2023-2024 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Arizona Health Care Cost Containment System (AHCCCS) Complete Care (ACC) — Arizona Long Term Care Elderly Physically Disabled (ALTCS EPD) — Developmental Disabilities (DD)

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United Healthcare® Community Plan

Welcome

Welcome to the UnitedHealthcare Community Plan care provider manual. This up-to-date reference PDF manual allows you and your staff to find important information such as how to process a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Find operational policy changes and other electronic transactions on our website at **UHCprovider.com**.

Click the following links to access different manuals:

- **UnitedHealthcare Administrative Guide** for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual
- A different Community Plan manual: go to UHCprovider.com/guides > **Community Plan Care Provider Manuals for Medicaid Plans by State**

Easily find information in this manual using the following steps:

1. Select CTRL+F
2. Type in the key word
3. Press Enter.

If you have questions about the information or material in this manual, or about our policies, please call **Provider Services** at **1-888-445-1638**

Important information about the use of this manual

If there is a conflict between your Agreement and this care provider manual, use this manual unless your Agreement states you should use it, instead. If there is a conflict between your Agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This manual will be amended as policies change.

Terms and definitions as used in this manual:

- "Member" or "customer" refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement
- "You," "your" or "care provider" refers to any health care provider subject to this manual, including physicians,clinicians, facilities and ancillary care providers, except when indicated
- "Community Plan" refers to UnitedHealthcare's Medicaid plan.
- "Your Agreement," "Provider Agreement" or "Agreement" refers to your Participation Agreement with us
- "Us," "we" or "our" refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this care provider manual
- Any reference to "ID card" includes both a physical or digital card

Thank you for your participation in our program and the care you offer our members.

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Participation agreement

If you have a concern about your Agreement with us, send a letter with the details to the address in your Agreement. A representative will look into your concern. If you disagree with the outcome, you may file for arbitration. If your concern relates to certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, follow the dispute procedures in your Agreement. After following those procedures, if one of us remains dissatisfied, you may file for arbitration.

If we have a concern about your Agreement, we'll send you a letter containing the details. If we can't resolve the concern through informal discussions, you may file an arbitration proceeding as described in your Agreement. Your Agreement describes where arbitration proceedings are held.

If a member asks to appeal a clinical or coverage determination on their behalf, follow the member appeal process in Chapter 10 of this manual or Member Handbook. You may locate the Member Handbook at UHCCommunityPlan.com.

Also reference Chapter 14 of this manual for information on care provider disputes, member appeals and member grievances.

UnitedHealthcare Community Plan disclaimer

You are contractually obligated to adhere to and comply with all terms of the plan and care provider Agreement, including all requirements described in this manual as well as all federal and state regulations governing the plan and care providers.

While this manual contains basic information about the Arizona Health Care Cost Containment System (AHCCCS) and the Division of Developmental Disabilities (DDD), you are required to fully understand and apply AHCCCS and DDD requirements when administering covered services.

COVID-19 information and resources

Visit AHCCCS's website, azahcccs.gov, for COVID-19 resources related to Community Plan of Arizona. The website also includes frequently asked questions and billing guidelines.

UnitedHealthcare Community Plan also has COVID-19 information available at UHCprovider.com > Resources > Resource Library > COVID-19 Information and Resources. Please review the Arizona updates and reach out to your provider advocate or Provider Services with any questions.

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Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	**1-800-445-1638**
Training	UHCprovider.com/training Chat with provider services: UHCprovider.com > Sign in > Contact Us	**1-800-445-1638**
Provider Portal	UHCprovider.com, then Sign In using your One Healthcare ID or go to Provider Portal Self Service: UHCprovider.com/en/resource-library/link-provider-self-service.html New users: UHCprovider.com > New User and User Access	**1-800-445-1638** **1-800-377-2055 (ALTC/EPD)**
Provider Portal Support	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal Contact Us page.	**1-855-819-5909**
CommunityCare Provider Portal Training	CommunityCare Provider Portal User Guide	
Resource Library	UHCprovider.com > Resources > Resource Library	

Integrated health plans

The AHCCCS Complete Care (ACC), Developmental Disabilities (DD) and Arizona Long Term Care Elderly Physically Disabled (ALTCS EPD) programs will manage the care care provider network for all health care services, including medical care and behavioral health services. Instead of navigating two separate networks for medical and behavioral services, members and care care providers will have the convenience of a single health plan. This allows the member's primary care provider (PCP) to offer medical and behavioral health services as long as it is within the scope of their practice. Accordingly, our programs provide an integrated plan that includes health services for members with special needs and chronic health conditions.

Specific guidelines and policies related to the Long Term Care programs are addressed throughout this document as well as within their chapters.

If you have questions about the information in this manual or about our policies, go to UHCprovider.com or call **Provider Services** at **1-800-445-1638**.

How to join our network

To join the UnitedHealthcare Community Plan care provider network, register with AHCCCS before the credentialing process. Register with the same specialty and demographic information you will provide when starting the credentialing process. Be aware you are not reimbursed for any AHCCCS-covered services unless you are an active AHCCCS-registered care provider.

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For information on becoming an AHCCCS care provider, please visit **azahcccs.gov**.

Once you have started the enrollment process with AHCCCS, you can start the credentialing process with UnitedHealthcare Community Plan. Please review the credentialing section in our Quality Management chapter.

For instructions on joining the UnitedHealthcare Community Plan care provider network, go to **UHCprovider.com/join**. There you will find guidance on our credentialing process, how to sign up for self-service and other helpful information.

Already in network and need to make a change?

To change an address, phone number, add or remove physicians from your TIN, or other changes, go to My Practice Profile at UHCprovider.com > Our Network > **Demographics and Profiles**.

Our approach to health care

Care Model

The Care Model program seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community to improve care coordination and elevate outcomes. Targeting UnitedHealthcare Community Plan members with chronic complex conditions who often use health care, the program helps address their needs holistically. Care Model examines medical, behavioral and social/environmental concerns to help members get the right care from the right care provider in the right place and at the right time.

The program provides interventions to members with complex medical, behavioral, social, pharmacy and specialty needs, resulting in better quality of life, improved access to health care and reduced expenses. Care Model provides a care management/coordination team that helps increase member engagement, offers resources to fill gaps in care and develops personalized health goals using evidence-based clinical guidelines. This approach is essential to improving the health and well-being of the individuals, families and communities UnitedHealthcare Community Plan serves. Care Model provides:

- Market-specific care management encompassing medical, behavioral and social care.
- An extended care team including PCP, pharmacist, medical and behavioral director.
- Options that engage members, connecting them to needed resources, care and services.
- Individualized and multidisciplinary care plans.
- Assistance with appointments with PCP and coordinating appointments. The Community Health Worker (CHW) refers members to an RN, behavioral health care provider or other specialists as required for complex needs.
- Education and support with complex conditions.
- Tools for helping members engage with care providers, such as appointment reminders and help with transportation.
- Foundation to build trust and relationships with hard-to-engage members.

The Care Model program goals are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured by inpatient (IP) admission and ER rates.
- Improve access to PCP and other needed services.
- Identify and discuss behavioral health needs.
- Evaluate social determinants of health (SDOH) needs.
- Refer members to housing resources when needs are identified. See Chapters 2 and 9 for more information.
- Improve access to pharmacy.
- Identify and remove social and environmental barriers to care.
- Improve health outcomes, measured by improved Healthcare Effectiveness Data and Information Set (HEDIS®) and Centers for Medicare & Medicaid Services (CMS) Star Ratings metrics.
- Empower the member to manage their complex/chronic illness or problem and care transitions.
- Provide care management of members with chronic

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- asthma, diabetes congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and depression.
- Improve coordination of care through dedicated staff resources and to meet unique needs.
- Engage community care and care provider networks to help ensure access to affordable care and the appropriate use of services.

To refer your patient who is a UnitedHealthcare Community Plan member to Care Model, call **Member Services** or **Provider Services**.

The Whole Person Care Initiative (WPCI) is an AHCCCS initiative launched in 2019 that invites all health care partners to move from "health care" to whole-person care. The WPCI strives to improve the overall health of the Arizonans we serve. For an overview of the initiative and more resources, go to:

- **azahcccs.gov/AHCCCS/Initiatives/AHCCCSWPCI/**
- **azahcccs.gov/AHCCCS/Initiatives/AHCCCSWPCI/resources.html**

Compliance

HIPAA mandates National Provider Identifier (NPI) usage in all standard transactions (claims, eligibility, remittance advice, claims status request/response, and authorization request/response) for all care providers who handle business electronically.

Evidence-based clinical review criteria and guidelines

AHCCCS and/or CMS required guidelines must be followed. If they cannot be, UnitedHealthcare Community Plan applies evidence based, peer reviewed concurrent review criteria, then UnitedHealth Group uses InterQual and American Society of Addiction Medicine (ASAM) clinic criteria to make medical care determinations for members with substance abuse and co-occuring disorders, then UnitedHealth Group applies evidence-based, peer reviewed concurrent review criteria. Hospital system review criteria are not adopted by UnitedHealthcare and are not acceptable.

UnitedHealthcare Community Plan also uses level of care utilization system (LOCUS), child and adolescent level of care/service intensity utilization system (CALOCUS-CASII) and early childhood service intensity instrument (ECSIII) for the evidenced-based clinical care guidelines that support utilization management for behavioral health services.

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster. Learn the differences by viewing our **Digital Solutions Comparison Guide**. Care providers in the UnitedHealthcare network will conduct business with us electronically. This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents, including appeals requests and decisions and prior authorization requests and decisions. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use Application Programming Interface (API), Electronic Data Exchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

Application Programming Interface

API is becoming the newest digital method in health care to distribute information to care providers and business partners in a timely and effective manner.

API is a common programming interface that interacts between multiple applications. Our API solutions allow you to electronically receive detailed data on claims status and payment, eligibility and benefits, claim reconsiderations and appeals (with attachments), prior authorization, referrals and documents. Information returned in batch emulates data in the UnitedHealthcare Provider Portal and complements EDI transactions, providing a comprehensive suite of services. It requires technical coordination with your IT department, vendor or clearinghouse. The data is in real time and can be programmed to be pulled repetitively and transferred to your practice management system or any application you prefer. For more information, visit **UHCprovider.**

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com/api.

Electronic Data Interchange

EDI is an online resource using your internal practice management or hospital information system to exchange transactions with us through a clearinghouse.

The benefit of using EDI is it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging into different payer websites to manually request information. This is why EDI is usually care providers' and UnitedHealthcare Community Plan's first choice for electronic transactions.

- Send and receive information faster
- Identify submission errors immediately and avoid processing delays
- Exchange information with multiple payers
- Reduce paper, postal costs and mail time
- Cut administrative expenses
- EDI transactions available to care providers are:
  - Claims (837),
  - Eligibility and benefits (270/271),
  - Claims status (276/277),
  - Referrals and authorizations (278),
  - Hospital admission notifications (278N), and
  - Electronic remittance advice (ERA/835).

Visit UHCprovider.com/EDI for more information. Learn how to optimize your use of EDI at UHCprovider.com/en/resource-library/edi/edi-optimization.html?cid=none.

Getting Started

- If you have a practice management or hospital information system, contact your software vendor for instructions on how to use EDI in your system.
- Contact clearinghouses to review which electronic transactions can interact with your software system. Read our Clearinghouse Options page for more information.

Point of Care Assist™

When made available by UnitedHealthcare Community Plan, you will do business with us electronically. Point of Care Assist integrates members' UnitedHealthcare health data within the Electronic Medical Record (EMR) to provide real-time insights of their care needs, aligned to their specific member benefits and costs. This makes it easier for you to see potential gaps in care, select labs, estimate care costs and check prior authorization requirements, including benefit eligibility and coverage details. This helps you to better serve your patients and achieve better results for your practice. For more information, go to UHCprovider.com/poca.

UHCprovider.com

This public website is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.

UnitedHealthcare Provider Portal

Chat support now available

Have a question? Skip the phone and chat with a live service advocate when you sign in to the UnitedHealthcare Provider Portal. Available 7 a.m.–7 p.m. CT, Monday–Friday, chat support can help with claims, prior authorizations,credentialing and member benefits.

This secure portal is accessible from UHCprovider.com It allows you to access patient information such as eligibility and benefit information and digital ID cards. You can also perform administrative tasks such submitting prior authorization requests, checking claim status, submitting appeal requests, and find copies of PRAs and letters in Document Library. All at no cost to you and without needing to pick up the phone.

To access the portal, you will need to create or sign in using a One Healthcare ID. To use the portal: If you already have a One Healthcare ID (formerly known as Optum ID), simply go to UHCprovider.com and click Sign In in the upper right corner to access the portal. If you need to set up an account on the portal, follow these steps to register.

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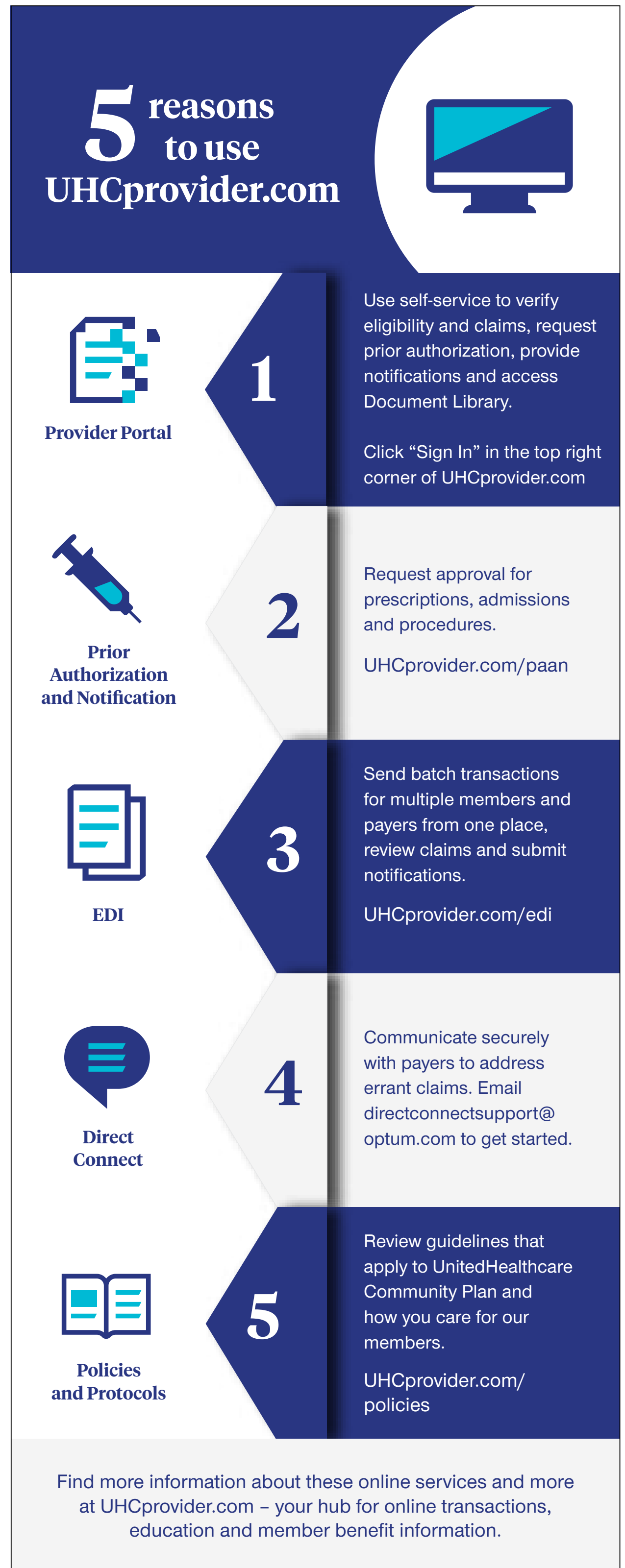

Here are the most frequently used portal tools:

- **Eligibility and benefits —** View patient eligibility and benefits information for most benefit plans. For more information, go to UHCprovider.com/eligibility.
- **Claims —** Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to UHCprovider.com/claims.
- **Prior Authorization and Notification —** Submit notification and prior authorization requests. For more information, go to UHCprovider.com/paan.
- **Specialty Pharmacy Transactions —** Submit notification and prior authorization requests for certain medical injectable drugs by selecting the Prior Authorization dropdown in the UnitedHealthcare Provider Portal. You will be directed to Prior Authorization and Notification capability to complete your requests.
- **My Practice Profile —** View and update your care provider demographic data that UnitedHealthcare members see for your practice. For more information, go to UHCprovider.com/mpp.
- **Document Library —** Access reports and correspondence from many UnitedHealthcare plans for viewing, printing or download. For more information on the available correspondence, go to UHCprovider.com/documentlibrary.
- **Paperless Delivery Options —** The Paperless Delivery Options tool can send daily or weekly email notifications to alert you to new letters added to your Document Library. With our delivery options, you decide when and where the emails are sent for each type of letter. This is available to Provider Portal One Healthcare ID password owners only.

Go to UHCprovider.com/portal to learn more about the portal. You can access self-paced user guides for many of the tools and tasks available in the portal at UHCprovider.com/training > Digital Solutions.

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Direct Connect

Direct Connect is a free online portal that lets you securely communicate with UnitedHealthcare Community Plan to address credit balances, overpayments and errant claims. This portal can replace previous methods of letters phone calls and spreadsheets. It also helps:

- Manage overpayments in a controlled process.
- Create a transparent view between care provider and payer.
- Avoid duplicate recoupment and returned checks.
- Decrease resolution timeframes.
- Real-time reporting to track statuses of inventories in resolution process.
- Provide control over financial resolution methods.

All users will access Direct Connect using the Provider Portal. On-site and online training is available.

Call **1-888-457-4759** 7 a.m. – 5 p.m. CT Monday – Friday to get started with Direct Connect. Or email directconnectsupport@optum.com.

Additional department resources

Inclusion and diversity

As a company who serves everyone, valuing inclusion and diversity is a critical part of who we are. Our culture celebrates and respects the differences that make each of us unique. We are dedicated to being champions of better health for all, including those who are underserved or overlooked in our communities. Office of Individual and Family Affairs.

Office of Individual and Family Affairs

UnitedHealthcare Community Plan's Office of Individual and Family Affairs (OIFA) works closely with you, our members and their loved ones to help ensure recovery from mental health issues and substance use challenges becomes a reality.

For more information or to set up a meet and greet, please call the OIFA administrator at **1-602-255-8605**.

Provider Services

Provider Services is the primary contact for care providers who require assistance. It is staffed with representatives trained specifically for UnitedHealthcare Community Plan. All issues received in Provider Services are acknowledged within three business days. You are notified of resolution within 30 business days. Notification of resolution is the action of telling you the issues have been resolved. It states a detailed description of the actions to be taken and when to expect resolution.

- UnitedHealthcare Community Plan Provider Services (ACC/DD): **1-800-445-1638**
- Long-Term Care (ALTCS EPD): **1-800-377-2055**

Provider Services can assist you with questions on Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more.

Provider Services works closely with all departments in UnitedHealthcare Community Plan.

Culturally and linguistically appropriate services

Because language and cultural barriers can affect access to health care, we have developed a Cultural Competency Program. This program helps:

- Ensure the member and family receive effective, understandable, respectful care compatible with their cultural health beliefs, practices and preferred language.
- Implement strategies to recruit, retain and promote a diverse staff and leadership representative of the demographic characteristics of the service area.
- Develop, implement, and promote goals and policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services

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(CLAS).

- Ensure all staff receives ongoing education and training in CLAS.
- Conduct initial and ongoing organizational self-assessments of CLAS-related activities and integrated cultural and linguistic competence related measures into internal audits, performance improvement programs, member satisfaction assessments, and outcome-based evaluations.
- Ensure data on member's race, ethnicity, and preferred language is collected in the member's medical record, integrated into management information systems and periodically updated.
- Maintain a current demographic profile of the service area as well.
- Communicate existing needs to accurately plan for and implement services that respond to the cultural and linguistic characteristic of the service area.
- Develop collaborative relationships with communities and use a variety of formal and informal mechanisms to facilitate member, family, and community involvement in designing and implementing CLAS-related activities.
- Ensure conflict and grievance resolution processes are culturally and linguistically sensitive. They should identify, prevent and resolve cross-cultural conflicts.
- Make information about the progress and successful innovations in implementing CLAS available to the public.

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program based on the AHCCCS Cultural Competency, Language Access Plan and Family/Patient Centered Care guidelines. You must support UnitedHealthcare Community Plan's Cultural Competency Program.

This means you must:

- Recruit and support culturally and linguistically diverse representation within governance, leadership and the workforce responsive to the population in the services area.
- Educate staff in culturally and linguistically appropriate policies and practices on an ongoing basis. Care providers with direct care responsibilities must complete mandated Cultural Competency training.

Additional information is available in the AHCCCS Contractors Operations Manual, Chapter 400 and the Division Provider Manual, Chapter 26.

To comply with the Language Access Services (LAS):

- Offer language assistance as specified in 45 CFR 92.4 to individuals who have limited English proficiency (LEP) and/or other communication needs. This includes sign language interpreters and American Sign Language (ASL) fluent staff, at no cost to members, to facilitate timely access to all health care and services.
- Tell all members that language assistance services are available in their preferred language, verbally and in writing.
- Help ensure the individuals providing language assistance are competent. Avoid using untrained family and friends and/or minors as interpreters.
- Identify the non-English languages within your service areas to meet those needs.
- Provide easy-to-understand print and multimedia materials as well as signage in the languages commonly used by those in the service area.
- Provide culturally competent services, considering members with LEP or reading skills and those with diverse cultural and ethnic backgrounds. This includes those who identify with Deaf culture as well as members with visual or auditory limitations. Options include access to a language interpreter, an ASL interpreter and written materials available in different formats as appropriate.
- Help ensure access to qualified oral interpreters and bilingual staff as well as certified sign language interpreters. You must provide oral interpretation, translation, sign language and disability-related services as well as auxiliary aids and alternative formats on request. Oral interpretation and sign language services are provided at no charge to AHCCCS-eligible persons and those determined to have a Serious Mental Illness (SMI).
- Conduct evaluations of the primary non-English languages spoken within the Tribal Regional Behavioral Health Authorities (T/RBHA) Geographical Service Areas (GSAs) and T/RBHA programs that affect cultural competence, access and quality of care.

We offer the following support services:

- **Language translation and American Sign Language (ASL) interpretation:** UHCCP provides

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translation and interpreter services to help ensure all members and their families understand the member's diagnosis and treatment plan in a culturally sensitive manner. Services are available to our members and to you, free of charge.

- More than 240 non-English languages and hearing-impaired services are available. These services are for UnitedHealthcare Community Plan members only. You will be asked for the member's AHCCCS ID when scheduling these services. Language translation and ASL interpretation may be scheduled for in person or virtual visits. For virtual visits, care providers may provide their own secure meeting platform such as Zoom, Teams, etc. or the link for the virtual meeting will be provided. To schedule language or interpretation services contact Provider Services.
  - T1013 (sign language or oral interpretive services, per 15 minutes) will not be separately reimbursed
  - Cultural competency in-service through office training
  - Pocket guide to culturally competent care
  - Member Services language capacity
  - **Materials for limited English-speaking members:** We provide simplified materials for members with LEP and who speak languages other than English or Spanish. We also provide materials for visually impaired members. For more information, go to **uhc.com/legal/nondiscrimination-and-language-assistance-notices**.

