicians, other health care providers, regulators, and others has never been greater. It's not only the right thing to do, it is necessary for our continued success and that of our business associates.

Compliance Program

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

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

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

Reporting and Auditing

Any unethical, unlawful or otherwise inappropriate activity by a UnitedHealthcare employee which comes to the attention of a physician should be reported to a UnitedHealthcare senior manager in the health plan or directly to the Ethics and Compliance Help Center at 800-455-4521.

UnitedHealthcare's Special Investigations Unit (SIU) is an important component of the Corporate Compliance Program. The SIU focuses on proactive prevention, detection, and investigation of potentially fraudulent and abusive acts committed by physicians and plan members. This department is responsible for the conduct and/or coordination of anti-fraud activities in all UnitedHealthcare business units.



A toll-free Fraud and Abuse Hotline, **866-242-7727**, has been set up to facilitate the reporting process of any questionable incidents involving plan members or physicians.

Please refer to the Fraud and Abuse section of this administrative guide for additional details about the UnitedHealthcare Fraud and Abuse Program.

An important aspect of the Corporate Compliance Program is assessing high-risk areas of UnitedHealthcare operations and implementing reviews and audits to ensure compliance with law, regulations, and contracts. When informed of potentially irregular, inappropriate or potentially fraudulent practices within the plan or by our providers, UnitedHealthcare will conduct an appropriate investigation. Providers are expected to cooperate with the company and government authorities in any such inquiry, both by providing access to pertinent records (as required by the Participating Provider Agreement) and access to provider office staff. If activity in violation of law or regulation is established, appropriate governmental authorities will be advised.

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

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

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

Fraud and Abuse

Fraud and abuse by physicians, members, health plans, employees, etc. hurts everyone. Your assistance in notifying UnitedHealthcare about any potential fraud and abuse that comes to your attention and cooperating with any review of such a situation is vital and appreciated. We consider this an integral part of our mutual ongoing efforts to provide the most effective health outcomes possible for all our members.

Definitions of Fraud and Abuse

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

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

Examples of fraud and abuse include:

Misrepresenting Services Provided

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

Falsifying Claims/Encounters

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

Administrative or Financial

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

Member Fraud or Abuse Issues

- Fraudulent/Altered prescriptions
- Card loaning/selling
- Eligibility fraud
- Failure to report third party liability/other insurance

Reporting Fraud and Abuse

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

- Go to UHCCommunityPlan.com and select 'Contact Us' to report information relating to suspected fraud or abuse.
- Call the UnitedHealthcare Special Investigations Unit Fraud Hotline at 866-242-7727.

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

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

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

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

Resolving Disputes

Agreement Concern or Complaint

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

If your concern or complaint relates to a matter which is generally administered by certain UnitedHealthcare procedures, such as the credentialing or Care Coordination process, you and UnitedHealthcare will follow the dispute procedures set forth in those plans 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 our agreement.

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

Arbitration proceedings will be held at the location described in your agreement with us.

In the event that a customer has authorized you to appeal a clinical or coverage determination on their behalf, that appeal will follow the process governing customer appeals outlined in the customer's benefit contract or handbook.

Arbitration

Any arbitration proceeding under your agreement will be conducted in Ohio 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 adr.org.

In the event a member has authorized you to appeal a clinical or coverage determination on their behalf, that appeal will follow the process governing member appeals outlined in the member's benefit contract or handbook.

Chapter 14: Prescription Benefits

Network Pharmacies

With a few exceptions, UnitedHealthcare Connected members must use network pharmacies to get their outpatient prescription drugs covered. A Network Pharmacy is a pharmacy where members can get their outpatient prescription drugs through their prescription drug coverage. We call them network pharmacies because they contract with our plan. In most cases, their prescriptions are covered only if they are filled at one of our network pharmacies. Once a member goes to one, they are not required to continue going to the same pharmacy to fill their prescription; they can go to any of our network pharmacies.

Covered Drugs is the general term we use to describe all of the outpatient prescription drugs that are covered by our plan. Covered drugs are listed in the formulary.

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before a prescription is filled at an out-of-network pharmacy, please contact the UnitedHealthcare Connected Member Services to see if there is a network pharmacy available.

1. We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, members will have to pay the full cost (rather than paying just the co-payment) when they fill their prescription. UnitedHealthcare Connected members can ask us for reimbursement for their share of the cost by submitting a paper claim form.
2. If a UnitedHealthcare Connected member is traveling within the US, but outside of the Plan's service area and becomes ill, loses or runs out of their prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy. In this situation, the member will have to pay the full cost (rather than paying just their co-payment) when they fill their prescription. The member can ask us to reimburse them for our share of the cost by submitting a claim form. Remember, prior to filling a prescription at an out-of-network pharmacy call our UnitedHealthcare Connected Member Services to find out if there is a network pharmacy in their area where the member is traveling. If there are no network pharmacies in that area, our Member Services may be able to make arrangements for the member to get their prescriptions from an out-of-network pharmacy.
3. If a UnitedHealthcare Connected member is unable to get a covered drug in a timely manner within our service area because there are not network pharmacies within a reasonable driving distance that provide 24-hour service.
4. If a member is trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail (these drugs include orphan drugs or other specialty pharmaceuticals).