Help ensure applicants for employment, employees and those to whom you provide service are not discriminated against due to race, creed, color, religion, sex, national origin or disability.

You must comply with federal regulations and Arizona Revised Statute (A.R.S.) §§ 36-2918, 36-2932, and 36-2957. These mandate that all persons, regardless of race, color, religion, sex, national origin, or political affiliation have equal access to employment opportunities and all other applicable federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI of the Civil Rights Act of 1964. The Division acts based on contractual obligations, state and federal codes and laws, including the Civil Rights Act of 1964 Public Law § 88-352.

Member Advocacy Council

The Member Advocacy Council (MAC) provides educational and collaborative opportunities for council members, UnitedHealthcare Community Plan members and their families and representatives. Working with our care providers and community partners, MAC obtains feedback and suggestions from council members to help improve services, the delivery system and the member experience. To learn more or to make a referral, please contact UnitedHealthcare Community Plan's Office of Individual and Family Affairs at advocate.oifa@uhc.com or Member Services at 1-800-348-4058 (e.g., member materials; website; family-centered, people-first resources).

Culturally competent and family-centered services

Member Advocacy Program

The ombudsman/member advocate oversees the Member Advocacy Program. They work with Member Services and Provider Services to help you provide accessible, effective, person- and family-centered culturally and linguistically appropriate care. This care must be delivered consistently and with evidence-based best practice guidelines.

This person coordinates and disseminates advocacy communications, providing assistance and support for members and families within the systems of care. They work with community and family advocacy organizations to share program updates, develop family-friendly materials, and act as a liaison for families and members to work with care providers to prevent or resolve issues.

The Member Advocacy Program supports families and care providers in navigating health and social service systems that provide care for children with special needs. The program works with state agencies, community service and advocacy organizations to identify barriers for individual members and systemic issues that may keep them from accessing services.

Family-centered culturally competent care

We provide family-centered care by:

- Recognizing the family as the primary source of support for the member's health care decision-

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making process. Service systems and personnel support the family's roles as decision-makers.

- Facilitating collaboration among members, families, care providers, and policy-makers for the:
  - Member's care.
  - Program development, implementation and evaluation.
  - Policy development.
- Promoting supportive exchange of unbiased information between members, families and care professionals.
- Recognizing cultural, racial, ethnic, geographic, social, spiritual, and economic diversity and individuality within and across all families.
- Implementing practices and policies that support members and families, including their medical, developmental, educations, emotional, cultural, environmental, and financial needs.
- Completing Family-Centered Cultural Competence trainings.
- Facilitating family-to-family support and networking.
- Promoting available, accessible and complete community, home and hospital support systems to meet the family's diverse, unique needs.

Privileges

To help our members access appropriate care and minimize out-of-pocket costs, you must have privileges at applicable in-network facilities or arrangements with an in-network care provider to admit and provide facility services. This includes full admitting hospital privileges, ambulatory surgery center privileges and/or dialysis center privileges.

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How to contact us

*We no longer use fax numbers for most departments, including benefits, prior authorization and claims.

Topic	Contact	Information
AHCCCS Provider Enrollment Portal (APEP)	azahcccs.gov AHCCCS Provider Enrollment • 1-800-794-6862 (In state – outside of Maricopa County) • 1-800-523-0231 (Out of state)	The AHCCCS Provider Enrollment Portal (APEP) is an online, electronic portal which streamlines and expedites the care provider enrollment process for care providers. APEP allows care providers a means to electronically submit a new enrollment or modify an existing care provider ID anytime of the day. The APEP system allows you to: • Enroll as an AHCCCS provider. • Update demographic data information (such phone and addresses). • Upload and/or update licenses and certifications. • Include the current population group sets served (for those care provider types asked to enter the population group sets during their AHCCCS registration) per new AHCCCS/ACC contract language. Learn more at azahcccs.gov/PlansProviders/APEP/ProviderEnrollment.html.
Arizona State Immunization Information System (ASIIS) Hotline	1-602-364-3899 or 1-877-491-5741	
Behavioral Health Claim	Provider Call Center: **1-800-445-1638** **United Behavioral Health** P.O. Box 30760 Salt Lake City, UT 84130-0760	Check eligibility, claims, benefits, authorization and appeals. Refer to Chapter 13 for timely filing guidelines. See Chapter 14 for reconsiderations, disputes and appeal information.
Benefits	UHCprovider.com/benefits Provider Services: **1-800-445-1638** ALTCS EPD Provider Services: **1-800-293-3740**	Confirm a member's benefits and/or prior authorization.
Cardiology Prior Authorization	For prior authorization or a current list of CPT codes that require prior authorization, visit UHCprovider.com/cardiology. Provider Services: **1-800-445-1638**	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Cardiovascular Prior Authorization	For prior authorization or a current list of CPT codes that require prior authorization, visit the Prior Authorization and Notification section of UHCprovider.com/azcommunityplan	Current prior authorization requirements are listed for ACC, DD, LTC and DSNP.

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Topic	Contact	Information
Case Management Offices (ALTCS EPD)	Maricopa County (Phoenix): 1-800-377-2055 Fax: 1-855-465-3075 Local: 1-602-255-8913	
Chiropractor Care	myoptumhealthphysicalhealth.com **1-800-873-4575**	Prior authorization not required for members younger than age 21. Adults allowed 20 visits per year, anything over 20 must be medically necessary.
Claims	Use the Provider Portal at UHCprovider.com > Contact Us for a complete list of medical and behavioral health claims addresses. ALTCS EPD: **1-800-377-2055** AHCCCS Complete Care Provider Services: **1-800-445-1638** Dental Claims: UHCproviders.com	Submit claims, check claim status and submit reconsiderations through the Provider Portal.
Claims Corrections, Disputes and Member Appeals (Medical)	Sign in to the Provider Portal at UHCprovider.com or go to UHCprovider.com/claims for more information. Provider Services: **1-800-445-1638** ALTCS EPD Provider Call Center: **1-800-377-2055** Corrected Claim & Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5290 Kingston, NY 12402-5290 Dental Corrected Claims: **UnitedHealthcare Community Plan Dental** P.O. Box 481 Milwaukee, WI 53201 Provider Disputes (ACC/DD/ALTCS EPD): **UnitedHealthcare Community Plan** Provider Claim Disputes 1 East Washington, Suite 900 Phoenix, AZ 85004 Member Grievances and Appeals: **UnitedHealthcare Community Plan Member Grievances and Member Appeals** 1 East Washington, Suite 900 Phoenix, AZ 85004	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with. A claims dispute must state you are filing a "dispute." Reference to an "appeal" indicates a member appeal. Member appeals include those related to pre-service denials.

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Topic	Contact	Information
Claim Overpayments	See the Overpayment section for requirements before sending your request. Sign in to UHCprovider.com/claims to access the Provider Portal Provider Services: **1-800-445-1638** ALTCS EPD Provider Services: **1-800-377-2055** Refund check mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800 Refunds requested by UnitedHealthcare Community Plan should be sent with a copy of the Overpayment Notification Letter to: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 101760 Atlanta, GA 30392-1760	Ask about claim overpayments.
Compliance	**UnitedHealthcare Community Plan Compliance Office** 1 East Washington, Suite 900 Phoenix, AZ 85004	

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Topic	Contact	Information
Crisis Lines	**National Crisis: 988, 988lifeline.org** **Statewide Crisis:** 1-844-534-4673 Cochise, Gila, Graham, Greenlee, La Paz, Santa Cruz, Yuma Counties: 1-866-495-6735 Pima County: 1-800-796-6762 Maricopa County: 1-800-631-1314 Apache, Coconino, Mohave, Navajo, Yavapai Counties: 1-877-765-4090 Veterans Crisis Lines (for veterans and those who support them): 1-800-273-8255, press 1 **Arizona Tribal Crisis Phone Numbers** Tribal Warm Line : 1-855-728-8630 Ak-Chin Indian Community: 1-800-259-3449 Strong Hearts Native Helpline (National) 1-844-762-8483 Fort McDowell Yavapai Nation: 1-480-461-8888 Gila River Indian Community: 1-800-259-3449 Hopi Tribe: 1-928-737-6300 Navajo Nation Chinle area: Monday – Friday / 8am – 5pm 1-928-674-2190 After Hours & Weekends: 1-928-551-0247 Dilkon area: Monday – Friday / 8am – 5pm 1-928-657-8000 After Hours & Weekends: 1-928-551-0624	Any member, regardless of eligibility, may call the crisis lines.
Dental	**Dental Benefit Providers** Dental Providers Customer Service, Member Eligibility & Claims Status 1-855-812-9208	Find more benefit information for members 21 years and older in Chapter 300 of the AHCCCS Medical Policy Manual or Chapter 300 of the Division Medical Policy Manual.
DES/DDD Health Care Services	1-602-771-8080	
Dual Complete AZ-S001	1-877-614-0623 TTY: 1-800-842-481	

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Topic	Contact	Information
Early and Periodic Screening Diagnosis and Treatment (EPSDT)	Fax: 1-844-885-8445	
Electronic Data Intake (EDI) issues	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315**	Contact EDI Support for issues or questions.
Electronic Payments & Statements (EPS)	**1-877-620-6194**	Enroll by going to **UHCprovider.com/eps**. Review the following guides: • **EPS Enrollment guide for Automated Clearing House (ACH) / Direct Deposit Opens in a new window**, • **EPS Enrollment guide for Virtual Card Payments (VCPs) Opens in a new window**
EDI Support Services	**1-800-210-8315**	
Eligibility	To access eligibility information, go to **UHCprovider.com** then Sign In to the Provider Portal or go to **UHCprovider.com/eligibility** Provider Call Center: **1-800-445-1638** ALTCS EPD Provider Call Center: **1-800-377-2055** The AHCCCS website also helps you verify eligibility. Visit **azweb.statemedicaid.us** and follow the prompts to create an account. For technical issues, call AHCCCS Customer Support at 1-602-417-4451.	Confirm member eligibility.
Enterprise Voice Portal	**1-800-445-1638**	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud, Waste and Abuse (Payment Integrity)	Payment integrity information: UHCprovider.com/azcommunityplan > Reporting Health Care Fraud, Waste and Abuse Reporting: **UHC.com/fraud** **1-800-455-4521**(NAVEX) or **1-877-401-9430**	Learn about our payment integrity policies. Report suspected fraud, waste or abuse by a care provider or member by phone or online.

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Topic	Contact	Information
Healthy First Steps/ Obstetrics (OB) Referral	Healthy First Steps: UHChealthyfirststeps.com **1-800-599-5985** UHCprovider.com/azcommunityplan > Provider Forms > Pregnancy Notification Form	For pregnant members, contact Healthy First Steps by calling or filling out the Pregnancy Notification Form.
Incontinence Briefs	UHCCommunityPlan.com/AZ	Incontinence briefs for members younger than 21 years are covered for a medical condition. Briefs are covered up to 240 per month. Anything exceeding 240 per month requires evidence of medical necessity. For members older than age 21, briefs are covered up to 180 per month. Anything exceeding 180 per month requires evidence of medical necessity. Please refer to AMPM 310-P.
Infusion and Enteral Services	Optum Infusion Services Effective until: 11/30/23 Optum Rx Effective12/1/23 **1-480-705-6200** Enteral Services: Preferred Homecare: **1-888-922-9809** Fax: 1-480-993-2089	For infusion services and Preferred Homecare for enteral services. Optum Infusion Services Effective until: 11/30/23 Optum Rx Effective12/1/23
Laboratory Services	UHCprovider.com > Our Network > Preferred Lab Network Labcorp 1-800-833-3984 Labcorp.com	Labcorp is our network laboratory.
Member Services	myUHC.com ACC/DD: **1-800-348-4058** ALTCS EPD: 1-800-293-3740	Members may call for help with issues or concerns. Available 8 a.m. – 5 p.m. Arizona Time, Monday through Friday.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network Management Support	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal Contact Us page. ncc-optum.secure.force.com/rfp **1-877-842-3210**	Self-service functionality for medical network are providers to update or check credentialing information. elf-service functionality to update or check credentialing information.

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Topic	Contact	Information
Network Management Team	**1-866-574-6088**	A team of provider relation advocates. Ask about contracting and care provider services.
NuMotion	Phoenix: 1-602-452-4320 Tucson: 1-520-323-4496	In-network care provider for wheelchair services.
NurseLine	**1-866-351-6827**	Available 24 hours a day, seven days a week.
Oncology Prior Authorization	UHCprovider.com>Prior Authorization>**Oncology** Optum **1-888-397-8129** Monday -Friday 7am – 7pm CST	For current list of CPT codes that require prior authorization for oncology
One Healthcare ID Support Center	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. **1-855-819-5909**	Contact if you have issues with your One Healthcare ID. Available 7 a.m. – 9 p.m. CT, Monday through Friday; 6 a.m. – 6 p.m. CT, Saturday; and 9 a.m. – 6 p.m. CT, Sunday.
Online Help Desk	**1-866-842-3278** Press option 1 for **UHCprovider.com** Press 3 for Optum	
OptumRx	Effective 12/1/23: OptumRx **1-480-705-6200** 2555 W. Fairview St., Ste 104 Chandler, AZ 85224-4708	OptumRx is a network infusion services care provider.
Pharmacy Services	**UHCprovider.com** **1-877-305-8952** (OptumRx) Pharmacy Prior Authorization: **1-800-310-6826** Pharmacy Prior Authorization Fax: **1-866-940-7328**	Preferred Drug List (PDL) information, including updates, is available on **UHCprovider.com**. You will be notified of changes before they take effect. See Chapter 4 for more information. The PDL, Pharmacy Prior Notification Request Form, and PDL Change Request Form are on the website and can be printed or saved. To obtain a print copy of the UnitedHealthcare PDL, contact Provider Services. Use the Provider Portal to access the PreCheck MyScript tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives.

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Topic	Contact	Information
Preferred Homecare	1-800-636-2123 or 1-888-922-9809 Fax: 1-866-265-0455 Enteral Services: 1-480-446-9010 Billing Address: 4602 E. Hammond Lane Phoenix, AZ 85034-6411	Preferred Homecare is our network durable medical equipment provider.
Prior Authorization/ Dental	**UHCproviders.com**	Find a list of covered dental services and prior authorization requirements on the provider portal.
Prior Authorization/ Notification for Pharmacy	**UHCprovider.com/priorauth** **1-800-310-6826**	Request authorization for medications as required.
Prior Authorization Requests/Advance & Admission Notification	**UHCprovider.com/paan** ACC/DD Prior Authorization Department: **1-866-604-3267** ALTCS EPD Prior Authorization Department: **1-800-377-2055** To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N Online Tool: **UHCprovider.com/paan** Phone: Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications."	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required. • Complete the notification or prior authorization process. • Upload medical notes or attachments. • Check request status Information and advance notification/prior authorization lists: Visit UHCprovider.com/azcommunityplan > **Prior Authorization and Notification**
Provider Services	**UHCprovider.com/AZcommunityplan** • ALTCS EPD: **1-800-377-2055** • ACC/DD: **1-800-445-1638**	Available 8 a.m. – 5 p.m. PT, Monday through Friday. ACC/DD: Available 8 a.m. – 5 p.m. PT, Monday through Friday.
Quality Management	Call Provider Services or Member Services ALTCS EPD: **1-800-377-2055**	Call the health plan Member Services number on the member's ID card to report quality of care concerns.
Radiology Prior Authorization	**UHCprovider.com/radiology** **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.

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Topic	Contact	Information
Regional Behavioral Health Authority	Arizona Complete Health (formerly CIC): 1-888-788-4408 Mercy Integrated Care (formally MMIC): 1-800-564-5465 Steward Health Choice Arizona (formerly HCIC): 1-800-322-8670 Gila River Health Care: **grhc.org** 1-520-562-3321 Navajo Regional Behavioral Health Authority: **nndbmhs.org** 1-928-871-6877 Pascua Yaqui Behavioral Health Centered Spirit Program: **pascuayaqui-nsn.gov/health-services/centered-spirit** 1-520-879-6060 Apache Behavioral Health Services: **wmabhs.org** 1-928-338-4811	
Referrals	UHCprovider.com > **Referrals**	Submit new referral requests and check the status of referral submissions.
Reimbursement Policy	**UHCprovider.com/AZcommunityplan** Bulletins and Newsletters **Guidelines/Policies/Manuals**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Substance Use Disorder (SUD) Helpline	Live chat at **liveandworkwell.com/recovery** or call 1-866-842-3278	Get access to a licensed behavioral health clinician or specialized Substance Use Recovery Advocate (SURA) 24 hours a day, seven days a week for help with referrals or other needs. This helpline is not an insurance benefit but a resource for people in any community.
Technical Support	Website: **UHCprovider.com/en/contact-us/technical-assistance.html** 1-866-209-9320 for Optum support or 1-866-842-3278, Option 1 for web support	Call if you have issues logging in to the Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit Line	1-800-784-8669	Ask about services for quitting tobacco/smoking.
Translation/ Interpretation Services	Provider Services **1-800-445-1638**	

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Topic	Contact	Information
Transportation (Non-Emergent)	Medical Transportation Brokerage of Arizona (MTBA) 1-602-889-1777 or 1-888-700-6822	Schedule transportation or for transportation assistance. To arrange non-urgent transportation, please call three days in advance. **Dual Complete AZ-S001**: • Up to 36 one-way trips are covered per calendar year (limited to ground transportation only). • Trips must be to or from plan-approved locations within the plan service area, limited to covered routine dental, vision, podiatry or hearing services not covered by Original Medicare. **Dual Complete AZ-Y001** (formerly Dual Complete One): • Up to 36 one-way trips are covered per calendar year (limited to ground transportation only). • Trips must be to or from plan-approved locations within the plan service area, limited to covered routine dental, vision, podiatry or hearing services not covered by Original Medicare.
Utilization Management	Provider Services **1-800-445-1638**	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. Request a copy of our UM guidelines or information about the program. For UM policies and protocols, go to UHCprovider.com > Resources > **Health Plans, Policies, Protocols and Guides**.
Vaccines for Children (VFC) program Arizona State Immunization Program	ArizonaVFC@azdhs.gov ASIISHelpDesk@azdhs.gov 1-602-364-3642 1-602-364-3899	Care providers must participate in the VFC Program administered by the Arizona Health Care Cost Containment System (AHCCCS) and must use the free vaccine when administering vaccine to qualified eligible children. Care providers must enroll as VFC care providers with AHCCCS to bill for the administration of the vaccine.

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Topic	Contact	Information
Vision Services	**NationwideVision.com**	All eligible members younger than 21 years may self-refer to Nationwide Vision for routine vision services. Members younger than 21 years are limited to one diagnostic eye exam in a 12-month period without obtaining prior authorization. Additional exams require prior authorization and should be obtained by the PCP/PCO from Nationwide Vision. For members 21 years and older, diagnosis and/or treatment of refractive errors are not covered unless prescriptive lenses or contacts are the sole prosthetic device.
Website for Arizona Community Plan	**UHCprovider.com/AZcommunityplan**	Access your state-specific Community Plan information on this website.

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Chapter 2: Care provider standards and policies

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com**	• ALTCS EPD: **1-800-377-2055** • ACC/DD: **1-800-445-1638**
Enterprise Voice Portal		**1-877-842-3210**
Eligibility	**UHCprovider.com/eligibility**	• ALTCS EPD: **1-800-377-2055** • ACC/DD: **1-800-445-1638**
Referrals	UHCprovider.com > **Referrals**	• ALTCS EPD: **1-800-377-2055** • ACC/DD: **1-800-445-1638**
Provider Directory	UHCprovider.com > Our Network > **Find a Provider**	• ALTCS EPD: **1-800-377-2055** • ACC/DD: **1-800-445-1638**

General care provider responsibilities

All services shall be rendered by care providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS care provider.

Non-discrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them based on age, sex, race, physical or mental handicap, national origin, religion, type of illness or condition per 42 CFR § 438.210(a)(3)(ii). You may only direct the member to another care provider if that illness or condition may be better treated by someone else.

Communication between care providers and members

The UnitedHealthcare Community Plan Agreement does not prevent you from advocating on behalf of the members based on 42 CFR § 438.102 and 42 CFR § 457.1222. It does not interfere with UnitedHealthcare Community Plan's ability to administer its quality improvement, utilization management or credentialing programs. Instead, we require communication between PCPs and other participating care providers. This helps ensure UnitedHealthcare Community Plan members receive both quality and cost-effective health services.

UnitedHealthcare Community Plan members and/or their representative(s) may take part in the planning and implementation of their care. To help ensure members and/or their representative(s) have this chance, UnitedHealthcare Community Plan requires you:

1. Educate members, and/or their representative(s) about their health needs.
2. Help members understand their right to file grievance and appeals based on their member rights and responsibilities. (See Chapter 10 for more details.)
3. Share findings of history and physical exams.
4. Discuss options (without regard to plan coverage), treatment side effects and symptoms management. This includes any self-administered alternative or information that may help them make care decisions.
5. Recognize members (and/or their representatives) have the right to choose the final course of action

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among treatment options.

6. Collaborate with the plan care manager in developing a specific care plan for members enrolled in high-risk case management.
7. Render covered services to members in an appropriate, timely, cost-effective manner and based on their specific agreement and AHCCCS requirements.
8. Maintain all licenses, certifications, permits or other prerequisites required by law to provide covered services.
9. Render services to members diagnosed 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
10. Tell all assigned AHCCCS pregnant women of voluntary prenatal HIV testing and the availability of medical counseling. Tell members where they can go for testing.
11. Use the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) to obtain a utilization report regarding the patient for the preceding 12 months at the beginning of each new course of treatment and at least quarterly while the prescription remains a part of the treatment before prescribing an opioid analgesic or benzodiazepine controlled substance listed as a Schedule II, III, or IV controlled medication.
12. Transmit any Schedule II controlled opioid substances to the dispensing pharmacy with an electronic prescription order as required by federal law or regulation.
13. Complete required re-enrollment process in compliance with AHCCCS guidelines as stated in 42 CFR § 455, Subpart E.
14. When transitioning a member to a new PCP or other network care provider, transfer the member's records within 10 working days of the change. If a member enrolls with a new health plan, share member information according to confidentiality rules.

Abuse, neglect and exploitation prevention

Based on the Minimum Subcontract Provisions and Executive Order 2019-03, care providers who directly serve children or vulnerable adults, as defined by A.R.S. § 46-451(A)(9), must develop policies, signage and training aimed at preventing abuse, neglect and exploitation as well as reporting incidents. Please implement and monitor policies aimed at preventing abuse, neglect and exploitation and report incidents, conduct investigations and complete routine testing of staff responses to simulated acts of exploitive, abusive and neglectful behavioral in a manner similar to routine fire and other emergency drills. Post signage about how to anonymously report abuse, neglect and exploitation that also explains whistleblower protections.

Provide official notice

Write to us within 10 calendar days if any of the following events happen:

1. Bankruptcy or insolvency.
2. Indictment, arrest, felony conviction or any criminal charge related to your practice or profession.
3. Suspension, exclusion, debarment or other sanction from a state or federally funded health care program.
4. Loss or suspension of your license to practice.
5. Departure from your practice for any reason.
6. Closure of practice.

You may use the Care Provider Demographic Update Form for demographic changes or to update NPI information for care providers in your office. This form is located at **UHCprovider.com** then Sign In > Provider Practice Profile.

You can also update your demographic and practice data information in the My Practice Profile app. Find more information on **UHCprovider.com**.

Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to another in-network care provider within a timely manner. This may include providing service(s) for a reasonable time at our in-network rate. Provider Services is available to help you and our members with the transition.

Arrange substitute coverage

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If you cannot provide care and must find a substitute, arrange for care from other UnitedHealthcare Community Plan care providers.

For the most current list of network professionals, review our Provider Directory at UHCprovider.com > Our Network > **Find a Provider**.

Administrative terminations for inactivity

Up-to-date directories are a critical part of providing our members with the information they need to take care of their health. To accurately list care providers who treat UnitedHealthcare Community Plan members, we:

1. End Agreements with care providers who have not submitted claims for UnitedHealthcare Community Plan members for one year and have voluntarily stopped participation in our network.
2. Inactivate any tax identification numbers (TINs) with no claims submitted for one year. This is not a termination of the Care Provider Agreement. Call UnitedHealthcare Community Plan to reactivate a TIN.

Changing an existing TIN or adding a care provider

Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the address listed on the bottom of the form.

- Download the W-9 form at irs.gov > Forms & Instructions > **Form W-9**.
- Download the Care Provider Demographic Information Update Form at UHCprovider.com > Our Network > Find a Provider > My Practice Profile Tool > **Care Provider Paper Demographic Information Update Form**.
- To update your care provider information online, go to UHCprovider.com > Our Network > Find a Provider > My Practice Profile Tool > **Go To My Practice Profile Tool**.

Otherwise, complete detailed information about the change, the effective date of the change and a W-9 on your office letterhead. Send this information to the email listed on the bottom of the demographic change request form.

Updating your practice or facility information

You can update your practice information through the My Practice Profile application on **UHCprovider.com**. Go to **UHCprovider.com** then Sign In > My Practice Profile. Or submit your change by:

- Completing the **Care Provider Demographic Change Form** and emailing it to the appropriate address listed on the bottom of the form
- Calling our Enterprise Voice Portal at **1-877-842-3210**

Also notify AHCCCS about these changes. Details and forms are found on **azahcccs.gov**. Registered AHCCCS care providers may also change their address with AHCCCS using this website.

After-hours care

Life-threatening situations require the immediate services of an emergency department. Urgent care can provide quick after-hours treatment and is appropriate for infections, fever, and symptoms of cold or flu.

If a member calls you after hours asking about urgent care, and you can't treat them, refer them to an urgent care center.

Participate in quality initiatives

You must help our quality assessment and improvement activities. You must also follow our clinical guidelines, member safety (risk reduction) efforts and data confidentiality procedures.

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for diseases and conditions. This is determined by United States government agencies and professional specialty societies. See Chapter 12 for more details on the initiatives.

Provide access

You must provide access to any of the following related to services you provide to UnitedHealthcare Community

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Plan members within 14 calendar days of our request:

- Premises
- Physical facilities
- Equipment
- Books
- Records
- Contracts
- Computer or other electronic systems
- Medical, financial or administrative records

We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for six years or longer if required by applicable statutes or regulations.

Performance data

You must allow the plan to use care provider performance data.

Comply with protocols

You must comply with UnitedHealthcare Community Plan's and Payer's Protocols, including those contained in this manual.

You may view protocols at **UHCprovider.com**.

Electronic Visit Verification

Care providers must comply with the AHCCCS Electronic Visit Verification (EVV) guidelines and protocols found on **azahcccs.gov/ahcccs/initiatives/evv**, if applicable. See Chapter 13 for more information.

Statewide closed loop referral system

As part of the WPCI, AHCCCS launched a statewide closed loop referral system called CommunityCares. This system integrates with existing electronic health record systems, patient and member portals, and care/case management systems to refer members to community-based organizations (CBOs) that provide services to address social risk factors of health. Use this system to make appropriate referrals. Learn more at **healthcurrent.org/sdoh**/.

Office hours

You must provide the same office hours of operation to UnitedHealthcare Community Plan members as those offered to commercial members.

Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to stop unintentional disclosure of protected health information (PHI). This includes passwords, screen savers, firewalls and other computer protection. It also includes shredding information with PHI and all confidential conversations. All staff is trained on HIPAA and confidentiality requirements.

Follow medical record standards

Please reference Chapter 11 for Medical Record Standards.

Inform members of advance directives

Members have the right to make their own health care decisioisns. This includes accepting or refusing treatment. They may execute an advance directive at any time. An advance directive is a document in which the member makes rules around their health care decisions if they later cannot make those decisions.

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Several types of advance directives are available. You must comply with Arizona state law requirements about advance directives.

Members are not required to have an advance directive. You cannot provide care or otherwise discriminate against a member based on whether they have executed one. Document in a member's medical record whether they have executed or refused to have an advance directive.

If a member has one, keep a copy in their medical record. Or provide a copy to the member's PCP. Do not send a copy of a member's advance directive to UnitedHealthcare Community Plan.

If a member has a complaint about non-compliance with an advance directive requirement, they may file a complaint with the UnitedHealthcare Community Plan medical director, the physician reviewer, and/or the state survey and certification agency as well as with the ADHS Division of Licensing Services.

Informed consent

Informed consent is an agreement to receive a service or treatment after the member has been told the associated risks and benefits. It must be obtained from a member or legal guardian prior to delivering services.

The AHCCCS guidelines regarding general and informed consent are available in the Medical Policy Manual, Chapter 300, Policy 320-Q.

In all cases where informed consent is required per Policy 320-Q, informed consent must include at a minimum:

- The member's right to participate in decisions regarding their care, including the right to refuse treatment and to express preferences about future treatment options;
- The information about the member's diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment;
- The risks of the proposed treatment, including side effects and refusing care;
- The alternatives to the proposed treatment, such as those that offer less risk or other adverse effects;
- That any consent given may be withheld or withdrawn in writing or orally at any time. When this occurs, you must document the member's choice in the medical record;
- The risks involved in revoking informed consent to treatment; and
- A description of clinical indications that might require stopping the proposed treatment.

Review details about documenting informed consent in Chapter 11.

AHCCCS and DDD appointment standards

These appointment standards apply to our ACC, DD, ALTCS EPD programs based on AHCCCS and DDD guidelines.

For the purpose of this section, "urgent" is defined as an appointment for medically necessary services to prevent deterioration of health following an acute onset of an illness, injury, condition or exacerbation of symptoms. Comply with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- After-hours care phone number: 24 hours, 7 days a week
- Emergency care: immediately or referred to an emergency facility
- Urgent care appointment: as quickly as the member's condition requires but no later than two business days of request
- Routine care appointment: within 21 calendar days

Specialty care

Specialists should arrange appointments for:

- Routine appointment type: within 45 calendar days of request/referral
- Urgent appointments: as quickly as the member's condition requires but no later than 2 business days

Dental care

Dental providers should arrange appointments for:

- Routine appointments: 45 calendar days of request
- Urgent appointments: as quickly as the member's condition requires but no later than 3 business days

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- Routine appointment (Comprehensive Health Plan (CHP) only): within 30 calendar days of request

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- First trimester: within 14 calendar days
- Second trimester: within 7 calendar days
- Third trimester: within three days of request
- High-risk: as quickly as the member's health condition requires and no later than 3 business days of identification of high risk, or immediately if an emergency exists

UnitedHealthcare Community Plan periodically conducts surveys to check appointment availability and access standards. All care providers must participate in all activities related to these surveys.

General behavioral health appointment standards for ACC, DD and ALTCS EPD

Behavioral health care provider appointments:

- Urgent appointments: as quickly as the member's health condition requires but not later than 24 hours
- Routine care:
  - Initial assessment within 7 calendar days of referral or request for service
  - First service as quickly as the member's condition requires but no later than 23 calendar days after initial assessment
    - For members age 18 years or older, no later than 23 calendar days after the initial assessment.
    - For members younger than 18 years, no later than 21 days after the initial assessment.
  - All subsequent services as quickly as the member's health condition requires but no later than 45 calendar days
- For psychotropic medications:
  - Assess the urgency of the need **immediately**
  - Provide an appointment, if clinically indicated, with a practitioner who can prescribe psychotropic medications within a time frame that helps ensure the member:
    - Does not run out of needed medications; or
    - Does not decline in their behavioral health condition before starting medication, but no later than 30 calendar days from the identification of need.

Additional behavioral health care appointment standards for DD LTC/ALTCS EPD members in legal custody of the Department of Child Safety and Adopted Children

- 72-hour Rapid Response (RR) (or within two hours for an urgent need request) assessment of the child's immediate behavioral and physical health needs be completed after notice is received that the Department of Child Safety (DCS) has removed the child from the home. The RR assessment includes screening for developmental delays, support to child/family placement, referral(s) for further assessments and connection to ongoing services, as needed.
- Seven days (or 24 hours for an urgent need) for an initial behavioral health assessment to be completed by an assigned service care provider after an initial referral or a request for ongoing behavioral health service.
- The first appointment must begin within the time frames indicated by clinical need, but no later than 21 calendar days of the completed behavioral health assessment.
- Ongoing behavioral health services should be provided based on the person's needs, but no longer than 21 calendar days from the identification of need. After that, provide services at least once a month for at least six months after the child enters DCS custody, unless services are refused by the guardian or the child is no longer in DCS custody. Provide services to:
  - Mitigate and address the child's trauma.
  - Support the child's temporary caretakers.
  - Promote stability and well-being.
  - Address the permanency goal of the child and family.

If a behavioral health service determined medically necessary is not initiated within 21 calendar days, the caregiver must notify AHCCCS Customer Service (1-602-

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364-4558 or 1-800-867-5808 or DCS@azahcccs.gov). Then any AHCCCS-registered care provider may be seen for the recommended services.

We coordinate care among the out-of-home placement, foster, adoptive or kinship parents, all care providers, and DCS, as appropriate.

Telephone standard and reporting

In compliance with the AHCCCS Contractor Operations Manual (ACOM), Chapter 400, Policy 435, we adhere to the following telephone performance standards when addressing member and care provider calls:

1. The Average Speed of Answer (ASOA) must be 45 seconds or less.
2. The Monthly Average Abandonment Rate (MAAR) must be 5% or less.
3. The Monthly First Contact Call Resolution Rate (MFCCR) must be 70% or better.
4. The Monthly Average Service Level (MASL) must be 75% or better.

UnitedHealthcare Community Plan will submit quarterly reports to AHCCCS as required by ACOM Chapter 400.

Care Provider Directory

Our online, searchable Care Provider Directory provides accommodation information for members with physical or cognitive disabilities such as the locations equipment, exam rooms, interior and exterior building accommodations for special needs and special treatment. The directory also lists the care provider's and staff's spoken languages and cultural competency. The icons and their descriptions about accessibility features are in the footer of the directory pages. Additional descriptions are provided online when a feature is selected.

To help keep the information current, you are required to tell us, within five business days, if there are any changes to your ability to accept new patients or any changes in your ability to provide accessible equipment, or accommodations for those members with physical or cognitive disabilities. Update your locations' accessibility information online through the My Practice Profile app. Please see Chapter 2 for more information. If a member, or potential member, contacts you, and you are no longer accepting new patients, report any inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional assistance in finding a care provider.

We are required to contact all participating care providers annually and independent physicians every six months. We require you to confirm your information is accurate or provide us with applicable changes.

If we do not receive a response from you within 30 business days, we have an additional 15 business days to contact you. If these attempts are unsuccessful, we notify you that if you continue to be non-responsive we will remove you from our directory after 10 business days.

If we receive notification the directory information is inaccurate, you may be subject to corrective action.

In addition to outreach for annual or bi-annual attestations, we are required to make outreach if we receive a report of incorrect care provider information. We are required to confirm your information.

To help ensure we have your most current care provider directory information, submit applicable changes to:

For delegated care providers, email your changes to Pacific_DelProv@uhc.com or delprov@uhc.com.

For non-delegated care providers, visit UHCprovider.com for the Care Provider Demographic Change Submission Form and further instructions.

The medical, dental and mental health care provider directory is located at UHCprovider.com > Our Network > Find a Provider.

Care provider attestation

Confirm your data every quarter through the Provider Portal on UHCprovider.com or by calling Provider Services. If you have received the upgraded My Practice Profile and have editing rights, access My Practice Profile in the Provider Portal to make many of the updates required in this section.

Prior authorization request

Prior authorization requests may include procedures,

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services, and/or medication.

Coverage may only be provided if the service or medication is deemed medically necessary, or meets specific requirements provided in the benefit plan.

See Chapter 4 for more information about making or responding to prior authorization requests.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

- **Urgent**: 24 hours
- **Non-urgent**: 10 business days

Requirements for PCPs and specialists serving in PCP role

Specialists include internal medicine, pediatrics, or obstetrician/gynecology

PCPs are an important partner in the delivery of care. The AHCCCS program requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

The PCP plays a vital role as a care manager in the UnitedHealthcare Community Plan system by improving health care delivery in four critical areas: access, coordination, continuity and prevention. As such, the PCP manages initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide 24 hours a day, seven days a week coverage and backup coverage when they are not available.

Medical doctors (MDs), doctors of osteopathy (DOs), nurse practitioners (NPs), physician assistants (PAs) and clinical nurse specialists (CNS) from any of the following practice areas can be PCPs:

- General practice
- Internal medicine
- Family medicine
- Pediatrics
- Obstetrics/gynecology

NPs may enroll with the state as solo care providers, but PAs cannot. PAs must be part of a group practice.

Members may change their assigned PCP by contacting **Member Services** at any time during the month. Member Services is available 8 a.m. – 5 p.m., Monday through Friday. Instructions for completing the **PCP Change Request Form** are available on UHCprovider.com.

We ask members who don't select a PCP during enrollment to select one. UnitedHealthcare Community Plan may auto-assign a PCP to complete the enrollment process.

Females have direct access (without a referral or authorization) to any OB/GYNs, midwives, PAs or NPs for women's health care services and any non-women's health care issues discovered and treated in the course of receiving women's health care services. This includes access to ancillary services ordered by women's health care providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP.

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support, and benefit from the PCP care management system. They help ensure coverage will include availability of 24 hours a day, seven days a week. During non-office hours, members should have access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) that will immediately page an on-call medical professional so referrals can be made for non-emergency services. **Recorded messages are not acceptable.**

The PCP role in managing care transitions may be to consult with the care/case manager to ensure members receive information about other health promotion activities. This may include medication management and adherence, use of medical equipment, potential for complications, communicating with care providers, scheduling of follow-up services and education regarding discharge planning.

Consult with other appropriate care providers to develop

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individualized treatment plans for UnitedHealthcare Community Plan members with special health care needs.

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.
- Provide all well baby/well-child services.
- Coordinate each UnitedHealthcare Community Plan member's overall course of care.
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a one MD practice and at least 30 hours per week for a two or more MD practice.
- Be available to members by telephone any time.
- Teach members about appropriate use of emergency services.
- Discuss available treatment options with members.

Responsibilities of PCPs and specialists serving in PCP role

Specialists include internal medicine, pediatrics, and/or obstetrician/gynecology

In addition to meeting the requirements for all care providers, PCPs must:

- Refer members for medically necessary specialty care.
- Maintain continuity of care for each assigned member.
- Provide clinical information about a member's health and medications to the treating care provider and behavioral health care provider.
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment.
- Treat UnitedHealthcare Community Plan members' general health care needs.
- Use clinical practice guidelines.
- Refer services requiring prior authorization to Provider Services or our Clinical or Pharmacy departments, as appropriate.
- PCPs must screen all members for behavioral health needs, SDOH and trauma. Screening tools can be found at providerexpress.com > Clinical Resources > **Behavioral Health Toolkit for Medical Providers**.
- Coordinate member's behavioral health care, the member's needs and services with their behavioral health care provider.
- Coordinate with the Regional Behavioral Health Authority (RBHA) for members who are DSNP, American Indian/Alaska Native, or who have opted out of RBHA that are SMI designated.
- Notify UnitedHealthcare Community Plan's Healthy First Steps to initiate a transfer to a Primary Care Obstetrician (PCO). PCOs perform EPSDT services for pregnant members younger than 21.
- Provide preventive health services based on AMPM.
- Take part in the Individual Service Planning (ISP) process with DES/DDD representative, particularly for medically involved DD/ALTCS EPD members.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and based on UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request within 10 business days. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per Agreement requirements. Purposes include medical record-keeping audits, encounter validation studies, STARS, HEDIS®, other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
- Comply with the AHCCCS and DDD Appointment Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.

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- Educate members about healthy behaviors during pregnancy. This includes proper nutrition and the dangers of lead exposure to mother and child. It also includes avoiding alcohol, tobacco and illegal drugs. Additionally, discuss sexually transmitted infections, the physiology of pregnancy, the process of labor and delivery, breastfeeding, substance/prescription opioid use and postpartum follow-up.
- Report to us or other appropriate authorities any incident, accident and death (IAD) reports. These include abuse, neglect, injury, exploitation, alleged human rights violations, and death in conformance with the AHCCCS and DDD Medical Policy Manual, Chapter 900. Submit IAD reports based on requirements established by AHCCCS and as specified in Attachment F3: Contractor Chart of Deliverables.
- Inform applicants, members, parents and legal representatives how to file complaints, grievances and appeals as well as request administrative hearings. Also explain expedited reviews.
- Give members, parents and legal representatives information about continuing, reducing or denying services within 30 days of enrollment or changes to the information.
- Document immunization services in the Arizona State Immunization Information System (ASIIS).

UnitedHealthcare Community Plan also conducts periodic access surveys to monitor for after-hours access. PCPs and obstetricians serving in the PCP role must take part in all survey-related activities.

Behavioral health care provider responsibilities

UnitedHealthcare Community Plan and its care provider network create, implement and support trainings to help ensure you receive appropriate training, education, and development opportunities. This practice results in:

- A consistent practice that provides voice and empowerment to staff members within your office.
- A qualified, knowledgeable and culturally competent workforce.
- Timely information about initiatives and best practices.
- Services delivered in a manner that results in achievement of the Arizona System Values and Guiding Principles as outlined in AMPM Policy 100 and 430.

Behavioral health care providers must help members apply for assistance and public programs. For members who are not currently Title XIX/XXI-eligible, you must help members complete a financial and eligibility screening and application to determine eligibility. Please review AMPM Policy 650 and 580 for more information that may be needed during the referral and intake process.

PCO responsibilities

- Schedule medically necessary care appointment for enrolled pregnant members to obtain prenatal care.
- Coordinate covered services for members.
- Counsel members and their families about members' medical care needs. This includes maternity, family planning and advance directives.
- Monitor progress and manage utilization of services to facilitate the return of care to the PCP within the postpartum time frame that aligns with current AHCCCS AMPM Policy 410 and Policy 420.
- Schedule time-specific office visits during an uncomplicated pregnancy based upon the recommended standards from the ACOG.
- Prenatal and postpartum care for the member to include the time frame that aligns with current AHCCSS AMPM Policy 410 and current ACOG guidelines for postpartum care.
- Follow reproductive health and wellness guidelines contained within our policies, such as screening members for perinatal and postpartum depression at least once during the pregnancy and then repeated at the postpartum visit. If needed, refer the member to the appropriate behavioral health care provider. The PCO will share health information about lifestyle habits that promote healthy pregnancies, including spacing of births and smoking cessation.
- Screening all pregnant members through the Controlled Substance Prescription Monitoring Program (CSPMP) once a trimester. Provide members receiving opioids with appropriate intervention and counseling, including referrals for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment.
- Screening all pregnant members for sexually transmitted infections (STI), including syphilis at the first trimester, third trimester and time of delivery.

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- Educate members regarding potential complications and adverse outcomes related to non-medically indicated cesarean sections and elective inductions prior to 39 weeks gestation.
- Refer members for support services to the Special Supplemental Nutrition Program of Women, Infants and Children (WIC), as well as other community-based resources to support health pregnancy outcomes. Learn more on UHCprovider.com in the Bulletin section, which provides free or low-cost primary, family planning, mental and dental health services to people without health insurance in Arizona.
- Upon the member's first prenatal office visit, send the OB clinical record as a referral to the Healthy First Steps Program.
  - ACOG Prenatal Form pages 1 and 2. (Sign in to access the required forms.)
  - Other prenatal forms that document past and present medical, psychosocial and obstetrical history
- Follow our global billing guidelines for obstetrical services, found on UHCprovider.com in the Policies and Clinical Guidelines section.

Perinatology referrals

A PCO or PCP may refer a member to a participating perinatologist when identifying a high-risk need. The PCO or PCP may transfer the member's care to a perinatologist by calling Provider Services.

Once the transfer of care is completed, the perinatologist becomes the member's PCO. They become responsible for the member's care for the duration of the pregnancy and in the postpartum time frame that aligns with current AHCCCS AMPM Policy 410 and ACOG guidelines for postpartum care.

PCP checklist

Verify eligibility and benefits on UHCprovider.com. Click "Sign In" in the top right corner to access the Provider Portal, or call Provider Services.

Check the member's ID card at the time of service. Verify member with photo identification.

Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/paan.

Refer patients to UnitedHealthcare Community Plan participating specialists when needed.

Identify and bill other insurance carriers when appropriate.

Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form.

Specialist responsibilities

In addition to applicable requirements for all care providers, specialists must:

- Contact the PCP to coordinate the care/services.
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer.
- Verify the eligibility of the member before providing covered specialty care services.
- Provide only those covered specialty care services, unless otherwise authorized.

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- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care according to timely guidelines.
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at one UnitedHealthcare Community Plan participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the AHCCCS and DDD Appointment Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, seven days a week. Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

Specialists may use medical residents in all specialty care settings under the supervision of fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

Prenatal care responsibilities

Pregnant UnitedHealthcare Community Plan members should only receive care from UnitedHealthcare Community Plan participating care providers.

Notify UnitedHealthcare Community Plan as soon as a member confirms pregnancy. This helps ensure appropriate follow-up and coordination by the **UnitedHealthcare Healthy First Steps** coordinator.

If you have questions, call **Healthy First Steps**. An obstetrician does not need approval from the member's care provider for prenatal care, testing or obstetrical procedures. Obstetricians may give the pregnant member a written prescription at any UnitedHealthcare Community Plan participating radiology and imaging facility listed in the care provider directory. Care care providers must help ensure all pregnant members are screened through the Controlled Substances Prescription Monitoring Program (CSPMP) once per trimester. For members receiving opioids, appropriate intervention and counseling must be provided. This includes referring them for behavioral health services for assessment and treatment.

Licensed midwife services

We cover maternity care and coordination services provided by participating licensed midwifes. The members must have an uncomplicated prenatal course and an expected low-risk labor and delivery and must meet eligibility and medical criteria specified in the AMPM, Chapter 400, Policy 410.

Risk status must initially be determined during the first visit and evaluated at each trimester thereafter using the current standardized assessment criteria and protocols for high-risk pregnancies outlined by the ACOG or Mutual Insurance Company of Arizona (MICA). A new risk assessment must be completed if a new complication or concern is identified. Refer to a qualified care provider if necessary.

Labor and delivery services provided by a licensed midwife cannot be provided in a hospital or other licensed health care institution. Licensed midwives must have an action plan in case of complications, including the name and address of an AHCCCS-registered physician and nearby acute care hospital in close proximity to the planned location of labor and delivery for referral, in the even that complications should arise. The licensed midwife must notify us or the AHCCCS Newborn Reporting Line of the birth no later than one day from the date of birth to enroll the newborn with AHCCCS.