Formulary

A formulary is a list of all the drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy, or through our network mail order pharmacy service and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage.

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program and both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. In other cases, we have decided not to include a particular drug. We may also add or remove drugs from the formulary during the year. If we change the formulary we will notify the member of the change at least 60 days before the effective date of change. If we don't notify the member of the change in advance, the member will get a 60-day supply of the drug when they request a refill. However, if a drug is removed from our formulary because the drug has been recalled from the market, we will NOT give a 60-days notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

To find out what drugs are on the formulary or to request a copy of our formulary, please contact UnitedHealthcare Connected Member Services. The number can be located on the back of the member's ID card.



Providers can also get updated information about the drugs covered by us by visiting our web site at UHCCommunityPlan.com.

Drug Management Programs (Utilization Management)

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed the following requirements and limits for our Plan to help us to provide quality coverage to our members. Examples of utilization management tools are described below:

- **Prior Authorization:** We require UnitedHealthcare Connected members to get prior authorization for certain drugs. This means that the UnitedHealthcare Connected physician or pharmacist will need to get approval from us before a member fills their prescription. If they don't get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, we limit the amount of the drug that we cover per prescription or for a defined period of time. For example, we will provide up to 30 tablets per prescription for simvastatin. This quantity limit may be in addition to a standard 30-day supply limit.
- **Step Therapy:** In some cases, we require members to first try one drug to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.
- **Generic Substitution:** When there is a generic version of a brand-name drug available our network pharmacies will automatically give the member the generic version, unless their doctor has told us that they must take the brand-name drug.

You can find out if the drugs you prescribe are subject to these additional requirements or limits by looking in the formulary. If your drug does have these additional restrictions or limits, you can ask us to make an exception to our coverage rules. Please refer to the section above for Exception Requests.

Chapter 15: Behavioral Health

UnitedHealthcare Connected members can receive mental health and substance abuse services.

Screening for Behavioral Health Problems

Primary Care Physicians are required to screen UnitedHealthcare Connected for behavioral health problems (a.k.a. chemical dependence) and mental health. Primary Care Physicians should file the completed screening tool in the patient's medical record.

Role of the Behavioral Health Unit

United Behavioral Health is an important resource to all providers when members experience mental health or substance abuse problems. The United Behavioral Health toll-free number is 866-261-7692.

- Responsible for member emergencies and requests for inpatient behavioral health admissions 24 hours, 7 days a week
- Fully supports primary care providers with assessment and referrals to mental health and substance abuse services
- Provides behavioral health case management
- Reviews, monitors, and authorizes behavioral health care
- Responsible for provider relations for behavioral health providers
- Staffed by professionals with extensive experience in mental health and substance abuse services

Behavioral Health Emergencies

If a provider believes the member is having a psychiatric emergency, the provider should either call 911 or direct the member to the designated county screening center or nearest hospital emergency room.



If the provider is unsure about resources or providers, please call **866-261-7692**.

Referrals for Behavioral Health Services



Primary Care Physicians and behavioral health providers should communicate with the Behavioral Health Unit by calling **866-261-7692**.

Providers should note the referral or request in the patient's medical record.

A member can self-refer to a participating behavioral health provider for outpatient services.

Behavioral Health Guidelines and Standards

UnitedHealthcare Connected utilizes the following diagnostic assessment tools and placement criteria guideline, consistent with current standards of care:

- DSM V-Fifth edition
- ASAM PPC-2 (American Society of Addiction Medicine)
- United Behavioral Health uses UNITED BEHAVIORAL HEALTH LEVEL OF CARE GUIDELINES for appropriateness of care and discharge reviews

United Behavioral Health expects providers to comply with our Timeliness Standards for Appointment Scheduling.