Based on AMPM Policy 410, labor and delivery services rendered through freestanding birthing centers should be provided by one of the following:

- Physician
- Certified nurse midwife who has hospital admitting privileges for labor and delivery services
- Licensed midwife who is following licensing and practice requirements as specified in A.A.C. R9-16-111 through 113.

Labor and delivery services may be provided in the member's home by:

- Physicians
- NPs

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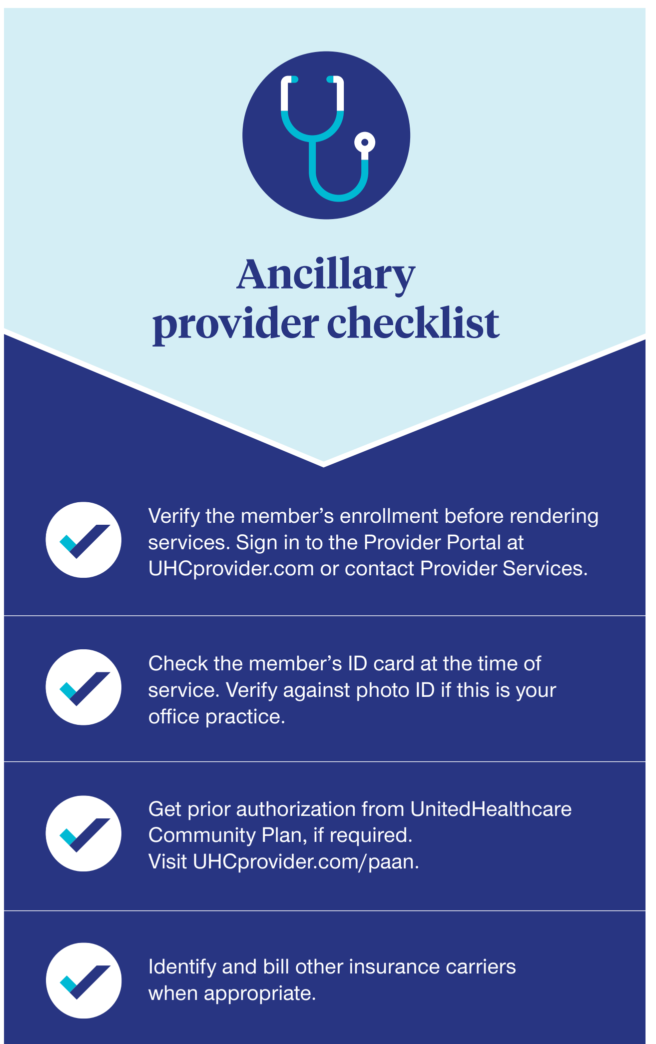
- Certified nurse midwives
- Licensed midwives who include such services within their practice.

Ancillary care provider responsibilities

Ancillary care providers include freestanding radiology, freestanding clinical labs, home health, hospice, dialysis, durable medical equipment, infusion care, therapy, ambulatory surgery centers, freestanding sleep centers and other non-care care providers. PCPs and specialists must use the UnitedHealthcare Community Plan ancillary network.

UnitedHealthcare Community Plan participating ancillary care providers should maintain sufficient facilities, equipment, and personnel to provide timely access to medically necessary covered services.



Home- and community-based services certification and care care provider enrollment

DES/DDD must certify you before you render AHCCCS-covered home- and community-based services (HCBS), including physical therapy for the habilitative needs of DD members older than 21 years. The Division's Office of Licensing, Certification and Regulation (OLCR) can help you sign the Care Provider Agreement, which includes federal requirements under 42 CFR § 431.107. Find more information in the **Divisions Provider Manual, chapter 61**. Find information about HCBS Certification resources on the Division's **Licensing & Certification website**.

Resources to support members with housing needs

UnitedHealthcare recognizes that access to safe, quality affordable housing, and the ability to maintain housing, are among the most critical drivers of health. Lack of housing directly impacts health outcomes. Members are better able to care for both their behavioral and physical health needs when they have access to stable housing.

Please reference **Chapter 9** for additional housing resources to share with members experiencing homelessness or affordable housing challenges.

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Chapter 3: Care provider office procedures and member benefits

Key contacts

Topic	Link	Phone Number
Member Benefits	UHCCommunityPlan.com/AZ	• ALTCS EPD: **1-800-293-3740** • ACC/DD: **1-800-348-4058**
Member Handbook	UHCCommunityPlan.com/AZ Go to Plan Details, then Member Resources, View Available Resource	
Provider Services	UHCprovider.com	• ALTCS EPD: **1-800-293-3740** • ACC/DD: **1-800-348-4058**8
Prior Authorization	UHCprovider.com/paan	• ALTCS EPD: **1-800-293-3740** • ACC/DD: **1-800-348-4058**
DSNP	UHCprovider.com/AZ > Medicare Advantage Health Plans > Arizona Dual Complete Special Needs	• ALTCS EPD: **1-800-293-3740** • ACC/DD: **1-800-348-4058**

Member benefit information

UnitedHealthcare Community Plan covers the following services only when medically necessary. All covered services must be provided by or arranged by the member's PCP. Some services require prior authorization.

For more details, review the AMPM. You may also go to UHCCommunityPlan.com/AZ for benefits or UHCprovider.com > Eligibility for more information.

UnitedHealthcare Community Plan members are offered the following covered services:

- PCP services
- Immunizations (shots)
  - ALTCS EPD older than 21 years; May receive diphtheria-tetanus, flu, pneumococcal, rubella, measles and hepatitis B immunizations
  - ALTCS EPD younger than 21 years; Refer to EPSDT chapter
- Prescriptions (subject to supply limits, formularies and prior authorization requirements)
- Lab and X-ray
- Radiology and medical imaging
- EPSDT services for Medicaid-eligible children younger than 21 years
- Specialist care
- Hospital services
- Emergency care
- Urgent care
- Incontinence briefs (diapers)
- Surgery services
- Physical exams
- Behavioral health services (See Chapter 9 for details)
- Children's rehabilitative services
- Covered conditions (as specified in A.A.C. R9-22 Article 13, and A.R.S. Title 36)
- Well woman and family planning services

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- Maternity care (pregnancy identification, prenatal, termination, labor and delivery, postpartum)
- Dialysis
- Glasses (for children younger than 21 years)
- Vision services/ophthalmology/optometry (for children younger than 21 years)
- Dental services (Find a dental benefit matrix with detailed code coverage information at **UHCproviders.com**. See Chapter 5 for details on covered dental services for children younger than 21 years old.)
- Audiology services
- Hearing aids and exams (for children younger than 21 years receiving EPSDT services)
- Podiatry services
- Orthotics
- Services related to CRS-qualifying conditions for members with CRS designation (a list of qualifying diagnoses is available at UHCprovider.com/azcommunityplan > **Provider Forms, Programs and References**)
- Services provided at IHS or Tribal Facilities provided to Title XXI American Indian/Alaska Native members
- AHCCCS-covered services Indian Health Care Providers (IHCPs) provide to American Indian/Alaska Native members
- Chiropractic services
- Early Detection Health Risk Assessment, Screening, Treatment and Primary Prevention (members 21 years and older)
- End of life care
- HCBS
- Home health/hospice services
- Metabolic medical foods (members diagnosed with a metabolic condition included under the ADHS Newborn Screening Program)
- Medical equipment, supplies, and prosthetic devices
- Rehabilitation therapy
- Ambulatory surgery
- Anti-hemophilic agents and related services (treatment of hemophilia and von Wilebrand's disease)
- Nutritional assessments therapy
- Post-stabilization care services
- Respiratory therapy
- Substance abuse transitional facility (members older than 18 years)
- Organs and tissue transplant services and related immunosuppressant medications
- Triage/screening and evaluation of emergency medical conditions
- Treat and refer services

Non-covered benefits for members older than 21 years

UnitedHealthcare Community Plan, under the direction of AHCCCS, will not pay for certain medical care for anyone who is 21 years or older. These services include:

- Vision exam/prescriptive lenses (excluding emergency medical services)
- Bone-anchored hearing aids and cochlear implants
- Hearing aids
- Insulin pumps
- Percussive vests
- Any transplant deemed not medically necessary or does not meet the coverage criteria outlined in the AMPM, Chapter 300
- Outpatient speech therapy (excluding ALTCS and DD members)
- TMJ treatment (except for reduction of trauma)
- Microprocessor – controlled lower limbs and joints for lower limbs
- Medical marijuana, or an office visit/other service that is primarily for the purpose of determined if a member will benefit from medical marijuana

UnitedHealthcare Community Plan ALTCS Developmental Disabilities (ALTCS DDD) members

In addition to the listed covered services, the following services are available for Developmental Disabilities (DD/ALTCS EPD) members and ALTCS DDD individuals enrolled in our Developmental Disabilities program:

- Adaptive aids/assistive technology (according to the Divisions Medical Policy Manual, Policy 1250-F)
- Hospice care or palliative services
- Specific prescriptions and over-the-counter medicines to meet special needs
- Certain specialized durable medical equipment (DME) approved by us

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- Augmentative and alternative communication (AAC)
  - Members who use AAC devices and/or applications on cell phones or tablets for communication must be allowed to keep the device to help them communicate. Under Title II of the Americans with Disabilities Act of 1990, applicable entities shall furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities. Providers should consult with members whenever possible to determine what type of auxiliary aid is needed for effective communication. To learn how members can be evaluated for an AAC device, call 1-800-293-3740.
  - ALTCS EPD members who use AAC devices and/or applications on cell phones or tablets to communicate must be allowed to keep the device. Under Title II of the Americans with Disabilities Act of 1990, applicable entities should provide appropriate auxiliary aids and services where necessary to help ensure individuals with disabilities can communicate effectively. Ask members to determine what type of auxiliary aid they need. To learn how members can be evaluated for an AAC device, call 1-800-445-1638.
- Physical therapy (PT) – PT has a maximum of 30 visits per benefit year for members older than 21 years
- Outpatient speech therapy (ST) – rehabilitative therapy services for individuals older than 21 years of age
- Outpatient occupational therapy (OT) – rehabilitative therapy services for individuals older than 21 years of age
- Emergency alert system - Members who live alone, are at risk of emergent care and cannot access emergency help may use monitoring devices. Prior authorization is not required. However, the member's physician must order them through a participating vendor:
  - Lifeline Systems Company: **1-800-368-2925**
  - American Medical Alert Corp (Connect America): **1-800-215-4206**

DD/ALTCS EPD members have other services available to them outside the health plan. If your patient needs these services, please review the Developmental Disabilities Program Prior Authorization Criteria located on UHCprovider.com in the Prior Authorization and Notification section, or call **1-602-771-8080**.

Services provided by DDD (non-health plan-related)

- Attendant care — assists with daily living
- Day treatment and training — services to promote independent living, self-care, communication and social relationships
- Employment support services — provided assistance in a job setting
- Home health aide/nursing — long-term care nursing, after acute benefit has been exhausted
- Respite care — certified caregiver to care for member while caregiver is away
- Habilitation
- Support coordination/coordinator (case management) – Each enrolled ALTCS DD member is assigned a DDD support coordinator (SC) who facilitates a person-centered approach to support members by assessing and determining the need for ALTCS services. The DDD SC also helps with advocating and resolving issues that affect the member's progress and access to services, including Medicaid services provided by UnitedHealthcare Community Plan. To reach the member's assigned DDD SC, call 1-844-770-9500 or email DDDCustomerServiceCenter@azdes.gov.
- Group home — provides long-term housing

Durable medical equipment

DME does not require prior authorization unless it is:

- On the Prior Authorization List.
- Provided by a vendor other than Preferred Homecare.

DME is equipment that provides therapeutic benefits to a member because of certain medical conditions and/or illnesses. DME consists of items which are:

- Primarily used to serve a medical purpose.
- Not useful to a person in the absence of illness, disability, or injury.
- Ordered or prescribed by a care provider.
- Reusable.
- Repeatedly used.
- Appropriate for home use.
- Determined to be medically necessary.

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See our Coverage Determination Guidelines at UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > **Medical & Drug Policies and Coverage Determination Guidelines for Community Plan**.

Preferred Homecare

Preferred Homecare provides the following DME, medical supplies and enteral services:

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

Request authorization for incontinence briefs by calling Preferred Homecare at 1-800-636-2123. You may also fax 1-866-265-0455. To find a nearby Preferred Homecare location, you may visit **preferredhomecare.com**. Members can find a network provider on **UHCCommunityPlan.com/AZ**. Call Preferred Homecare for enteral services at 888-922-9809.

Numotion

To request wheelchair services from Numotion for current or former CRS members, please call one of the following locations:

- Phoenix: 1-602-452-4320
- Tucson: 1-520-323-4496

Optum Rx infusion services

Optum Rx is our network provider for infusion services effective 12/1/2023. Call 1-480-705-6200 for more information. Optum Rx is a leading pharmacy care business, advancing drug accessibility and affordability for the 1 million people we reach every day through our differentiated pharmacy services.

The pharmacy is the most utilized touch point in health care. Powered by strong clinical expertise and integrated data, our 29,000 team members – including more than 12,500 clinicians, pharmacists and pharmacy technicians – advocate for access to medical, pharmacy and behavioral health therapies for the people we have the privilege to serve.

With our full-spectrum, personalized pharmacy services, we simplify how consumers, clients and partners navigate the pharmacy space. By delivering improved and integrated experiences, we provide them the assurance needed to navigate the health system.

Prosthetic and orthotic devices

Prosthetic and orthotic devices help members perform daily tasks. We require prior authorization for codes listed on the Prior Authorization list or that have a rental cost of more than $500.

For members younger than 21 years old with orthotic limitation:

- We cover reasonable repairs or adjustments of purchased orthotics to make the orthotic serviceable and/or when the repair cost is less than purchasing another unit.
- We replace the component if, when you request authorization, you provide documentation showing the component is not operating effectively.

For members 21 years or older, orthotics coverage applies if:

- The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare guidelines.
- The orthotic costs less than all other treatments or surgical options to treat the same condition.
- A physician or PCP orders the orthotic.

Home health care services

Home health care services include professional nurse visits, therapies, social work services, equipment, and member medications. AHCCCS covers medically necessary home health services provided in a setting where normal life activities take place as a cost-effective alternative to hospitalization.

Pre-hospitalization

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

Post-hospitalization

These services are limited to the post-hospitalization rehabilitative or recovery period. Or they are provided in lieu of hospitalization.

Home health care services provided in a member's home include:

- Assessment of home health needs.
- IV therapies.
- Wound evaluation.
- Administration of medications.
- Monitoring vital signs.
- Monitoring oxygen administration.
- Monitoring and assessing patient physical signs.
- Teaching and evaluating of therapies.
- Enterostomal therapy and teaching.
- Catheter insertion, care and teaching.
- Instruction for home health care to member or caregivers.

Exclusions and limitations

The care provider overseeing the member's care must order home health care services. Please review the posted **Prior Authorization List** to see if you need to make a request.

Assignment to PCP panel roster

Once a member is assigned a PCP, view the panel rosters electronically on the Provider Portal at **UHCprovider.com** then Sign In. The portal requires a unique user name and password combination to gain access.

Each month, PCP panel size is monitored by reviewing PCP to member ratio reports. When a PCP's panel approaches the max limit, it is removed from auto-assignment. The state requires PCPs to send notice when their panels reach 85% capacity. To update the PCP panel limits, send a written request.

1. Go to **UHCprovider.com**.
2. Select Sign In on the top right.
3. Log in.
4. Click on Community Care.

The Community Care Roster has member contact information, clinical information to include HEDIS® measures/Gaps in Care, is in an Excel format with customizable field export options, and can be pulled at the individual practitioner or TIN level. You may also use **Document Library** for member contact information in a PDF at the individual practitioner level.

You may also find the Document Library quick reference guide at UHCprovider.com > Resources > The UnitedHealthcare Provider Portal Resources > Document Library > **Self-Paced User Guide**.

Choosing a PCP

Each enrolled UnitedHealthcare Community Plan member either chooses or is assigned a PCP. The assignment considers the distance to the PCP, the PCP's capacity and if the PCP is accepting new members. Member Services department will assign members to the closest available and appropriate PCP, considering the following:

- Member request – All members are asked to choose who they want as a PCP. If the member identifies a PCP, UnitedHealthcare Community Plan will assign that enrollee to the requested PCP.
- Auto-assignment – If a member does not choose a PCP within 10 days, the member will be auto-assigned to a PCP accepting new patients in the member's geographical area.
- Re-enrollments – Members that lost their AHCCCS eligibility and have become eligible again will be reassigned to the previous PCP unless the member requests a different PCP at the time of re-enrollment.

Depending on the member's age, medical condition and location, the choice of PCP may cover a variety of practice areas, such as family medicine, general practice, internal medicine, pediatrics, gynecology and obstetrics.

UnitedHealthcare Community Plan policies and procedures designed to address member PCP assignments include care providers that participate in Value-Based Purchasing (VBP) initiatives, including Accountable Care Organizations (ACOs). In addition to member choice and location, which first determine

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member PCP assignment, UnitedHealthcare Community Plan considers care providers that demonstrate high value and improved outcomes (e.g. HEDIS®) as part of our PCP auto-assignment. Care providers in groups with higher HEDIS® performance, as well as those that demonstrate greater efficiency, receive preferential member auto-assignment.

If the member changes the initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare Community Plan to change the PCP at any other time, the change will be effective on the request date.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

Medically necessary health care services or supplies are medically appropriate and:

- Necessary to meet members' basic health needs.
- Cost-efficient and appropriate for the covered services.

Member assignment

Assignment to UnitedHealthcare Community Plan

The AHCCCS assigns eligible members to UnitedHealthcare Community Plan daily. We manage the member's care on the date the member is enrolled until the member is disenrolled from UnitedHealthcare Community Plan. We are also responsible during Prior Period Coverage (PPC) to pay for any medically necessary covered service for which a member may be eligible. Prior Quarter Coverage (PQC) is provided by AHCCCS, not UnitedHealthcare Community Plan. AHCCCS makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month's end, but at times may occur mid-month.

At enrollment time, members can request a Member Handbook by calling Member Services at 1-800-348-4058. They can also find a copy at UHCCommunityPlan.com. The handbook explains the member's health care rights and responsibilities through UnitedHealthcare Community Plan.

Members may select a participating PCP when more than one is available in the member's service area. Provider Services maintains a current list of all participating PCPs by service area.

If a member asks UnitedHealthcare Community Plan to change their PCP at any other time, the change will be made effective on the date of the request.

Members may change their PCP up to three times per year. In addition to the PCP, members with Children's Rehabilitative Services (CRS) designation may receive services from a specialist who manages care related to their CRS condition. For a CRS-qualifying diagnosis list, go to UHCprovider.com > Resources > Health Plans > Choose Your Location > Arizona > UnitedHealthcare Community Plan of Arizona Homepage > Provider Forms, Programs and References.

Download a copy of the Member Handbook at UHCcommunityplan.com/AZ. Go to Plan Details, then Member Resources, View Available Resource.

Immediate enrollment changes

Immediate enrollment into managed care means the responsible payer for members, including newborns, may change from Fee for Service (FFS) to Community Plan or another managed care organization (MCO) during hospitalization. To avoid delays in claims processing and payment, have the payer assignment checked daily.

Get eligibility information by calling Provider Services.

Unborn/newborn enrollment changes

Encourage members to notify AHCCCS when they know they are expecting. AHCCCS notifies MCOs daily of an unborn child when AHCCCS learns a member associated with the MCO is expecting. The MCO or you may use the online change report through the Arizona website to report the baby's birth. With that information, AHCCCS verifies the birth through the member's

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enrollment and newborn's date of birth. The MCO and/or the care provider's information is taken as a lead. To help speed up the process, the member should notify AHCCCS when the baby is born.

Members may call the AHCCCS Beneficiary Support Specialist at **1-602-417-7100**.

Newborns may get UnitedHealthcare Community Plan-covered health services beginning on their date of birth. Check eligibility daily until the mother has enrolled the baby in a managed care plan.

PCP selection

Although unborn children cannot be enrolled with an MCO until birth, ask your members to select and contact a PCP for their baby prior to delivery. This will help avoid the delays and confusion that can occur with deferred PCP selections.

UnitedHealthcare Community Plan Members can go to **myUHC.com/communityplan** to look up a care provider.

Removing members from a roster

A PCP may wish to have a member removed from the roster because the member is non-compliant or disruptive. The PCP must inform the member in writing of their removal from the panel. Remain available to assist with medical care for 30 days from the date of the letter.

1. To transfer the member, forward a copy of the member's notice along with a written request for removal to UnitedHealthcare Community Plan with the specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider's name.

   Mailing address:
   UnitedHealthcare Community Plan
   Member Services Department
   1 East Washington, Suite 900
   Phoenix, AZ 85004
2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have five business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them.

If a transfer to a behavioral health care provider is recommended, the transition period to the behavioral health care provider or RBHA should take place within 30 days and no later than 90 days.

Member eligibility

UnitedHealthcare Community Plan serves members enrolled with Arizona's Medicaid program. AHCCCS determines program eligibility. An individual who becomes eligible for the Arizona program either chooses or is assigned to one of the Arizona-contracted health plans.

Member ID card

Check the member's ID card at each visit, and copy both sides for your files. Verify the identity of the person presenting the ID card against some form of photo ID, such as a driver's license. AHCCCS has added MVD photos to its online verification tool that you can use to verify a member's eligibility.

If a fraud, waste and abuse event arises from a care provider or a member, file a report at **UHC.com/fraud**. Or you may call AHCCCS in Arizona: 1-602-417-4045. Toll Free Outside of Arizona Only: 1-888-ITS-NOT-OK or 1-888-487-6686. You may also call the **Fraud, Waste, and Abuse Hotline**.

If a member does not bring their card, call **Provider Services** at **1-800-445-1638**. Also document the call in the member's chart.

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Member identification numbers

Each member receives a nine-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. The AHCCCS Medicaid Number is also on the member ID card. See Member ID Card for Billing in Chapter 13, Billing and Submission, of this manual for more information.

Verifying member enrollment

Verify member eligibility prior to providing services. Determine eligibility in the following ways:

- Provider Portal: access the Provider Portal through **UHCprovider.com/eligibility**
- **UnitedHealthcare Community Plan Provider Services** is available from 7 a.m. — 5 p.m. CT, Monday through Friday.
- **AHCCCS Online** (also verifies DDD)
- ALTCS EPD Provider Services Center 1-800-293-3740

UnitedHealthcare Dual Complete (DSNP)

HMO SNP is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid.

For general information about DSNP, go to **uhc.com/medicaid/dsnp**.

For information about UnitedHealthcare Dual Complete products, please see the Medicare Products chapter of the Provider Administrative Guide for Commercial and Medicare Advantage Products at **UHCprovider.com/guides**. For Arizona-specific DSNP information, go to UHCprovider.com/AZ > Medicare > **Arizona Dual Complete® Special Needs Plans**.

A list of covered services by DDD is available at **Available DDD Services & Supports | Arizona Department of Economic Security (az.gov)** or call members DDD Support Coordinator at 1-844-770-9500, ext. 1.

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Chapter 4: Medical management

Key contacts

Topic	Link	Phone Number
Referrals	UHCprovider.com > Referrals	• ALTCS EPD: **1-800-293-3740** • ACC/DD: **1-800-445-1638**
Prior Authorization	UHCprovider.com/paan	• ALTCS EPD: **1-800-293-3740** • ACC/DD: **1-800-445-1638**
Pharmacy	professionals.optumrx.com	• ALTCS EPD: **1-800-293-3740** • ACC/DD: **1-800-445-1638**
Dental	UHCproviders.com	**1-855-812-9208**
Healthy First Steps	UHChealthyfirststeps.com	**1-800-599-5985**

Medical management improves the quality and outcome of health care delivery. We offer the following services as part of our medical management process.

Ambulance services

Air ambulance

Air ambulance is covered only when the services are medically necessary and transportation by ground ambulance is not available. It is also only covered when:

- Great distances or other obstacles keep members from reaching the destination.
- Immediate admission is essential.
- The pickup point is inaccessible by land.

Non-emergent air ambulance requires prior authorization.

For authorization, go to UHCprovider.com/paan or call Provider Services.

Emergency ambulance transportation

An emergency is a serious, sudden medical or behavioral condition that may include severe pain. Without immediate attention, the affected person could suffer serious:

- Injury, placing the patient's health, or health of unborn child, in jeopardy.
- Impairment to bodily functions.
- Dysfunction of a bodily organ or part.

Emergency transports (in- and out-of-network) are covered and subject to medical review. Supporting documentation of medical necessity includes the trip report. The report should detail all the following:

- Medical condition, signs and symptoms, procedures, treatment
- Transportation origin, destination, and mileage
- Supplies
- Necessity of attendant, if applicable.

They do not require an authorization.

Bill ambulance transport as a non-emergency transport when it doesn't meet the definition of an emergency transport. This includes all scheduled transports to nursing facilities or the member's residence.

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Non-emergency transportation

Non-emergency transportation services are available for AHCCCS-covered services and are arranged by the Medical Transportation Brokerage of Arizona (MTBA). Transportation is provided by taxi, van, bus or public transit, depending on a member's needs. Wheelchair and stretcher services are provided if required by medical necessity.

According to the AHCCCS FFS Care provider Manual, Chapter 5 and Chapter 14, you must abide by the following rules for non-emergent ambulance and transportation to be covered:

- You must submit original and destination modifiers for emergency and non-emergent transportation procedure codes.
- If you submit a corrected claim, you must document the proper frequency code and original claim number in box 22 of paper claim submissions or loop 2300 of an electronic submission. This is outlined in this manual's corrected claim section.

To schedule non-emergent transportation, call MTBA at **1-602-889-1777** or **1-88-700-6822** between 6 a.m. – 7 p.m. Arizona Time, Monday through Friday.

Emergency Triage, Treat and Transport (ET3)

AHCCCS participation in ET3 allows Medicaid recipients to access the most appropriate emergency services at the right time and in the right place. This reduces hospital admissions, improves quality and reduces costs.

Medicare-enrolled ambulance suppliers and care providers CMS has selected for participation are eligible for reimbursement for services offered to AHCCCS members. (The care provider must also be an AHCCCS-registered care provider.) More information is available on the AHCCCS website at azahcccs.gov.

Cardiology prior authorization program

We use the prior authorization process to help support compliance with evidence-based and professional society guidance for cardiology procedures.

You must obtain prior authorization for the following cardiology procedures:

- Diagnostic catheterizations
- Electrophysiology implant procedures (including inpatient)
- Echocardiograms
- Stress echocardiograms

Cardiology procedures do not require prior authorization if performed in the following places of service:

- ER
- Observation unit
- Urgent care
- Inpatient stay (except for electrophysiology implants).

If you do not complete the entire prior authorization process before performing the procedure, we will reduce or deny the claim. Do not bill the member for claims we deny for this reason.

Request prior authorization online or by phone at:

- Online: UHCprovider.com/cardiology > select the Go to Prior Authorization and Notification Tool
- Phone: **1-866-889-8054**, 7 a.m. — 7 p.m., Monday through Friday.

Make sure the medical record is available.

For the most current list of CPT codes that require prior authorization, a prior authorization crosswalk, and/or the evidence-based clinical guidelines, go to UHCprovider.com/cardiology > Specific Cardiology Programs.

Dental services

Adults 21 years and older are covered for limited medical and surgical services by a dentist. Adult ALTCS EPD and DD members have a $1,000 routine dental benefit limit per contract year. All members 21 years and older have emergency dental services of $1,000 per contract year.

For members who reside in an ICF/IID, UnitedHealthcare Community Plan is responsible for all medically necessary dental services, including emergency dental services, dental screening, preventive services,

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therapeutic services and dental appliances in accordance with 42 CFR 438.460.

Dental services provided to American Indian/Alaska Native members within an IHS/638 Tribal facility are not subject to the $1,000 adult emergency or $1,000 ALTCS EPD and DD routine dental benefit limits. Services performed outside of the IHS/638 Tribal facilities are limited to the $1,000 emergency dental benefit for members 21 years of age and older. The additional $1,000 is for dental services for members on ALTCS EPD and DD. Medically necessary services that are eligible for 100 percent federal reimbursement and provided by an IHS or 638 Tribal facility to Title XIX members will be reimbursed by AHCCCS Division of Fee-for Services Management (DFSM).

Find more details about adult dental benefits in Chapter 300 of the **AHCCCS Medical Policy Manual**. To find a dental provider, go to **UHCprovider.com** > Our Network > Find a Provider > Dental Providers by State, Network or Location.

Emergency/urgent care services

Emergency services do not require prior authorization.

While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about appropriate emergency room use. An emergency is a medical condition that could cause serious health problems or even death if not treated immediately. A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fevers, cough, colds and sore throats.

Covered services include:

- Hospital emergency department room, ancillary and care provider service by in and out-of-network care providers.
- Medical examination.
- Stabilization services.
- Access to designated Level I and Level II trauma centers or hospitals meeting the same levels of care for emergency services.
- Emergency ground or air transportation.
- Emergency dental services, limited to broken or dislocated jaw, severe teeth damage, and cyst removal.

We pay out-of-network AHCCCS-registered care providers for emergency services at the current program rates at the time of service. We try to negotiate acceptable payment rates with out-of-network care providers for covered post-stabilization care services for which we must pay.

Emergency room care

For an emergency, the member should seek immediate care at the closest ER. If the member needs help getting to the ER, they may call 911. No referral is needed. Members have been told to call their PCP as soon as possible after receiving emergency care. They pay no out-of-pocket cost for ER or emergency ambulance services.

Before they are treated, UnitedHealthcare Community Plan members who visit an ER should be screened to determine whether they have a medical emergency. Prior authorization is not required for the medical screening. UnitedHealthcare Community Plan covers these services regardless of the emergency care provider's relationship with UnitedHealthcare Community Plan.

After the member has received emergency care, the hospital must seek approval within one hour for pre-approval for more care to make sure the member remains stable. If the hospital needs to appeal the decision or if does not receive a decision within one hour and/or they need to speak with a peer (medical director), call **1-800-955-7615**. The treating care provider may continue with care until the health plan's medical care provider is reached, or when one of these guidelines is met:

1. A plan care provider with privileges at the treating hospital takes over the member's care.
2. A plan care provider takes over the member's care by sending them to another place of service.
3. UnitedHealthcare Community Plan and the treating care provider reach an agreement about the member's care.
4. The member is released.

Depending on the need, the member may be treated in the ER, in an inpatient hospital room, or in another setting. This is called Post Stabilization Services. Members do not pay for these services. This applies whether the member receives emergency services in or outside their service area.

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Urgent care (non-emergent)

Urgent care services are covered.

For a list of urgent care centers, contact **Provider Services** at **1-800-445-1638**.

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

Nurses in the Health Services Department review emergency admissions within one business day of notification.

Deliver emergency care without delay. Notify UnitedHealthcare Community Plan about admission within 24 hours, unless otherwise indicated. Use the Prior Authorization and Notification tool on the Provider Portal at UHCprovider.com/paan, EDI 278N transaction at UHCprovider.com/edi, or call **Provider Services** at **1-800-445-1638**.

UnitedHealthcare Community Plan uses evidence-based, nationally accredited, clinical criteria for determinations of appropriateness of care. UnitedHealthcare Community Plan does not reward for denials.

The criteria are available in writing upon request or by calling **Provider Services** at **1-800-445-1638**.

If a member meets an acute inpatient level of stay, admission starts at the time you write the order.

For policies and protocols, go to UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans.

End-of-life care responsibilities

End of Life (EOL) care allows members to receive Advance Care Planning, palliative care, supportive care and hospice services. Members who receive EOL care may receive curative or palliative care until they choose to receive hospice care. To comply with AMPM 310-HH, members younger than 21 years may receive curative care with EOL care and hospice care.

Perform the following services when caring for members with a chronic or terminal illness.

Advance care planning

Have a face-to-face discussion with the member and persons designated by the member when conducting Advance Care Planning. This includes:

- Teaching them about the member's illness and the care options available;
- Identifying the member's care, social, psychological and spiritual needs;
- Developing a written member-centered care plan that identifies the member's choices for care and treatment;
- Sharing the member's wishes with family, friends, and their care providers; and
- Completing advance directives. Refer to AHCCCS AMPM Policy 640.

Palliative care

Help ensure members of any age with serious, chronic, or complex illnesses receive appropriate, medically necessary, member-centered palliative care in addition to treatment. Palliative care includes:

- Improved pain management
- Behavioral health services
- Supportive care
  - Coordination of natural supports
  - Referrals to meet the member and family's social needs
  - Referrals to the appropriate community resources for spiritual needs

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Facility notification requirements

Facilities are responsible for admission notification for the following inpatient admissions (even if an advanced notification was provided prior to the actual admission date):

- Planned/elective admissions for acute care
- Unplanned admissions for acute care
- Skilled nursing facility (SNF) admissions
- Admissions following outpatient surgery
- Admissions following observation

You must use ADT alerts to facilitate timely follow-up with members after admission or discharge from hospitals and ERs. You are required to send observation stay notifications and acute discharge notifications:

- Send discharge notifications from acute or observation stays within 24 hours after actual weekday discharge (or by 5 p.m. Arizona time on the next business day if the 24-hour limit would require notification on a weekend or holiday).
- Send emergency department (ED) notifications from hospitals using ADT or 278N transactions within 24 hours after actual weekday admission.

For weekend and holiday admissions, please provide the notification by 5 p.m. local time on the next business day.

We also support the notification intake through EMR, prior authorization and notification (PAAN), or phone. We only accept ED notifications through 278N or ADT.

If you would like to use either of these automated channels but do not yet have the technology set up:

- Contact your current claims processing vendor or clearinghouse.
- Submit through the **Optum EDI portal**.

Family planning

Family planning services and supplies are covered when provided to members who choose to delay or prevent pregnancy in accordance with AMPM Policy 420. They include delivering information and counseling to help members make informed decisions about specified family planning methods available.

Care providers with members of reproductive age must document in the medical record that they have notified the member, either verbally or in writing, of the family planning services available. Enrolled members who are eligible to receive full health care coverage may receive family planning services. These medical, surgical, pharmacological and laboratory services include:

- Contraceptive counseling, medication, and/or supplies, including, oral and injectable contraceptives, LARC, diaphragms, condoms, foams and suppositories.
- Related medical and laboratory exams and radiological procedures, including ultrasounds and family planning.
- Treatment of complications resulting from contraceptive use, including emergency treatment.
- Natural family planning education or referral to qualified health professionals.
- Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse (Mifepristone, also known as Mifeprex or RU-486, is not post-coital emergency oral contraception).
- Sterilization:
  - Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. The procedure is effective three months following insertion. The member must continue using another form of birth control for the first three months to prevent pregnancy, and
  - At the end of the three months, a hysterosalpingogram will be performed confirming that the member is sterile.

We cover the following family planning services:

- Pregnancy screening.
- Pharmaceuticals, when associated with medical conditions related to family planning or other medical conditions.
- Screening and treatment for Sexually Transmitted Infections (STI) regardless of sex.
- Sterilization services when the requirements are met (including hysteroscopic tubal sterilizations).
- Pregnancy termination as specified in **AMPM Policy 410**, including Mifepristone (Mifeprex or RU-486).

The following are not covered as family planning services:

- Infertility services, including diagnostic testing, treatment services and reversal of surgically induced infertility.
- Pregnancy termination counseling.
- Pregnancy terminations except as specified in

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AMPM Policy 410.
- Hysterectomies for sterilization. Refer to AMPM Policy 310-L for hysterectomy coverage requirements.

Parenting/childbirth education programs

- Childbirth education is covered.
- Parenting education is not covered.

Voluntary sterilization

Members must meet the following criteria before they may be sterilized:
- Be at least 21 years old when they sign the AHCCCS-approved consent form (Attachment A) in AHCCCS AMPM.
- Not been declared mentally incompetent.
- Gave consent without coercion.
- Wait 30 days, but not more than 180 days, between giving informed consent and undergoing sterilization. The exception is premature delivery or emergency abdominal surgery. Members may consent to be sterilized during these events if at least 72 hours have passed since they gave informed consent. For premature delivery, the member must have given informed consent at least 30 days before the expected delivery date.

Any member requesting sterilization must sign the consent form with a witness present. Make sure members with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, and members with vision and hearing concerns fully understand the information in the consent form. Before the member signs the consent form, give them a copy of the form and provide the following:
- Consent form requirements (See 42 CFR § 50.204).
- An explanation of the procedure as well as answers to their questions.
- A description of available alternative methods.
- Knowledge that they can withdraw consent at any time before surgery without affecting future care and/or loss of federally funded program benefits.
- Advice that the sterilization procedure is irreversible.
- A full description of the risks that may follow the procedure, including the type and possible effects of anesthetic.
- A full description of what members can expect as a result of the sterilization.
- Notification that sterilization cannot be performed for at least 30 days after they give consent.

Sterilization consents may NOT be obtained when a member:
- Is in labor or childbirth.
- Wants or is terminating a pregnancy.
- Is under the influence of alcohol or other substances that affect that member's awareness.

Hearing services

The following hearing services are covered for members 21 years of age and younger.

Monaural and binaural hearing aids are covered, including fitting, follow-up care, batteries and repair. Bilateral cochlear implants, including implants, parts, accessories, batteries, charges and repairs are covered. Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries are covered for members 21 years or younger.

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice. These services require prior authorization and a certificate of terminal illness (COTI).

Home hospice

UnitedHealthcare Community Plan covers benefits for routine home care every day the member is home, under hospice and not receiving continuous home care. We cover care provider hospice at the member's home during a medical crisis. A medical crisis is when a member requires continuous nursing care to manage symptoms.

Respite hospice

Inpatient hospital or nursing facility respite care is covered for the hospice care provider each day the member is in an inpatient facility and receiving respite care. Hospice inpatient respite care is short-

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term inpatient care provided to the member when necessary to relieve the caregiver. The combined total cannot exceed 600 hours per benefit year. Additional information is available in **AMPM Policy 1250**.

Inpatient hospice

Inpatient care is covered during a sudden medical crisis. General inpatient care may be necessary for pain control or acute/chronic symptom management not provided in any other setting. Inpatient hospice care includes a hospital or an in-network hospice inpatient facility that meets the hospice standards for staffing and member care.

UnitedHealthcare Community Plan covers residential inpatient hospice services. UnitedHealthcare Community Plan will cover hospice care provider benefits for both the hospice services provided and the facility residential services.

Laboratory

Lab services

Laboratory Corporation of America, Labcorp, is the in-network care provider for UnitedHealthcare Community Plan members.

Use a network laboratory care provider, when referring members for lab services not covered in the office. Medically necessary laboratory services ordered by a PCP, other care providers or dentist in one of these laboratories do not require prior authorization except as noted on our prior authorization list.

When submitting claims, have a Clinical Laboratory Improvement Amendment number (CLIA #). Otherwise, claims will deny. CLIA standards are national and not Medicaid-exclusive. CLIA applies to all care providers rendering clinical laboratory and certain other diagnostic services.

See the **Billing and Submission** chapter for more information.

You can also prevent claims from being denied by referring members to a network lab and diagnostic services care providers as well as obtaining appropriate prior authorization. Emergent laboratory services, coupled with same-day procedures, will not deny.

Bill these CPT codes in the following places of service:

- POS 11 (Office)
- POS 20 (Urgent Care)
- POS 49 (independent clinic)
- POS 50 (FQHC)
- POS 53 (mental health clinic)
- POS 54 (intermediate care facility)
- POS 71/72 (rural health clinic)

CPTs Codes			
81000	85014	87880	Q0091
81002	86490	89190	Q0111
82270	86580	36415	S3620
84030	87210	36416	
85013	87804	99000	
Effective May 1, 2022, for Medicaid:			
80305*	83036	87502	83655
82075*	80061	82247	

*Identified lab codes will be reimbursed when billed using Medication Assisted Treatment (MAT) related diagnosis codes.

Genetic testing provisions

Prior authorization requests must include documentation showing how the genetic testing is consistent with coverage limitations. Genetic testing is only covered when the results of such testing are needed to differentiate between treatment options.

Genetic testing is not covered when used to:

1. Determine specific diagnoses or syndromes when such diagnoses would not definitively alter the medical treatment of the member except as described in 2.a.i. or 2.a.ii.,
2. Determine the likelihood of associated medical conditions occurring in the future,
3. Continuously monitor or test potential complications or sequelae of a suspected genetic anomaly,

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4. Determine current or future reproductive decisions,
5. Determine eligibility for a clinical trial, or
6. Pay for panels or batteries of tests that include one or more medically necessary tests, along with tests that are not medically necessary, when the medically necessary tests are available individually.

Experimental or investigational testing is not covered, according to AHCCCS guidelines.

Maternity/pregnancy/ well-woman care

Well-woman preventative care visit

A yearly well-woman preventive care visit helps identify disease risk factors as well as current physical/ behavioral health problems. It also promotes healthy lifestyle habits. As such, the well-woman preventative care visit involves the following:

- Physical exam (well exam) that assesses overall health.
- Breast exam.
- Pelvic exam (as necessary, according to current recommendations and best standards of practice).
- Review and administration of immunizations, screenings, and testing as appropriate for age and risk factors.
- Screening and counseling on maintaining a healthy lifestyle and minimizing health risks, including the following:
  - Proper nutrition.
  - Physical activity.
  - Elevated BMI.
  - Tobacco/substance use, abuse, and/or dependency.
  - Depression.
  - Physical and domestic violence, including gathering information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems.
  - Sexually transmitted infections.
  - Human Immunodeficiency Virus (HIV).
  - Family planning.
- Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
  - Reproductive history and sexual practices.
  - Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake.
  - Physical activity or exercise.
  - Oral health care.
  - Disease management.
  - Emotional wellness.
  - Recommended intervals between pregnancies
  - Initiation of necessary referrals when further evaluation, diagnosis, and/or treatment is needed.

Genetic screening and testing is not covered.

Well-woman preventative care service standards

AHCCCS covers the human papillomavirus (HPV) vaccine for male or female members as recommended by CDC or ACIP.

- Coordinate with the Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) Program in the delivery of immunization services if providing vaccinations to EPSDT members younger than 19 years.
- Provide immunizations based on the Advisory Committee on Immunization Practices Recommended Schedule. Refer to the CDC website at cdc.gov/vaccines.
- Enroll and re-enroll annually with the VFC program. Note each EPSDT member's immunizations in the Arizona State Immunization Information System (ASIIS) registry.
- Do not use AHCCCS funding to purchase vaccines covered through the VFC program for members younger than 18 years.

Pregnancy notification risk screening

Notify UnitedHealthcare Community Plan immediately of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program.

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Access the digital Notification of Pregnancy form at UHCprovider.com/azcommunityplan > Provider Forms > General Forms > [Pregnancy Notification Form](#). You may also call Call Healthy First Steps at **1-800-599-5985** or fax the notification form to **1-877-353-6913**.

Pregnancy/maternity

Bill the initial pregnancy visit as a separate office visit.

You may bill global days if the mother has been a UnitedHealthcare Community Plan member for three or more consecutive months or had seven or more prenatal visits.

Medicaid does not consider ultrasounds medically necessary if they are done only to determine the fetal sex or provide parents with a photograph of the fetus. We allow the first three obstetrical ultrasounds per pregnancy. The fourth and subsequent obstetrical ultrasound procedures will only be allowed for identified high-risk members. High-risk member claims must include the corresponding diagnosis code.

Pregnant UnitedHealthcare Community Plan members should receive care from UnitedHealthcare Community Plan care providers only. UnitedHealthcare Community Plan considers exceptions to this policy if:

1. the member was in their third trimester of pregnancy when they became a UnitedHealthcare Community Plan member, and
2. the member has an established relationship with a non-participating obstetrician.

UnitedHealthcare Community Plan must approve all out-of-plan maternity care, with the exception of family planning services and supplies. Members do not need a referral from their PCP for OB/GYN care. Perinatal home care services are available for members when medically necessary.

Maternity admissions

All maternity admissions require notification. Days in excess of 48 hours for vaginal deliveries and 96 hours for C-section require clinical information and medical necessity review.

Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, the online Prior Authorization and Notification tool at **UHCprovider.com/paan**, or by calling **Provider Services** at **1-800-445-1638.**

Provide the following information within one business day of the admission:

- Date of admission.
- Member's name and Medicaid ID number.
- Obstetrician's name, phone number, care provider ID.
- Facility name (care provider ID).
- Vaginal or cesarean delivery.

If available at time of notification, provide the following birth data:

- Date of delivery.
- Gender.
- Birth weight.
- Gestational age.
- Baby name.

For additional pregnant member and baby resources, see Healthy First Steps Rewards in **Chapter 8**.

Post maternity care

UnitedHealthcare Community Plan covers post-discharge care to the member and their newborn. The attending care provider decides the location and post-discharge visit schedule. Prior authorization is required for home health care visits for postpartum follow-up. Post-discharge home care consists of a minimum of two visits, at least one in the home, according to accepted maternal and neonatal physical assessments. These visits must be conducted by a registered professional nurse with experience in maternal and child health nursing or a care provider. The first post-discharge visit should occur within 24 to 48 hours after the member's discharge date.

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Newborn enrollment

The hospital is responsible to notify the county of all deliveries, including UnitedHealthcare Community Plan members.

The hospital provides enrollment support by providing required birth data during admission.

Home care and all prior authorization services

The discharge planner ordering home care should call Provider Services to arrange for home care.

Medically necessary home uterine monitoring technology is covered for members with premature labor contractions before 35 weeks gestation as an alternative to hospitalization. Please refer to the AHCCCS and DDD Medical Policy Manual Policy 410 for more information.

Hysterectomies

Hysterectomies cannot be reimbursed if performed solely to render the individual permanently incapable of reproducing, or if there was more than one purpose to the procedure, and it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Members who get hysterectomies for medical reasons must be told, orally and in writing, they will no longer be able to have children (i.e., result in sterility). Please refer to AHCCCS and DDD Medical Policy Manuals 310 L for further details.

All hysterectomy claims (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by a consent form. (Refer to AMPM Policy 820 Attachment A- Hysterectomy Consent and Acknowledgment Form).

The member and member's representative, if any, should sign and date the form stating they were told before the surgery that the procedure will result in permanent sterility.

Find the form at: azahcccs.gov > Plans/Providers > Guides - Manuals - Policies > AHCCCS Medical Policy Manual (AMPM).

Exception: Care providers are not required to complete AMPM Policy 820 Attachment A prior to performing Hysterectomy if the physician performing the hysterectomy documents one of the following:

1. The member was already sterile before the Hysterectomy. As the physician performing the hysterectomy, you certify in writing the member was sterile at the time of the hysterectomy. You must also state the cause of the sterility.

2. You certify, in writing, the hysterectomy was performed under a life-threatening emergency in which prior acknowledgment was not possible. Include a description of the emergency.