Appendix

Prior Authorization List UnitedHealthcare Connected™ Effective March 1, 2014

Community & State MMP Authroization Requirements	
Category	Ohio 3/1/2014
Abortion	No Prior Authorization
Bariatric Surgery	Prior Auth Required
Bone Growth Stimulator	Prior Auth Required
BRCA Genetic Testing	Prior Auth Required
Breast Reconstruction (Non-Mastectomy)	Prior Auth Required
Cochlear Implants and Other Auditory Implants >\$1000	Prior Auth Required >\$1000
Cosmetic & Reconstructive	Prior Auth Required
DME >\$1000	Prior Auth Required >\$1000
Enteral/Parenteral Services	Prior Auth Required
Experimental & Investigational	Prior Auth. Make sure these are never denied with the reason code - not a covered benefit. OH does not have a covered benefit under medicaid - in medical necessity - state has last word.
Home Health Care	Prior Auth Required
IMRT	Prior Auth Required
Injectable Medications - Acthar	Prior Auth Required
Injectable Medications - Botox	Prior Auth Required
Injectable Medications - IVIG	Prior Auth Required
Injectable Medications - Makena	Prior Auth Required
Injectable Medications - Xolair	Prior Auth Required
Joint Replacement	Prior Auth Required
Muscle Flap Procedures	Prior Auth Required
Non-Emergent Air Ambulance Transports	Prior Auth Required
Orthognathic Surgery	Prior Auth Required
Orthotics >\$1000	Prior Auth Required >\$1000
Prosthetics >\$1000	Prior Auth Required >\$1000
Proton Beam Therapy	Prior Auth Required

Community & State MMP Authroization Requirements	
Category	Ohio 3/1/2014
Radiology Services CareCore Code List - https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=14088e54f9b6a210VgnVCM1000002f10b10a	Prior Auth Required
CareCore Cardiology Program including: Diagnostic Heart Catheterization Stress Echocardiography Transthoracic Echocardiography Cardiac Implantable Devices https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=14088e54f9b6a210VgnVCM1000002f10b10a	No Auth Required
Septoplasty/Rhinoplasty	Prior Auth Required
Sleep Apnea Procedures & Surgeries	Prior Auth Required
Sleep Studies	No prior authorization unless it's done by a non-par provider
Spinal Stimulator for Pain Management	Prior Auth Required
Spinal Surgery	Prior Auth Required
Sterilization	No Prior Authorization
Transplants	Prior Auth Required
Vagus Nerve Stimulation	Prior Auth Required
Vein Procedures	Prior Auth Required
Ventricular Assist Devices	Prior Auth Required

Ohio Prior Authorization Fax Request Form

Fax: 800-897-8317

Phone: 800-366-7304

Please complete all fields on the form referring to the list of services that require authorization at UHCCCommunityPlan.com. Submit all relevant clinical data such as progress notes, treatment rendered, tests, lab results, and radiology reports to support the request for services. This will help us process your request without delay. Failure to provide sufficient information will delay your request.

Date: _____ Contact person: _____ Phone: _____

Fax: _____ HIPAA secure fax line? Yes No

Requesting Provider: _____ TIN/NPI: _____

Member Information

Member name: _____ Member ID/JD#: _____ Date of birth: _____
 Member pregnant? Yes No Related to a motor vehicle accident or work-related injury? Yes No
 Member have other insurance? Yes No If yes, Medicare Part A Part B
 Other insurance name and policy # _____

Type of Request

Routine Expedited/Urgent (Request must include a physician's order stating that waiting for a decision under a standard timeframe could endanger the member's life, health, or ability to regain maximum functionality or would cause serious pain.)
 Inpatient Outpatient Home

Servicing Provider and Facility Information

Servicing provider: _____ TIN/NPI: _____
 Address: _____ Fax: _____
 Date of service: _____ In network Out of network
 Servicing facility: _____ TIN/NPI: _____
 Address: _____ In network Out of network
 Will out of network provider accept Medicaid/Medicare default rate? Yes No

Clinical Information

Diagnoses: _____ ICD-9 codes: _____
Required CPT/HCPCS Code(s): _____
 Miscellaneous and/or unlisted codes **description required:** _____
 Number of visits: _____ Start date: _____ End date: _____
 Frequency: _____ DME Cost: \$ _____
 Number of previous visits/service description/CPT/HCPCS codes?: _____

Confidentiality Notice: The documents in this correspondence may contain confidential health information that is privileged and subject to state and federal privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). This information is intended for the sole use of the addressee named above. If you are not the intended recipient, you are hereby notified that reading, disseminating, disclosing, distributing, copying, acting upon, or otherwise using the information contained in this correspondence is strictly prohibited. If you received this information in error, please notify UnitedHealthcare to arrange for the return of the documents to us or to verify their destruction.

Glossary of Terms

Basic Benefits

All health and medical services that are covered under Medicare Part A and Part B and Medicaid, except hospice services and additional benefits. All members of UnitedHealthcare Connected receive all Basic Benefits.

CMS

The Centers for Medicare & Medicaid Services, the Federal Agency responsible for administering Medicare.

Contracting Hospital

A Hospital that has a contract to provide services and/or supplies to UnitedHealthcare Connected members.

Contracting Medical Group

Physicians organized as a legal entity for the purpose of providing medical care. The Contracting Medical Group has an agreement to provide medical services to UnitedHealthcare Connected Members.