UnitedHealthcare Community Plan requires, along with your claim, a copy of the AHCCCS Hysterectomy form in AMPM Policy 820 Attachment A at:

azahcccs.gov > Plans/Providers > Guides - Manuals - Policies > AHCCCS Medical Policy Manual (AMPM). or the documentation of why the form was not needed.

Mail the claim, medical records attachments, consent forms and encounters to:

UnitedHealthcare Community Plan

P.O. Box 5290

Kingston, NY 12402-5290

Reimbursement is made upon completion of documentation requirements and UnitedHealthcare Community Plan review. The member may not be billed if consent forms are not submitted.

Pregnancy termination services

We cover pregnancy termination in the following cases:

- The pregnant member suffers from a physical disorder, injury or illness. This includes a life-endangering condition caused by or arising from the pregnancy. This condition would, as certified by a physician, place a member in danger of death unless the pregnancy is terminated.
- The pregnancy is a result of rape or incest.
- The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuing the pregnancy could be pose a serious physical or mental health problem for the pregnancy member by:
  - Creating a physical or mental health problem for the pregnant member or impairing a bodily function of the pregnant member,
  - Causing dysfunction of a bodily organ or part of the pregnant member or exacerbating a health

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problem of the pregnant member, or

- Preventing the pregnant member from obtaining treatment for a health problem. The attending physician must acknowledge that a pregnancy termination is medically necessary by submitting the Certificate of Necessity for Pregnancy Termination. The certificate must certify that, in the physicians' judgment, one or more of the above criteria have been met. Other required documentation includes:
  - The care provider must get written informed consent keep it in the member's chart for all pregnancy terminations. If the pregnant member is younger than 18 years, or is 18 years or older and considered an incapacitated adult (as defined in A.R.S. § 14-5101), we require a dated signature of the pregnant member's parent or legal guardian indicating approval of the pregnancy termination procedure.
  - When the pregnancy is the result of rape or incest, you must get documentation that the incident was reported to the proper authorities. This includes the name of the agency to which it was reported, the report number (if available) and the date the report was filed. This documentation requirement must be waived if the treating care provider certifies the member was unable, for physical or psychological reasons, to comply with the requirement.

Except in cases of medical emergencies, you must get prior authorization for all covered pregnancy terminations from the UnitedHealthcare Community Plan medical director or designee. A completed Certificate of Necessity for Pregnancy Termination and Verification of Diagnosis by Contractor for Pregnancy Termination Requests must be submitted with the prior authorization request. The certificates are on azahcccs.gov in the AHCCCS Medical Policy Manual, Chapter 410.

In cases of medical emergencies, you must submit all documentation of medical necessity to UnitedHealthcare Community Plan within two working days of the date the termination was performed.

Sterilization and hysterectomy procedures

Reimbursement for sterilization procedures are based on the member's documented request. This policy helps ensure UnitedHealthcare Community Plan members thinking about sterilization are fully aware of the details and alternatives. It also gives them time to consider their decision. In addition, UnitedHealthcare Community Plan must have documented evidence that all the sterilization requirements have been met before making a payment. The member must sign the AHCCCS Consent Form at least 30 days, but not more than 180 days, before the procedure. The member must be at least 21 years old when they sign the form.

The member must not be mentally incompetent or live in a facility treating mental disorders. The member may agree to sterilization at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since signing the consent form. However, in the case of premature delivery, they must have signed the form at least 30 days before the expected delivery date. If the requirements are not met for both sterilization procedures and hysterectomies, UnitedHealthcare Community Plan cannot pay the care provider, anesthetist or hospital.

Sterilization informed consent

A member has only given informed consent if the AHCCCS Consent Form for sterilization is properly filled out and all information is explained. The member must be provided a thorough explanation of the sterilization procedure and other family planning options. They understand that sterilizations are irreversible. Informed consent is an agreement to receive services before they occur after receiving all information regarding the associated risks and benefits. Other consent forms do not replace the Medical Assistance Consent Form. Informed consent may not be obtained while the member is in labor, seeking an abortion, or under the influence of alcohol or other substances that affect awareness.

Sterilization consent form

Use the consent form for sterilization:

- **Complete all applicable sections of the form.** Complete all applicable sections of the consent form before submitting it with the billing form. AHCCCS cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.

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- Your statement section should be completed after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.
- The state's definition of "shortly before" is not more than 30 days before the procedure. Explain the procedure to the member within that time frame. However, do not sign and date the form until after you perform the procedure.

The Sterilization Consent Form is on **azahcccs.gov** in the AHCCCS Medical Policy Manual, Chapter 420, Attachment A.

Have three copies of the consent form:

1. For the member.
2. To submit with the Request for Payment form.
3. For your records.

Neonatal Intensive Care Unit (NICU) case management

The NICU Management program manages inpatient and post-discharge neonatal intensive care unit (NICU) cases to improve outcomes and lower costs. Our dedicated team of NICU case managers, social workers and medical directors offer both clinical care and psychological services.

The NICU Case Management program helps ensure NICU babies get quality of care and efficiency in treatment. Newborns placed in the NICU are eligible upon birth. High risk newborns placed in the NICU are eligible upon birth for NICU Case Management services.

The NICU Case Management team works closely with Neonatal Resource Services (NRS) team neonatologist and Utilization Management nurses, health plan registered nurses and social worker care managers to support and coordinate needed care for NICU infants and their families, as appropriate.

Inhaled nitric oxide

Use the NRS guideline for Inhaled Nitric Oxide (iNO) therapy at UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > **For Community Plans**.

Outpatient services

Refer to the Prior Authorization list available at UHCprovider.com/azcommunityplan > **Prior Authorization and Notification**.

Covered outpatient services include:

- Ambulatory surgery.
- Outpatient diagnostic and laboratory services.
- Ancillary services.
- Clinic services.
- Multi-specialty interdisciplinary clinic (MSIC):
  - Amputee
  - Arthritis/rheumatology
  - Cardiac
  - Cystic fibrosis
  - Ear, nose and throat (ENT)
  - Endocrine
  - Eye
  - Feeding
  - General Surgery
  - Genetics
  - Hand
  - Metabolic
  - Myelomeningocele
  - Neurofibromatosis
  - Neurology
  - Neurosurgery
  - Nutrition
  - Orthodontia
  - Orthopedics
  - Cerebral palsy
  - Plastic surgery
  - Pulmonary
  - Rhizotomy
  - Scoliosis
  - Sickle cell anemia
  - Urology
  - Wheelchair

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- Community-Based Field Clinics
  - Outreach clinics may include:
    - Cardiac
    - ENT
    - Orthopedic
    - Neurology
    - Plastic surgery

Radiology prior authorization program

We use the prior authorization process to help support compliance with evidence-based and professional society guidance for radiology procedures.

You must obtain prior authorization for the following advanced imaging procedures if you provide them in an office or outpatient setting.

- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron-emission tomography (PET)
- Nuclear medicine
- Nuclear cardiology

Advanced imaging procedures do not require prior authorization if performed in the following places of service:

- ER
- Observation unit
- Urgent care
- Inpatient stay

If you do not complete the entire prior authorization process before performing the procedure, we will reduce or deny the claim. Do not bill the member for claims we deny for this reason.

Request prior authorization online or by phone at:

- Online: UHCprovider.com/radiology > Go to Prior Authorization and Notification Tool.
- Phone: **1-866-889-8054** from 8 a.m. – 5 p.m. CT, Monday through Friday. Make sure the medical record is available. An authorization number is required for each CPT code.

For a list of Advanced Outpatient Imaging Procedures that require prior authorization, a prior authorization crosswalk, and/or the evidence-based clinical guidelines, use the Provider Portal through UHCprovider.com or use the search option at UHCprovider.com/radiology > Specific Radiology Programs > Community Plan (Medicaid).

Screening, Brief Interventions, and Referral to Treatment (SBIRT) Services

SBIRT services are covered when:

- Provided by, or under the supervision of, a certified care provider or other certified licensed health care professional within the scope of their practice.
- Determining risk factors related to alcohol and other substance use/abuse disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed.

For more information, see AHCCCS FFS Provider Manual, Chapter 19 at azahcccs.gov > Plans/Providers > Guides - Manuals - Policies.

What is included in SBIRT?

Screening: With just a few questions on a questionnaire or in an interview, you can identify members who have alcohol or other substance use problems and determine how severe those problems already are. Three of the most widely used screening tools are the Alcohol Use Disorders Identification Test (AUDIT), the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and the Drug Abuse Screening Test (DAST).

Brief intervention: If screening results indicate at risk behavior, individuals receive brief interventions. The intervention educates them about their substance use, alerts them to possible consequences and motivates them to change their behavior.

Referral to treatment: Refer members whose screening indicates a severe problem or dependence to a licensed

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and certified behavioral health agency for assessment and treatment of a substance use disorder.

SBIRT services are covered when all the following are met:

- The care provider is AHCCCS certified.
- The billing care provider has an appropriate taxonomy to bill for SBIRT.

The SBIRT assessment, intervention, or treatment takes places in an AHCCCS-allowed place of service.

For more information about SBIRT services and outreach, see the AHCCCS Behavioral Health Practice Tools at **azahcccs.gov.**

Oncology

Prior authorization

To help ensure our member benefit coverage is medically appropriate, we regularly evaluate our medical policies, clinical programs and health benefits based on the latest scientific evidence, published clinical guidelines and specialty society guidance.

For information about our Oncology prior authorization program, including radiation and chemotherapy guidelines, requirements and resources, go to uhcprovider.com > Prior Authorization > **Oncology** or call Optum at 888-397-8129 Monday -Friday 7am – 7pm CT.

Pharmacy

Preferred Drug List

The UnitedHealthcare Medicaid Preferred Drug List (PDL) helps you select medically appropriate, high-quality and cost-effective drugs for members. The PDL applies only to prescription medications dispensed by participating pharmacies to outpatient members. The PDL is organized by therapeutic class. Specialty pharmacy medications are available through our specialty pharmacy network. Drugs on the PDL that are part of this program are identified by a “SP” in the “Requirements and Limits” section of each page.

You must prescribe and encourage the use of generic drugs on the PDL whenever appropriate. If a member’s treatment requires a non-preferred medication, call Pharmacy Prior Authorization at 1-800-310-6826.

PDL information, including updates, is on **UHCprovider.com**. We notify you of PDL changes in various ways depending on the change and contractual requirements. We notify you by letters, bulletins, newsletters, website postings and fax blasts before they take effect. The PDL, Pharmacy Prior Notification Request Form, and PDL Change Request Form can all be printed or saved. For a print copy of the PDL, contact Provider Services.

Review the AHCCCS Drug List and pharmacy information at azahcccs.gov > Plans/Providers > **Pharmacy**.

Pharmacy prior authorization

Dispense medications as an emergency 72-hour supply when drug therapy must start before prior authorization is secured and the prescriber cannot be reached. The rules apply to non-preferred PDL drugs and to those affected by a clinical prior authorization edit.

To request pharmacy prior authorization, call Pharmacy Prior Authorization at 1-800-310-6826 or use the online Prior Authorization and Notification tool on the Provider Portal. We provide notification for requests within 24 hours of receipt.

Step therapy

Step Therapy drugs are covered if the member’s pharmacy history shows this process has been followed. If it does not, the care provider must submit a prior authorization request. The prescriber must submit information explaining why the member cannot use the required drug first. However, members who have been stabilized on a medication while in service by the

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behavioral health care provider will be maintained on that medication when discharged and seeing PCP for medication management. If the PCP identifies a change in the member's condition, they may use step therapy until the member is stabilized again. UnitedHealthcare Community Plan covers the cost of the medication and dose the member had been stabilized on.

E-prescribing

With e-prescribing, you can electronically transmit new prescriptions and responses to renewal requests to a pharmacy without having to write or fax the prescriptions. E-prescribing can improve members' health and financial well-being by helping them avoid preventable medication errors and optimizing their prescription drug benefits.

Members experience higher satisfaction rates and health outcomes through:

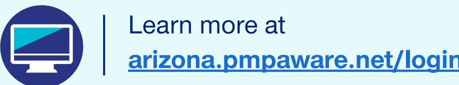
- Reduced adverse drug events,
- Fewer trips to the pharmacy,
- Lower wait time, and
- Greater accuracy.

The PHI contained in all prescriptions, whether written or electronic, is protected by federal and state laws, including HIPAA.

Pharmacy Controlled Substance Prescription Monitoring Program

The CSPMP lets you view controlled substances dispensed to a member. The report lists the drug, quantity, days supply, prescriber, pharmacy, and payment method (e.g., cash or billed to a third party). The default look-back period is 12 months but can be changed. The database can pull in data from other states, which helps you when seeing a new patient or those near the state borders.

Per Arizona law, before prescribing an opioid analgesic or benzodiazepine controlled substance, you must get a patient utilization report from the monitoring program's central database tracking system showing the member's prescriptions for the previous 12 months. You must get it at the beginning of each new course of treatment and at least quarterly while the member uses that prescription.



Learn more at **arizona.pmpaware.net/login**.

Specialty pharmacy medications

The Specialty Pharmacy Management Program provides high-quality, cost-effective care for our members. A specialty pharmacy medication is a high-cost drug that generally has one or more of the following characteristics:

- Used by a small number of people
- Treats rare, chronic, and/or potentially life-threatening diseases
- Has special storage or handling requirements such as needing to be refrigerated
- May need close monitoring, ongoing clinical support and management, and complete patient education and engagement
- May not be available at retail pharmacies
- May be oral, injectable, or inhaled

Specialty pharmacy medications are available through our specialty pharmacy network. For more information about specialty pharmacy medications, go to **UHCprovider.com/priorauth**.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

- Patient name and ID number.
- Ordering care provider name and TIN/NPI.
- Rendering care provider and TIN/NPI.
- ICD-10-clinical modifications (CM).
- Anticipated dates of service.

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Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent Pre-service	Within five working days of receipt of medical record information required but no longer 14 calendar days of receipt	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/Expedited Pre-service	Within 72 hours of request receipt	Within 72 hours of the request	Within 72 hours of the request
Concurrent Review	Within 24 hours or next business day following	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within 2 business days
Retrospective Review	Within 30 calendar days of receiving all pertinent clinical information	Within 24 hours of determination	Within 24 hours of determination and member notification within 2 business days

- Type of service (primary and secondary) procedure codes and volume of service, when applicable.
- Service setting.
- Facility name and TIN/NPI, when applicable.

Submit notifications online using our Prior Authorization and Admission Notification tool on the Provider Portal at UHCprovider.com/paan. If you have questions, please call [Provider Services].

For behavioral health prior authorizations, please call Prior Authorization at **1-800-348-4058**.

Medical claims review

We help ensure state and federal dollars are appropriately used on behalf of our members. To do so, we perform pre- and postpayment medical claims review.

Medical claims reviewers (MCRs) use medical review criteria to confirm billed services are covered and medically necessary. MCRs evaluate claims for ER, transportation, and inpatient and outpatient medical services.

MCRs also help determine if services were provided according to policy, particularly related to medical necessity and emergency services. They also audit appropriateness, utilization, and quality of the service provided.

Appropriate documentation to process a claim is required in the following scenarios:

- Inpatient claims with cost-per-day thresholds may qualify for an outlier reimbursement. For an inpatient claim to be paid, the outlier payment the facility may bill a Condition Code 61 in any of the Condition Code fields (18-28) on the UB-04.
- All hospitals for inpatient claims that may qualify for outlier payment should include itemization of charges.
- When unlisted procedures are billed, include the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used that details what service was provided.
  - Medicaid services:
    - Behavioral health/substance abuse.

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- ER notes.
- Physician orders, MD, RN, and social work notes.
- Medical Admission Risk System (MARS) for each day of hospitalization.
- Discharge orders and/or instructions.
- Psychiatric evaluation and discharge summary.
- Cardiology services.
- Radiological service interpretation.
- Home health visits.
- Injectable drugs.
- Urgent care.
- Pharmacy supplies.
- Prosthetics.
- Surgical procedures with modifier 22 indicating unusual procedural service.
- Itemized bill for claims where member is eligible for part of the date span but not the entire date span.
- Elective abortions require a Certificate of Necessity for Pregnancy Termination and Operative Report.

Medical policies and coverage determination guidelines can be found at UHCprovider.com > Policies and Protocols > For Community Plan > **Medical & Drug Policies and Coverage Determination Guidelines for Community Plan**.

Concurrent review guidelines

UnitedHealthcare Community Plan requires you to chart progress notes for each day of an inpatient stay. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, SNFs, home health care, behavioral health admissions to psychiatric hospitals, Institution for Mental Diseases (IMD), and ambulatory facilities. Concurrent review nurses perform a record review or phone review of the services provided in these facilities for medical necessity, bed day limits and appropriateness of the level of care. Absent superseding state (AHCCCS) and/or CMS required guidelines, we use InterQual, ASAM clinical criteria for primary substance abuse events including co-occurring mental health and substance use disorders, followed by our evidenced-based, peer-reviewed concurrent review criteria to assist clinicians in making informed decisions in many health care settings. InterQual review criteria or hospital system review criteria are not adopted by UnitedHealthcare Community Plan and are not acceptable review criteria.

You must work with UnitedHealthcare Community Plan for all information, documents or discussion requests. This includes gathering clinical information on a member's status for concurrent review and discharge planning. When criteria are not met, the case is sent to a medical director.

UnitedHealthcare Community Plan denies payment for days that do not have a documented need for acute care services. Failure to document results in payment denial to the facility and you.

Concurrent review details

Concurrent review is notification within 24 hours or one business day of admission. It finds medical necessity clinical information for a continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone or record review.

Your cooperation is required with all UnitedHealthcare Community Plan requests for information, documents or discussions related to concurrent review and discharge planning including: primary and secondary diagnosis, clinical information, care plan, admission order, member status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information by access to Electronic Medical Records (EMR).

Your cooperation is required with all UnitedHealthcare Community Plan requests from our interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone. You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director.

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

- Prevent, diagnose, alleviate or cure a physical or mental illness or condition.

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- Maintain health.
- Prevent the onset of an illness, condition or disability.
- Prevent or treat a condition that endangers life, causes suffering or pain or results in illness or infirmity.
- Prevent the deterioration of a condition.
- Promote daily activities; remember the member's functional capacity and capabilities appropriate for individuals of the same age.
- Prevent or treat a condition that threatens to cause or worsen a handicap, physical deformity, or malfunction; there is no other equally effective, more conservative or substantially less costly treatment available to the member.

AHCCCS does not cover experimental or investigational services.

Determination process

Benefit coverage for health services is determined by the member specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, or Summary Plan Description, and applicable laws.

Evidence-based clinical guidelines

UnitedHealthcare Community Plan uses the following evidence-based clinical guidelines to guide our quality and health management programs:

- InterQual supports utilization management for physical health services.
- LOCUS, CALOCUS-CASII and ECSIII support utilization management for behavioral health services.
- ASAM clinical criteria for primary substance abuse events.

For more information on our guidelines, go to UHCprovider.com.

Medical and drug policies and coverage determination guidelines

Find medical policies and coverage determination guidelines at UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > Medical and Drug Policies and Coverage Determination Guidelines for Community Plan.

Multi-specialty interdisciplinary clinic

The multi-specialty interdisciplinary clinic (MSIC) is the health home for members with special health care needs, including members with CRS conditions. Upon enrollment, every member is assigned to one of four regionally based MSICs. The MSIC provides accessible, continuous, complete, family-centered, compassionate, and culturally effective care. We coordinate with MSICs and PCPs to create an integrated approach to care and the decision-making process.

The MSIC must have an integrated EMR for each member maintained and available for the multi-specialty treatment team and community care providers. The EMR must contain all information needed to help coordinate care delivered by multiple care providers in various locations and times and be available electronically through the HIE for the multi-specialty treatment team and community care providers.

All participating care providers must retain medical records. The records must be retained for at least three years after the child's 18th birthday or for at least six years after the last date the child received medical or health care services from the care provider, whichever date occurs later, based on state law.

Please see the Medical Record chapter for more information.

Nursing services

Nursing services include:

- Direct nursing care given during specialty clinics

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and supervision of subordinate nursing staff during specialty clinics.
- Documented nursing care assessments, interventions, implementation, and revisions of care following evaluations.

Child life services

Each of the four MSICs provide child life services. Child life services include organization of individual, family, or group activities that help reduce the member and family's fear of an illness, medical care, and procedures. Child life activities may include;

- Group activities of expressive play.
- Pre-operative teaching and medical play that increases understanding and confidence.
- Support and coping strategies for the member during painful procedures.

Care coordination services

Care coordination services include:

- Medical, behavioral and special needs Integrated care.
- Coordinated health care through multi-specialty interdisciplinary approach to care.
- Coordination of member health care needs through a service plan. (See AHCCCS Medical Policy Manual, Chapter 500, Policy 560.)
- Collaboration with care providers, communities, agencies, service systems, member and families.
- Sharing information with other appropriate professionals, with the member's or family's consent.
- Coordination, communication, and support services that help manage the member's transition of care.
- Other activities as described in the AMPM.

Referral guidelines

PCPs must coordinate member referrals for medically necessary services beyond their scope of practice to a specialist or another care provider. Members may also request services from a network care provider without a referral form. When possible, direct health plan referrals and members to participating care providers. Monitor the referred member's progress and help ensure they are returned to your care as soon as appropriate.

Participating care providers who do not require PCP coordination are:

- Vision care providers
- Dentists
- Radiologists

Members who self-refer for their well-woman exam and members requesting behavioral health services do not need a referral. However, PCPs must consult with the member's behavioral health care providers about the member's treatment plan. Our behavioral health care coordinators and medical directors are available for consultation regarding the guidelines.

You may receive requests for prescription refill orders, DME orders and referrals for specialty care. When a case manager reaches out to you, respond as quickly as possible.

We require prior authorization of all out of-network referrals. The nurse reviews the request for medical necessity and/or service. If the case does not meet criteria, the nurse routes the case to the medical director for review and determination. Out-of-network referrals are approved for the following:

- Continuity of care issues
- Necessary services are not available within network

When appropriate, you must communicate the final disposition of each referral to the referral source and UnitedHealthcare Community Plan within 30 days of the member receiving an initial assessment.

UnitedHealthcare Community Plan monitors out-of-network referrals on an individual basis. Care provider or geographical location trends are reported to Network Management to assess root causes for action planning.

Autism spectrum disorder referrals

UnitedHealthcare Community Plan offers a network of care providers offering evaluation, diagnosis and treatment of autism spectrum disorders (ASDs) to our special needs members. PCPs may refer members with suspected diagnoses of autism directly to a specialized ASD diagnosing care provider. Find health care professionals available for ASD evaluation, diagnosis

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and treatment at **UHCCommunityPlan.com/AZ**. Select your plan, and then click on Member Resources. Scroll down to Resources for Members with Autism Spectrum Disorder.

As a reminder, referring your patients to other care providers who participate in the UnitedHealthcare network can help save them money and reduce administrative effort.

Reimbursement

UnitedHealthcare Community Plan authorization helps ensure reimbursement for all covered services. You should:

- Determine if the member is eligible on the date of service by using the Provider Portal available at **UHCprovider.com**, contacting UnitedHealthcare Community Plan's Provider Services Department, or the Arizona Medicaid Eligibility System.
- Review the **Reimbursement Policies** and Clinical Guidelines.
- Submit documentation needed to support the medical necessity of the requested procedure.
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized.
- Determine if the member has other insurance that should be billed first.

UnitedHealthcare Community Plan will not reimburse items such as:

- Services UnitedHealthcare Community Plan decides are not medically necessary.
- Non-covered services.
- Services provided to members not enrolled on the dates of service.

Second opinion benefit

A UnitedHealthcare Community Plan member may obtain a second opinion about a treatment or procedure. Scheduling the appointment for the second opinion should follow the appointment availability standards established by AHCCCS and listed in the AMPM. These standards are defined in Chapter 2. Request a second opinion from a qualified care provider within UnitedHealthcare Community Plan's network. A second opinion may be received from an out-of-network care provider if there is no in-network coverage.

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Care providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward the report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network care provider is not available, services can be provided by a non-network care provider if prior authorization is requested and approved. Please refer to Chapter 1 for Prior Authorization contact information.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations.
- If follow-up care is recommended, the member meets with the PCP before receiving treatment.

Services requiring prior authorization

UnitedHealthcare Community Plan provides AHCCCS/DDD-covered, medically necessary services that meet or exceed our regulators' standards and requirements. You are required to coordinate member care within our care provider network. When possible, direct all health plan member referrals to participating care providers. Referrals and services rendered outside the network are permitted with prior authorization approval. Non-compliance may result in delay or denial of reimbursement. Prior authorization is not a guarantee of payment.

Unless another department or unit has been specially designated to authorize a service, prior authorization requests are routed through the Prior Authorization Intake department. Department nurses and medical directors are available 8 a.m. to 5 p.m., Arizona time. Requests can be made by phone or online.

The most frequently used services requiring prior authorization are in our Prior Authorization Lists on UHCprovider.com/azcommunityplan > **Prior Authorization and Notification**.

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Requesting prior authorization

Use the following steps to obtain prior authorization:

- Direct requests to UnitedHealthcare Community Plan's Prior Authorization Intake department:
  - Verify member eligibility using the Provider Portal.
  - Identify and bill other carriers as needed.
  - Submit request online by selecting the Prior Authorization and Notification tile on your Provider Portal dashboard. Or go to **UHCprovider.com/paan.**
  - Call Provider Services at 1-800-445-1638.
  - Call the ALTCS EPD Prior Authorization at 1-800-377-2055.
- All requests require:
  - A valid member ID number.
  - Name of referring care provider.
  - Name of servicing care provider.
  - The current applicable CPT, ICD-10 and HCPCS codes for the services being requested.
  - The designated place of service.

The department documents and evaluates requests. It checks:

- The member is enrolled with the health plan at the time of the request and on each date of service.
- The requested service is a covered benefit.
- The service is medically necessity and appropriate, using national medical review criteria based on AHCCCS program requirements, applicable policies and procedure, contracts and law.
- All rendering care providers, facilities and vendors must be actively registered with AHCCCS.
- The service is being provided by a participating care provider in the appropriate setting.
- All services rendered by a non-participating care provider include supporting documentation.
- Other insurance for coordination of benefits should handle the request first.

We do not approve retroactive authorizations for therapy services. This includes physical, occupational and speech therapy.

Dental prior authorizations

Emergency treatment done where prior authorization could not be requested in advance can be reviewed retrospectively at time of claim submission.

A prior authorization number cannot be issued by phone or fax. Surgical center or hospital authorizations may be called into the UnitedHealthcare Dental Unit if emergency or urgent treatment needs to be rendered at a hospital or surgi-center. Submit prior authorization requests on the dental provider web portal at **UHCproviders.com**. Or mail to:

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

Responding to prior authorization requests

The UnitedHealthcare Community Plan Pre-Service Review Team makes determinations and notifies requesters of approval or denial of authorization within the AHCCCS regulatory requirements:

- STANDARD Request (i.e., elective/routine/non-urgent) – A decision and notification is made no later than 14 calendar days following the receipt of the request. This time frame may be extended up to 14 days if the member or care provider requests an extension or if more information is needed and the delay is the member's best interest.
- EXPEDITED Request (i.e., Urgent/STAT) – These requests should ONLY be made when the standard time frame could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function. A decision and notification will be made no later than 72 hours following the receipt of the request, with a possible extended up to 14 days if the member or care provider requests an extension or if more information is needed and the delay is in the member's best interest.
- Medication requests require a 24-hour decision time frame except where an extension is allowed. The time frame may be extended to 7 days.

Authorization is not a guarantee of payment. Billing guidelines must be met.

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Prior authorization denials

Denial of authorization requests for medical necessity occurs only after a UnitedHealthcare Community Plan medical director has reviewed the request and determines that the service does not meet criteria. You may speak with a medical director to discuss the decision.

Requests are often denied because they lack supporting medical documentation. If more information is requested and not received within the designated time frame, the request may be denied. You can submit additional medical records after receiving a denial of a service request. We enter a new case into the prior authorization system for review with the supporting documentation.

For a list of services that require prior authorization, go to UHCprovider.com > Prior Authorization.

Seek prior authorization within the following time frames

- **Emergency or Urgent Facility Admission:** one business day.
- **Inpatient Admissions; After Ambulatory Surgery:** one business day.
- **Non-Emergency Admissions and/or Outpatient Services (except maternity):** at least 14 days beforehand; if the admission is scheduled fewer than five business days in advance, use the scheduled admission time.

Telehealth

These services are delivered through asynchronous (store and forward), remote patient monitoring, teledentistry or telemedicine (interactive audio and video). This technology helps deliver care and services directly to the member and maximize the care provider network. The technology can also be used to enhance communication, increase educational opportunities for members, member's families, staff, and you. The AHCCCS and DDD AMPM Policy 320-I has more information.

Services provided through telemedicine technology may include:

- Outreach clinics.
- Care provider consultation.
- Other professional consultation or services.
- Member, family and professional education, and video conference meetings or trainings.

Utilization management guidelines

Call Provider Services to discuss the guidelines and utilization management.

Utilization management (UM) is based on a member's medical condition and is not influenced by monetary incentives. UnitedHealthcare Community Plan pays its in-network PCPs and specialists on a FFS basis. We also pay in-network hospitals and other types of care providers in the UnitedHealthcare Community Plan network on a FFS basis. The plan's UM staff works with care providers to help ensure members receive the most appropriate care in the place best suited for the needed services. Our staff encourages appropriate use and discourages underuse. The UM staff does not receive incentives for UM decisions.

UM appeals

UM appeals are considered medically necessary appeals. They contest UnitedHealthcare Community Plan's UM decisions. This includes such things as UnitedHealthcare Community Plan's admission, extension of stay, level of care, or other health care services determination. They do not include benefit appeals, which are appeals for non-covered services.

Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal. See Appeals in Chapter 14 for more details.

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Chapter 5: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)/prevention

Key contacts

Topic	Link	Phone Number
EPSDT	azahcccs.gov > Policy Manuals > Medical Policy Manual (AMPM) > Chapter 400	1-602-417-4410
Vaccines for Children	azdhs.gov > Public Health Preparedness Epidemiology & Disease Control Arizona Immunization Program - Vaccines for Children	1-602-364-3642

The **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** benefit provides comprehensive and preventive health care services for children younger than age 21 who are enrolled in Medicaid. EPSDT focuses on continuum of care by assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended treatment and appropriate follow-up. This includes coverage of the following:

- Inpatient and outpatient hospital services
- Laboratory and X-ray services
- Physician services
- Naturopathic services
- NP services
- Medications
- Dental services
- Therapy services
- Behavioral health services
- Medical equipment
- Medical appliances and supplies
- Orthotics
- Prosthetic devices
- Eyeglasses
- Transportation and family planning services
- Women's preventive care services
- Maternity services when applicable, as specified in AMPM Chapter 400

EPSDT also includes diagnostic, screening, preventive and rehabilitative services.

Follow the EPSDT periodicity schedule (AMPM Policy 430, Attachment A) for all eligible UnitedHealthcare Community Plan members to age 21, including pregnant women. Find the schedule in the General Forms section at UHCprovider.com > Resources > Health Plans > Choose Your Location > Arizona > UnitedHealthcare Community Plan of Arizona Homepage > Provider Forms, Programs and References and in the AHCCCS Medical Policy Manual at azahcccs.gov > Plans/Providers > Guides - Manuals - Policies > AHCCCS Medical Policy Manual (AMPM). EPSDT screening includes immunizations, hearing, vision, speech screening and nutritional assessments; dental screening; behavioral health screening; and growth and development tracking.

Birth to age five population

Care providers who work with the birth to age 5 population must have knowledge of early childhood development, be able to identify resources and needs within the family/guardian/caregiver environment, and communicate assessment results to parents/guardian/caregivers and other professionals. Use the Working with Birth Through Five Population Practice Tool on azahcccs.gov when working with this population and their guardians/caregivers.

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EPSDT forms and periodicity schedules

AHCCCS EPSDT Clinical Sample Template, which you must use to document all age-specific required information related to EPSDT screenings and visits, are on UHCprovider.com in the General Forms section. They are also on azahcccs.gov in Chapter 400 of the AMPM.

The AHCCCS EPSDT Clinical Sample Templates may be used or care providers may choose to utilize their electronic health record system, as long as the electronic form includes all components present on the AHCCCS EPSDT Clinical Sample Templates.

. Submit the completed forms to UnitedHealthcare Community Plan at the following address. A copy of the form must be placed in the member's chart.

Send EPSDT forms to:

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

Development disability services and coordination with regional centers

Developmental disabilities are severe and chronic disabilities due to a mental or physical impairment that begins before the member reaches adulthood. These disabilities include intellectual disability, cerebral palsy, epilepsy, autism, and disabling conditions related to intellectual disability or requiring similar treatment. AHCCCS is responsible for a system of diagnosis, counseling, care management, and community support of persons with intellectual disability, cerebral palsy, epilepsy, and autism for children older than 36 months to adulthood.

Referral – If you determine supportive services would benefit the member, refer the member to DES/DD for approval and assignment of a regional center care manager who is responsible for scheduling an intake assessment. Determination of eligibility is the responsibility of the regional center interdisciplinary team. While the regional center does not provide overall care management for their clients, they must assure access to health, developmental, social, and educational services from birth throughout the lifespan of individual who has a developmental disability.

Continuity of Care – The regional center will determine the most appropriate setting for eligible HCBS and will coordinate these services for the member in collaboration with the PCP and health plan coordinator. The Care Coordinator and PCP continue to provide and manage primary care and medically necessary services. If the member does not meet criteria for the program or placement is not currently available, UnitedHealthcare will continue care coordination as needed to support the member's screening, preventive, medically necessary, and therapeutic covered services.

Full screening

Perform a full EPSDT screen in compliance with the AHCCCS Periodicity Schedule (AMPM Policy 430, Attachment A) requirements. Include:

- Complete health and Developmental history, including growth and Developmental Screening 42 CFR § 441.56(b)(1). This includes physical, nutritional, and behavioral health assessments. Refer to the Centers for Disease Control and Prevention website cdc.gov/healthyweight/assessing/bmi/index.html for Body Mass Index (BMI) and growth chart resources.
- PCP-provided nutritional assessment, nutritional screening, and behavioral health screening and services
- Interval history
- Comprehensive physical examination
- Anticipatory guidance
- Lab/immunizations (lab and administration of immunizations is reimbursed separately)
- Lead assessment
- Health education, counseling and chronic disease self-management
- Personal-social and language skills
- Fine motor/gross motor skills
- Appropriate hearing, vision and speech
- Tuberculosis (TB)
- Dental/oral health screening
- Developmental and behavioral health screening and services, which may include PSYRATS (psychotic symptom rating scales) and ADAMS (anxiety depression and mood scale)

Without all these components, you cannot bill for a full

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screen. You may only bill for a partial screen.

After the screening, PCPs may treat behavioral health conditions within their scope of practice. For behavioral health conditions outside their scope of practice, refer the member to a specialty care provider skilled in treating those conditions. When a PCP has started medication management service for a member to treat a behavioral health disorder, and then determines the member should be transferred to a behavioral health care provider (including RBHA, AIHP or T/RBHA) for evaluation and/or continued medication management services, the PCP must coordinate the transfer of care.

Interperiodic screens

Interperiodic screens are medically necessary screens outside the standard schedule that do not require the full screen. Office visits and full or partial screenings happening on the same day by the same care provider are not covered unless medical necessity is noted in the member's record.

Interperiodic screens are often used for school and athletic physicals. A physical exam may be needed for a certificate stating a child is physically able to take part in school athletics. This also applies for other school physicals when required as conditions for educational purposes.

Prescriptive lenses and frames

As part of EPSDT, eyeglasses and other vision services for members younger than 21 years are covered to correct or help conditions discovered during vision screenings. This includes eyeglass replacement and repair. There are no restrictions for EPSDT members to replace and repair eyeglasses when medically necessary for vision correction. This includes loss, breakage or refraction change. Frames for eyeglasses are also covered when provided by our in-network care provider, Nationwide Vision. In addition, care providers and dispensers are cautioned about upselling equipment for members. Members are not required to agree to any upgrades.

Blood lead screening

EPSDT covers blood lead screening and testing appropriate to age and risk. Blood lead testing is required for all members at 12 months and 24 months of age and for those members between the ages of 24 months through six years who have not been previously tested or who missed either the 12-month or 24-month test. Lead levels may be measured at times other than those specified if thought to be medically indicated by the care provider, by responses to a lead poisoning verbal risk assessment, or in response to parent/Health Care Decision Maker (HCDM), Designated Representative (DR)s concerns. Additional screening for children through six years of age is based on the child's risk as determined by either the member's residential zip code or presence of other known risk-factors.

Payment for laboratory services not separately billable and considered part of the payment made for the EPSDT visit include: 99000, 36415, 36416, 36400, 36406 and 36410. In addition, payment for all laboratory services are based on limitations or exclusions stated in your Agreement.

Developmental screening

A developmental screening is a separately billable service by PCPs who care for EPSDT members. Follow these guidelines when screening children for developmental delays at the 9-, 18- and 24-month EPSDT visits:

Required EPSDT Developmental Screening Tools
General Developmental screenings must be conducted at 9 months, 18 months, and 30 months EPSDT visits using an AHCCCS approved developmental screening tool.

* General Developmental Screening Tools that can be used include:

- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
- Parent's Evaluation of Developmental Status Developmental Milestones (PEDS-DM)
- Survey of Well-Being in Young Children (SWYC) – general and autism specific tool.

* Autism Spectrum Disorder (ASD) Specific Developmental Screening at the 18 months and 24 months EPSDT visits:

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- ASD specific Developmental Screening should occur at the 18 and 24 months EPSDT visits.

The following Autism Specific Developmental Screening tools have been approved for use by AHCCCS and may be submitted for payment for AHCCCS members:

- Modified Checklist for Autism in Toddler, Revised, with Follow-Up (M-CHAT-R/F)
- Survey of Well-Being in Young Children (SWYC)

Keep a copy of the Developmental Screening tool in medical record.

Training Requirements for Developmental Screenings
You must provide proof of Developmental Screening tool training certification in order to bill for this service.

The AHCCCS-required Developmental Screening tools and training information can be found via the following websites:

[publications.aap.org]

[AZ Department of Health services,]

Screenings
Bill the use of AHCCCS-approved developmental screening tools separately using CPT®-4 code 96110. Add the EP modifier to the 96110 code for the 9-, 18- and 30-month visits. List a developmental screening CPT code with EP modifier in addition to the preventive medicine CPT codes.

AHCCCS requires the following for your claims to be eligible for payment of code 96110:

- You have met the developmental screening tool training requirements.
- The claim is for the 9-, 18- or 30-month EPSDT visit.
- You used an AHCCCS-approved developmental screening tool.

Organ and tissue transplant services

EPSDT covers medically necessary organ and tissue transplants approved for reimbursement based on respective transplant policies.

Nutritional assessment

We cover the assessment provided by the member's PCP as a part of the EPSDT screening specified in the AHCCCS EPSDT periodicity schedule and on an interperiodic basis as determined necessary by the member's PCP. We also cover nutritional assessments provided by registered dietitian when ordered by the member's PCP. To initiate a referral for a nutritional assessment, the PCP must use the UnitedHealthcare Community Plan referral form. Prior authorization is not required when the PCP orders the assessment unless the assessment is rendered by a non-par care provider.

Nutritional therapy

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

Enteral nutritional therapy

Enteral nutrition provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Prior authorization is not required when provided by our in-network care provider, Preferred Homecare.

Parenteral nutritional therapy

Parenteral Nutritional Therapy provides nourishment through the venous system to members with severe pathology of the alimentary tract.

Prior authorization is not required when provided by our in-network care provider, Preferred Homecare.

Commercial oral supplemental nutritional feedings

These feedings provide nourishment and increase caloric intake as a supplement to the member's intake of other age-appropriate foods. Prior authorization is required for commercial oral nutritional supplements unless the member is also receiving nutrition through enteral or parenteral feedings. Prior authorization is not required for the first 30 days if the member requires commercial oral nutritional supplements on a temporary basis due to an emergent condition.

The PCP or attending physician must use Certificate

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of Medical Necessity for Commercial Oral Nutritional Supplements form. This form must document that the PCP or attending physician has provided nutritional counseling as a part of EPSDT services. The documentation must specify alternatives that were tried to boost caloric intake and/or change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

Oral health services

An oral health screening helps identify gross dental or oral lesions. It is not a thorough clinical examination and does not involve making a diagnosis or treatment plan. Depending on the screening results, you may refer the member to a dentist within the following timelines:

- Urgent: As quickly as the member's health condition requires but no later than three days of request
- Routine: Within 45 calendar days of request

PCPs refer EPSDT members for appropriate services identified in the screening process and for routine dental care based on the AHCCCS Dental Periodicity Schedule (AMPM Policy 431, Attachment A). Note this referral on the EPSDT Clinical Sample Templates and in the member's medical record.

PCPs who have completed the AHCCCS-required training may be reimbursed for fluoride varnish applications completed at the EPSDT visits for members who are at least six months old with at least one tooth. Other applications occuring every three months during an EPSDT visit, up until member's fifth birthday, may be reimbursed according to your agreement. Fluoride varnish application does not take the place of an oral health visit.

Find AHCCCS-recommended training for fluoride varnish application on **smilesforlifeoralhealth.org**. Per dental refer to Training Module 6 (Carries Risk Assessment Fluoride Varnish and Counseling). Care providers must upload a copy of their certificate to the Council for Affordable Quality Healthcare (CAQH) ProView **portal**. This certificate is required in order to request payment for fluoride varnish application. It will also be used during the credentialing process to verify completion of required training for reimbursement.

EPSDT covers the following dental services:

- Emergency dental services:
  - Treatment for pain, infection, swelling and/or injury,
  - Removal of infected and non-restorable primary and permanent teeth, as well as retained primary teeth. Extractions are limited to symptomatic teeth.
  - General anesthesia, conscious sedation or minimal sedation when local anesthesia cannot be used or when management of the member requires it. Refer to AMPM Policy 430.
- Preventive dental services include:
  - - Diagnostic services, including full and periodic exams. Give two oral examinations and two oral prophylaxis per member per year for all members up to 21 years of age. For members up to 5 years old, you may apply fluoride varnish four times a year (i.e., one every three months). Additional exams or treatments may be deemed medically necessary.
  - Radiology services screening for diagnosing dental abnormalities and/or pathology. These include panoramic or full-mouth X-rays, supplemental bitewing X-rays, and occlusal or periapical films, as medically necessary and following the AAPD recommendations.
  - Panorex films as the AAPD recommends, up to three times per care provider for children between 3 to 20 years old. Films needed above this limit must be medically necessary and go through the prior authorization process.
  - Oral prophylaxis performed by a dentist or dental hygienist that includes oral hygiene instructions to member or their representative.
  - Topical fluoride applications. Prophylaxis paste containing fluoride or fluoride mouth rinses do not meet the AHCCCS standard for fluoride treatment.
  - Dental sealants for first and second molars are covered twice per first or second molar, per care provider/location. This allows for three years of intervention between applications in members younger than 15 years old. This includes the ADHS school-based dental sealant program (**Cavity Free AZ**) and the participating care providers. Further applications must be medically necessary and require prior authorization.
  - Space maintainers when posterior primary teeth are lost and when deemed medically necessary.
- All therapeutic dental services when they are medically necessary and cost effective. They may be subject to prior authorization. These services include:

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- Periodontal procedures, scaling/root planing, curettage, gingivectomy, and osseous surgery.
- Crowns. When appropriate, use stainless steel crowns for primary and permanent posterior teeth. Use composite, prefabricated stainless steel crowns with a resin window or crowns with esthetic coatings for anterior primary teeth. Use precious or cast semi-precious crowns on functional permanent endodontically treated teeth, except third molars, for members 18 to 21 years old.
- Endodontic services including pulp therapy for permanent and primary teeth, except third molars (unless a third molar is functioning in place of a missing molar).
- Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations. The exception is if the member is 18 to 21 years old and has had endodontic treatment.
- Restorations of anterior teeth for children younger than 5 years, when medically necessary. Children 5 years and older with primary anterior tooth decay should be considered for extraction if presenting with pain or severely broken down tooth structure. They may be considered for observation until the point of exfoliation as the dental provider determines.
- Removable dental prosthetics, including complete dentures and removable partial dentures.
- Orthodontic services and orthognathic surgery when medically necessary and determined to be the PCP's and the dentist's primary treatment of choice. When the child's condition warrants it, use a multi-specialty interdisciplinary approach.

Conditions that may require orthodontic treatment include:

- Congenital craniofacial or dentofacial malformations requiring reconstructive surgery.
- Trauma requiring surgery.
- Problems with the maxillary and/or mandibular bone structures.

AHCCCS does not cover services rendered for cosmetic purposes.

Cochlear and osseointegrated implantation

Candidates for cochlear implants must meet medical necessity, including the following indications:

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

Cochlear implantation requires prior authorization.

Coverage of medically necessary services for osseointegrated implantation is limited to EPSDT members.

Conscious sedation

AHCCCS covers conscious sedation for members receiving EPSDT services. Coverage is provided for the following procedures except as specified:

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

Additional applications of conscious sedation for members receiving EPSDT services will be considered on a case-by-case basis. They require review for medical necessity and prior authorization.

Behavioral health services

AHCCCS covers behavioral health services for members eligible for EPSDT services. EPSDT behavioral health services include the services listed in Federal Law 42 USC 1396d(a) used to correct or improve mental illnesses and conditions discovered by the screening services.

Screenings Include:

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The following screenings are separately billable, and a copy kept in the member's medical record, refer to the Medical Coding page on the AHCCCS website.

i. Postpartum consisting of a standard norm-criterion referenced screening tool to be performed for screening the mother/parent for signs and symptoms of postpartum depression during the 1, 2, 4 and 6-month EPSDT visits. Positive screening results require referral to appropriate case managers and services at the respective maternal health plan, and

ii. Adolescent Suicide consisting of a standardized, norm-referenced screening tool specific for suicide and depression shall be performed at annual EPSDT visits beginning at age 10 years of age. Positive screening results require appropriate and timely referral for further evaluation and service provision.

iii. Adolescent Substance Use Disorder (SUD) screening consisting of a standard criterion-referenced screening tool specific for substance use shall be performed at annual EPSDT visits beginning at 12 years of age. Positive screening results require appropriate and timely referral for further evaluation and service provision.

Care management services

In EPSDT, care management involves identifying the health needs of a child, ensuring necessary referrals are made, maintaining health history, and initiating further evaluation/diagnosis and treatment when necessary.