Contracting Pharmacy

A pharmacy that has an agreement to provide UnitedHealthcare Connected Members with medication(s) prescribed by the Members' Participating Providers in accordance with UnitedHealthcare Connected.

Covered Services

Those benefits, services or supplies which are:

- Provided or furnished by Participating Providers or authorized by UnitedHealthcare Connected or its Participating Providers
- Emergency Services and Urgently Needed Services that may be provided by non-Participating Providers
- Renal dialysis services provided while you are temporarily outside the Service Area
- Basic and Supplemental Benefits

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) Serious jeopardy to the health of the individual or in the case of a pregnant woman, the health of the woman or her unborn child; 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

Emergency Services

Covered inpatient or outpatient services that are 1) furnished by a Provider qualified to furnish Emergency Services; and 2) needed to evaluate or stabilize an Emergency Medical Condition.

Experimental Procedures and Items

Items and procedures determined by UnitedHealthcare Connected and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, UnitedHealthcare Connected will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or rely upon determinations already made by Medicare.

Fee-for-Service Medicare

A payment system by which doctors, hospitals and other providers are paid for each service performed (also known as traditional and/or original Medicare).

Grievance

An expression of dissatisfaction about any matter other than an action; includes grievances. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Beneficiary's rights.

Home Health Agency

A Medicare-certified agency which provides intermittent Skilled Nursing Care and other therapeutic services in your home when Medically Necessary, when Members are confined to their home and when authorized by their Primary Care Physician.

Hospice

An organization or agency certified by Medicare, which is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people and their families.

Hospital

A Medicare-certified institution licensed in Ohio, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term Hospital does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

Hospitalist

A hospitalist is a Member of a growing medical specialty who has chosen a field of medicine that specifically focuses on the care of the hospitalized patient. Before selecting this new medical specialty, hospitalists must complete education and training in internal medicine.

As a key Member of the health care team and an experienced medical professional, the hospitalist takes primary responsibility for inpatient care by working closely with the patient's primary care physician.

Independent Physicians Association (IPA)

A group of physicians who function as a Contracting Medical Provider/Group yet work out of their own independent medical offices.

Medically Necessary

Medical Services or Hospital Services that are determined by UnitedHealthcare Connected to be:

- Rendered for the diagnosis or treatment of an injury or illness; and
- Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and
- Not furnished primarily for the convenience of the Member, the attending Participating Provider, or other Provider of service.

UnitedHealthcare Connected will make determinations of Medical Necessity based on peer reviewed medical literature, publications, reports, and evaluations; regulations and other types of policies issued by federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by UnitedHealthcare Connected.

Medicare

The Federal Government health insurance program established by Title XVIII of the Social Security Act.

Medicare Part A

Hospital insurance benefits including inpatient Hospital care, Skilled Nursing Facility Care, Home Health Agency care and Hospice care offered through Medicare.

Medicare Part A Premium

Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the Self-Employment Tax paid by self-employed persons. If Members are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, island, or local government employment to be insured, Members do not have to pay a monthly premium. If Members do not qualify for premium-free Part A benefits, Members may buy the coverage from Social Security if Members are at least 65 years old and meet certain other requirements.

Medicare Part B

Supplemental medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both Hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, Durable Medical Equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Part A.

Medicare Part B Premium

A monthly premium paid to Medicare (usually deducted from a Member's Social Security check) to cover Part B services. Members must continue to pay this premium to Medicare to receive Covered Services whether Members are covered by an Medicare Advantage Plan or by Original Medicare.

Medicare Advantage (MA) Plan

A policy or benefit package offered by a Medicare Advantage Organization under which a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area covered by UnitedHealthcare Connected. An MAO may offer more than one benefit Plan in the same Service Area. UnitedHealthcare Connected is an MA plan.

Member

The Medicare beneficiary entitled to receive Covered Services, who has voluntarily elected to enroll in the UnitedHealthcare Connected and whose enrollment has been confirmed by CMS.

Non-Contracting Medical Provider or Facility

Any professional person, organization, health facility, hospital, or other person or institution licensed and/ or certified by the Ohio or Medicare to deliver or furnish health care services; and who is neither employed, owned, operated by, nor under contract to deliver Covered Services to UnitedHealthcare Connected Members.

Participating Provider

Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the Ohio Department of Medicaid, Ohio Department of Aging, or Medicare to deliver or furnish health care services.

This individual or institution has a written agreement to provide services directly or indirectly to UnitedHealthcare Connected Members pursuant to the terms of the Agreement.

Primary Care Physician

The Participating Provider who a Member chooses to coordinate their health care. The Primary Care Physician is responsible for providing covered services for UnitedHealthcare Connected Members and coordinating recommendations to specialists. Primary Care Physicians are generally Participating Providers of Internal Medicine, Family Practice or General Practice