Chiropractic services

Chiropractic services are covered when ordered by the member's PCP during an EPSDT visit to members younger than 21 years and performed by an in-network care provider.

Personal care services

AHCCCS covers personal care services, as appropriate and medically necessary.

Incontinence briefs

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

- The member is older than 3 years and younger than 21.
- The member is incontinent due to a documented disability that causes incontinence of bowel and/or bladder.
- The PCP or attending physician has issued a prescription ordering the incontinence briefs.
- Incontinence briefs do not exceed 240 per month unless the prescribing physician presents evidence of medical necessity for more than 240 per month for the member diagnosed with chronic diarrhea or spastic bladder.
- The member obtains incontinence briefs from Preferred Homecare.
- Prior authorization has been obtained as required.

Physical, occupational and speech therapies

AHCCCS covers physical therapy, occupational therapy and speech therapy necessary to improve defects and physical and mental illnesses and conditions discovered by the screening services. Therapies are covered under both an inpatient and outpatient basis when medically necessary. See AMPM Policy 310-X for restrictions and limitations.

Review the prior authorization lists on UHCprovider.com.

Billing for additional services

You may bill for a sick visit (CPT codes 99202-99215) at the same time as an EPSDT service if you:

- Find an abnormality or address a preexisting problem while performing an EPSDT service. The problem is significant enough to require additional evaluation and management service (E/M).
- Document the sick visit on a separate note.
- Add modifier 25 to the Office/Outpatient code. This indicates a significant, separately identifiable E/M service was provided by the same physician on the same day as the preventive medicine service.

The history, exam, and medical decision-making components of a separate sick visit already performed during the course of an EPSDT visit are not considered

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when determining the level of the additional service (CPT code 99202-99215).

Arizona Early Intervention Program

The Arizona Early Intervention Program (AzEIP) is a system of professionals working with parents and families of children, from birth to age 3, with developmental delays and/or disabilities. AzEIP provides assistance, encouragement and treatment. It allows early intervention and developmental services to occur in a family's natural environment.

UnitedHealthcare Community Plan works with AzEIP and DD support coordinators, PCPs, servicing care providers (therapists/facilities) and member families. Together, they help ensure the child has medically eligible services, such as physical therapy, speech therapy and/or occupational therapy, based on EPSDT guidelines. Care providers working with this population will receive an AzEIP Request for EPSDT Services and documentation completed by an AzEIP service coordinator. The AzEIP Request for EPSDT services and documentation is sent to UnitedHealthcare Community Plan for review and then to the care provider. If the care provider feels the services are medically necessary, the care provider sends back the request with signature, date and diagnosis codes related to the therapy request. The AzEIP coordinator at UnitedHealthcare Community Plan coordinates prior authorization and notifies the AzEIP service coordinator of approved services.

AzEIP eligibility

A child is eligible for AzEIP when they:

- Have a developmental disability;
- Are younger than 36 months old;
- Are developmentally delayed; or
- Have a condition that will likely cause a developmental delay.

Help these members get the right care by following these guidelines when requesting physical therapy, occupational therapy, or speech/feeding evaluation:

- A child younger than 36 months old may have a developmental delay when they **have not reached 50% of the developmental milestones expected at their age** in one or more of the following areas:
  - Physical: fine and/or gross motor and sensory (includes vision and hearing)
  - Cognitive
  - Language/communication
  - Social or emotional
  - Adaptive (self-help)
- Conditions likely to lead to a developmental delay include chromosomal abnormalities; genetic or congenital disorders; sensory impairments; inborn metabolism errors; nervous system disorders; congenital infections; severe attachment disorders; and issues related to exposure to toxic substances, including fetal alcohol syndrome. Examples of established conditions for AzEIP eligibility include neural tube defects (e.g., spinal bifida); intraventricular hemorrhage, grade 3 or 4; periventricular leukomalacia; cerebral palsy; Downs syndrome, and pediatric under-nutrition.
- If the member is in need of non-medically necessary services not covered by Medicaid but are covered under individuals with Disabilities in Education Act (IDEA) Part C, please notify our EPSDT coordinator at 1-602-255-8196 or 1-602-255-8108 if you have not previously submitted an AzEIP referral.

Targeted care management

Targeted care management (TCM) consists of care management services for specified targeted groups to access medical, social, educational, and other services provided by a regional center or local governmental health program as appropriate.

The five target populations include:

- Children younger than age 21 at risk for medical compromise
- Medically fragile individuals
- Individuals in frail health, older than age 18 and at risk of institutionalization
- Members in jeopardy of negative health or psychosocial outcomes
- Members infected with a communicable disease, including tuberculosis, HIV/AIDS, etc., or who have been exposed to communicable diseases, until the risk of exposure has passed

Continuity of Care – UnitedHealthcare Community Plan is responsible for coordinating the member's health care with the TCM care provider and for determining the

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Medical Necessity of diagnostic and treatment services recommended by the TCM care provider that are covered services under the Agreement.

Vaccines for children program

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

You must coordinate with the Arizona Department of Health Services Vaccine for Children Program (VFC) in the delivery of immunization services. The "SL" (SL – state supplied) modifier indicates vaccines administered under the federal VFC program and should be coded accordingly on the 837p or CMS 1500 claim form.

Through the VFC program, the federal and state governments purchase and make available vaccines for AHCCCS children under age 19 at no cost to care providers. Your office must order to Immunizations. We do not reimburse for the vaccine ordered by the VFC Program, but we reimburse for administering the vaccine.

PCPs with members younger than 19 years assigned to panel must participate in VFC and meet standardized vaccine management requirements related to ordering, storage/handling, and reporting. These children must be:

- Eligible for Medicaid.
- American Indian or Alaska Native, as defined by the Indian Health Services Act.
- Uninsured.
- Underinsured (these children have health insurance, but the benefit plan does not cover immunizations

Vaccine administration fees are reimbursable when submitted with an appropriate CPT and modifier code. See the **Modifier Reference Policy** located in our Reimbursement Policies on uhcprovider.com We cannot reimburse for private stock vaccines when they are available through VFC.

Contact **VFC** if you have questions.
Phone: **1-602-364-3642**

You must re-enroll in VFC annually based on AHCCCS contract requirements.

Document each EPSDT age member's immunizations in the Arizona State Immunization Information System (ASIIS) registry. Also keep the ASIIS immunization records of each EPSDT member in ASIIS, based on A.R.S. Title 36, Chapter 135.

For information about ASIIS trainings, visit **azdhs.gov**. You may also call the ASIIS hotline at **1-602-364-3899** or **1-877-491-5741**. For information on Arizona immunizations, visit **The Arizona Partnership for Immunizations**.

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Chapter 6: Long-term care elderly, physically disabled (ALTCS EPD)

UnitedHealthcare Community Plan serves the North and Central Geographic Service Area's (GSA) for ALTCS EPD. Central GSA includes Maricopa, Gila and Pinal Counties. North GSA includes: Mohave, Coconino, Apache, Navajo and Yavapai.

Enrollment choice in a county with choice and change of contractor: Arizona long-term care system contractors

Enrollment choice in a choice county

Enrollment choice is available when:

- An applicant lives in a county with choice, and that county has fiscal responsibility.
- A member moves from another county to their own home in a county with choice, unless the member's current contractor is available in that county.
- A member moves from another county to a nursing facility or alternative residential setting in a county with choice, and the current contractor has chosen to negotiate an enrollment change.
- A member is currently enrolled with a contractor serving a county with choice, but a valid condition exists (see Section B) for requesting an enrollment change to another contractor serving in that county.
- A former member resides in a county with choice and reestablishes eligibility that results in reenrollment more than 90 days after disenrollment.
- A member reaches the annual anniversary date.

Enrollment choice is not available for:

- An American Indian/Alaska Native member with on-reservation status.
- A member whose county of fiscal responsibility is not a county with choice (unless the current contractor chooses to negotiate a change).
- A member who was disenrolled from a contractor in a county with choice but then reestablishes ALTCS EPD eligibility that results in reenrollment within 90 days from disenrollment.
- A member who moves to a county with choice, and their current contractor is available in that county.

Requests for contractor changes within a county of choice

An enrollment change from one contractor to another, in a county with choice, can be made outside of a member's annual enrollment choice for the following reasons:

Medical Continuity of Care Requests

Contractor changes may be approved on a case-by-case basis to help ensure the member's access to care. To provide continuity of care on a temporary basis for the member's period of illness, the current contractor may agree to a reimbursement schedule with the member's care provider rather than approve a contractor change.

If both contractors' medical directors approve the change request:

- The current contractor sends the completed Contractor Change Request (CCR) Form to the requested contractor and the AHCCCS Central Office. Refer to AMPM Exhibit 1620-8.
- The current contractor tells the member the change is approved and when it takes effect.

If the requested contractors deny the request:

- The CCR Form is returned to the current contractor.
- The current contractor must notify the member in writing when the change request is denied. The denial notice must include the contractor's grievance, appeal system policy and timeframes for filing a grievance.
- The current contractor may forward the CCR Form to the AHCCCS chief medical officer (CMO) or designee for a final decision.
- If the AHCCCS CMO or designee approves the change, the CCR Form is returned to the current contractor for submission to the AHCCCS Central Office.
- If the AHCCCS chief medical officer or designee denies the change request, AHCCCS will provide written notice of the denial. It will include notice of appeal rights to the member and to both the current and requested contractors.

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Incorrect Network Information or Agency Error

The applicant or representative made an enrollment choice based on incorrect information about the facility, residential setting, PCP or other care provider contracting with the chosen contractor.

This decision might have been based on information supplied by the network database, marketing materials, or agency error. Such information includes omissions or failure to share network limitations in the contractor's marketing material or database submissions. The current contractor submits a Member Change Report for these requests.

Lack of Initial Enrollment Choice

In this case, an ALTCS EPD applicant residing in a county with choice was not offered a choice of contractors during the application process. The current contractor submits a Member Change Report for these requests.

Lack of Annual Enrollment Choice

The member was entitled to participate in an annual enrollment choice but was not sent notice. Or the notice was not received. Alternatively, the member was sent an Annual Enrollment Choice notice but could not participate due to circumstances beyond the member's control (e.g., member or representative was hospitalized, anniversary date fell within a 90-day disenroll/reenroll period). The current contractor submits a Member Change Report for these requests.

Family Continuity of Care

The member, either through auto-assignment or the choice process, was not enrolled with the same contractor as their family members. The current contractor submits a Member Change Report for these requests.

Continuity of Care Providers

The contractor's agreement with the institutional, residential or employment supports care providers from whom the member receives services is terminated. The member or their representative requests to change to a contractor who works with their care provider. The member must be receiving services from the care provider at the time of the Agreement termination. The current contractor submits a Member Change Report for these requests.

Failure to Correctly Apply the 90-Day Reenrollment Policy

A member who lost ALTCS EPD eligibility and was disenrolled, yet was reapproved for ALTCS EPD eligibility within 90 days of the disenrollment date but enrolled with a different contractor. The current contractor submits a Member Change Report for these requests.

Member moves to own home in another county

When a member lives in their own home, the following policies apply:

- The county of fiscal responsibility is the county where the member lives.
- Enrollment is with a contractor serving the geographic service area (or fiscal county) where the home is located.
- When the member moves to their own home in a county with choice and is not already enrolled with a contractor serving that county, the member must be given an opportunity to choose a contractor. The member will be enrolled with the contractor through the enrollment choice process.

Member Responsibilities

The member must report a move or anticipated move to the current contractor and AHCCCS.

Contractor Responsibilities

The current contractor must:

- Notify AHCCCS that the member moved by sending a Member Change Report.
- Explain service limitations to a member who moves out of the contractor's service area.
- Transition the member to the new contractor based on the requirements and protocols in AMPM, Chapter 500.

Member moves to a nursing facility or alternative residential setting in another county

When a contractor places a member in a nursing facility or alternative residential setting in a different county (either to receive specialized treatment or because of lack of beds in the contractor's county), the county of fiscal responsibility and enrollment do not change.

When the current contractor chooses to contract with the nursing facility or alternative residential setting in

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another county, the enrollment and county of fiscal responsibility do not change.

When the member moves to a county with choice, the enrollment choice process must be completed before the current contractor can start negotiations with a requested contractor.

Current Contractor Responsibilities

When the current contractor is notified that a member either has moved or plans to move to another county, and the current contractor does not serve the other county, the current contractor has the following options:

- Retain the member and contract with an out of county care provider.
- Negotiate an enrollment change for the member.
- Negotiate a single case agreement with the facility while plans are made to move the member to a participating facility.

When enrollment change is the preferred option, the current contractor must:

- Complete a CCR Form and send it to the contractor serving the GSA or the requested contractor in a county with choice.
- Transition the member when a change is approved.

Requested Contractor's Responsibilities

When a contractor receives the CCR Form, they must:

- Approve or deny the change request by completing the CCR Form.
- Transition the member when the change request is approved. Otherwise, the AHCCCS CMO or designee directs the change.

Additional contractor responsibilities

The contractor must provide information on the contractor change policy in:

- The Member Handbook.
- The care provider manual.

The current contractor must promptly address a member's concerns, including but not limited to:

- Availability and accessibility of services.
- Quality of care.
- Case management responsiveness.
- Transportation service availability.
- Institutional care issues.
- Care provider office hours.
- Office waiting time.
- Network limitations and restrictions.

When the current contractor cannot resolve through the normal case management process issues the member raises about quality of care and delivery of medical service, they must refer the issue to:

- The current contractor's Quality Management department.
- The AHCCCS Quality Management department.

When an enrollment change occurs while the member is hospitalized, the current contractor must notify the hospital before the enrollment with the receiving contractor.

If the current contractor does not provide such notice to the hospital, the current contractor is still responsible for payment of hospital services provided to the member until the date notice is provided to the hospital as required in the AMPM Policy 520.

When the contractor denies the member's enrollment change request, the current contractor must process any resulting member grievances or hearing requests.

Refer to the AHCCCS CONTRACTOR OPERATIONS MANUAL Chapter 400, policy 403 for more information.

Long-term care (LTC) services

Case management

The UnitedHealthcare Community Plan case manager coordinates services and support based upon "the completion of comprehensive assessment(s). LTC services are coordinated and provided to sustain member's current level of functioning and promote maintenance of the highest level of functioning possible in the least restrictive setting." All LTC services require prior notification by the case manager. All facility settings require prior notification by the case manager. All facility settings require the appropriate enrollment,

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licensure and insurance liability coverage. You must send copies of updated licenses and certificates upon renewal. Not providing this information may result in non-payment of rendered services and termination of your UnitedHealthcare Community Plan agreement.

Case managers conduct onsite assessments of members. They also assess the type and amount of services being rendered to the member. If a care provider's performance is unsatisfactory, we will contact the care provider with the findings and care issues. The care provider must address the issues and follow up with UnitedHealthcare Community Plan promptly. If a quality management issue emerges, we follow appropriate procedures to help ensure the member receives the highest quality of care.

Members residing in nursing facilities or assisted living facility settings are responsible for the Member Share of Cost (MSOC) or Room and Board (R&B) payment as applicable. We use three long-term care settings:

1. **Nursing Facility –** Case management member evaluations are completed every 180 days or as the member's conditions changes. The case management must prior authorize the placement.
    - Nursing facilities, including skilled nursing.
    - Institution for mental disease.
2. **Assisted Living Facility –** Case management member evaluations are completed every 90 days or as the member's condition changes. See "HCBS Alternative Residential Settings" in this chapter for more details. In some instances, a member may be eligible to receive HCBS while residing in an Assisted Living Facility. The case manager determines if an HCBS is appropriate. They also prior authorize the assisted living facility placement.
3. **Home- and Community-Based Services –** Case management member evaluations are completed every 90 days or as the member's condition changes. Members living in a private home or apartment may receive the following services based on the case manager's evaluation and authorization of services:
    - **Adult Day Health Care –** Includes supervision; medication assistance; recreation and socialization; personal living skills training; health monitoring; and preventive, therapeutic and restorative services.
    - **Attendant Care –** Includes supervision, bathing assistance, food preparation and feeding assistance, housekeeping services, medication reminders, recreation and socialization.
    - **Member-Directed Service Options –** Allow members to have more control and flexibility over how certain services are delivered. Members can select the model of direct care services to be provided, by opting for Traditional Attendant Care Services, Self-Directed Attendant Care, Agency with Choice or Spouses as Caregivers.
    - **Behavioral Management Services –** See the Behavioral Health chapter of this manual.
    - **Community Transition Service –** The Community Transition Service is a fund that helps ALTCS EPD-institutionalized members reintegrate into the community by providing financial assistance to move from an ALTCS EPD institutional setting to their own home.
    - **Durable Medical Equipment –** Custom and standard items require an order by the member's care provider and must be prior authorized by the Prior Authorization department. This service is limited to a one-time benefit per five years per member.
    - **Emergency Alert System –** Monitoring devices for members who live alone, are at risk of emergent care and cannot access emergency assistance. The case manager authorizes the service. However the service must be ordered by the member's physician (e.g., PCP, specialist) through one of the following network vendors:
        - Lifeline Systems Company: 1-800-368-2925
        - American Medical Alert Corp (Connect America): 1-800-215-4206
    - **Group Respite –** An alternative to adult day health care.
    - **Habilitation –** Provision of training independent living skills or special developmental skills: sensory-motor development; orientation and mobility and behavior intervention. Physical, occupational or speech therapies may be provided as a part of or in conjunction with other habilitation services.
    - **Home-Delivered Meals –** Provides nutritious food to members who live in their own home but may not be eating adequate amounts of nutritious food to maintain good health. Only one meal may be approved for an enrollee on any given day. Providers of home-delivered meals, and those employed, must have applicable food handling/preparation permits.
    - **Home/Environmental Modifications –** Allows

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modifications to member's existing residences to enable a member to function safely and as independently as possible. Our case managers conduct onsite assessments to determine the appropriateness of an environmental modification or repair.

- **Home Health Services –** Includes home health aides, home health skilled nursing, and private-duty nurses for ventilator dependent enrollees only. It also provides medically necessary supplies and therapy services. See "Medical Supplies Included in FFS Home Health Nursing Visits" for supplies included in the FFS rate at the end of the chapter.
- **Home Health Aide –** Provides nursing-related services under the direction of a registered nurse or care provider. These services must be ordered by the PCP and authorized by the case manager. Home health aides must have current Arizona Board of Nursing, CPR and First Aid certification. A home health aide visit may include any of the following:
  - Assessment of the enrollee's health or functional level.
  - Monitoring and documentation of vital signs.
  - Assistance with contingency programs.
  - Assistance with self-administration of medications.
  - Assistance with feeding.
  - Assistance with ambulation, transfer, range of motion and use of equipment.
  - Assistance with daily living activities.
  - Enrollee or family training of health care tasks.
- **Licensed Health Aide –** If an ALTCS member who is younger than 21 years of age and eligible to receive private duty nursing or skilled nursing respite care services has a parent, guardian or family member that can provide Licensed Health Aide (LHA) services, they may only provide care to that member and only if consistent with that member's plan of care. The LHA has a scope of practice that is the same as a Licensed Nursing Assistant (LNA) and may also provide medication administration, tracheotomy care, enteral care and therapy and any other tasks approved by the State Board of Nursing in rule.
- **Home Health Nurse –** Provides skilled nursing services the PCP ordered. They must be provided by a licensed nurse under the supervision of a care provider. These services can only be provided on an intermittent basis. These services are considered as skilled.

  If a licensed/Medicare-certified home health agency is not available in an enrollee's community, does not have adequate staff, or will not provide services through UnitedHealthcare Community Plan, a non-Medicare-certified, licensed home health agency or an independent RN may provide skilled nursing services. RNs providing these services must provide documentation of services performed according to PCP orders. We monitor the service delivery and quality of care.

  Skilled nursing assessments and care for members with pressure sores, surgical wounds, tube feedings, etc. must be provided by a Medicare-certified home health agency or independent nurse. Written monthly reports must be submitted to the PCP and our case manager. Skin assessments must be performed at least monthly for members prone to breakdown of skin integrity due to their health status or care needs.
- **Private-Duty Nurse –** Home health private duty nurse services are provided on a continuous basis to avoid hospitalization or institutionalization when care cannot be safely managed intermittently. Private duty services must be ordered by the PCP and authorized by UnitedHealthcare Community Plan. If a LPN provides services, a physician must provide supervision. These services are only available to ventilator-dependent members.
- **Homemaker Services –** May be provided to preserve or improve upon the safety and sanitation of a member's living condition, nutritional value of meals and to maintain or increase the member's self-sufficiency. A homemaker only provides services that pertain to the member. A homemaker may clean the enrollee's living space, such as their bedroom; conduct meal planning, shopping, and food preparation with clean up; and clean and put away the member's laundry.
- **Home Maintenance Program –** If a member's restoration potential is evaluated as insignificant or at a plateau, a Home Maintenance Program

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can be initiated. A licensed therapist, the enrollee, family, caregiver or non-skilled personnel is trained to help maintain the member's functions. We authorize the initial establishment of the Home Maintenance Program through a licensed therapist if the service is determined appropriate by the PCP, our medical director, and Utilization Management.

- **Hospice** – Includes physician services, nursing services, medication for the terminal illness, therapies, aid services, homemaker services, medical social services, medical supplies and appliances, and short-term respite and counseling, including bereavement and support. The member's care provider must certify that the member is terminally ill, with a prognosis of six months or less. They must state the enrollee desires palliative versus curative treatment. Hospice is a prior-authorized service. If the member is receiving services under Medicare, the services do not require PCP orders or our case management's prior authorization. However, because our case manager monitors the member's care, the hospice care provider must notify the case manager of the hospice election. Hospice services must be provided through a Medicare-certified agency. If the member has Medicare, hospice benefits must be chosen instead of regular Medicare benefits.
- **Personal Care** – Includes bathing assistance, food preparation and feeding assistance, homemaker services, medication reminders, and recreation and socialization. Personal care services may involve bathing, toileting, dressing, nail care and feeding; assistance with transferring, ambulating and use of special equipment. They may also include training of family/caregivers.
- **Respite Care** – Is provided in both inpatient and outpatient settings for a short-term period to relieve the family. Respite services can be available up to 24 hours a day and is limited to 600 hours per fiscal year.

HCBS alternative residential settings

Members residing in these settings are responsible for their room and board (R&B) payment at the beginning of each month. We determine the R&B amount based on AHCCCS and health plan guidelines.

1. Assisted living facilities – licensed by Arizona Department of Health Services (ADHS)
    - Adult Foster Care (AFC) – up to four residents in the home. The sponsors, or homeowners, reside in the home with the residents.
    - Assisted Living Home (ALH, formerly Adult Care Home) – up to 10 residents in the home. Owners of ALHs typically do not reside in the residence. ALHs must be staffed 24 hours per day, seven days per week.
    - Assisted Living Center (ALC) – more than 10 residents in the center. ALCs must be staffed 24 hours per day, seven days per week. Members residing in ALCs must be offered the choice of single occupancy rooms. If no single occupancy rooms are available at the time of move-in, or if a member is offered a single occupancy room and declines but later requests to move into a single-occupancy room, the member must be placed on a wait list for a single occupancy room. They may not be passed over by other residents (regardless of payer source) on the wait list. ALCs that have varying sizes and layouts for single-occupancy rooms may designate a room size/layout for ALTCS EPD members in which if a single-occupancy room size/layout not designated becomes available. In this case, the ALC is not required to place the ALTCS EPD member in that specific unit.
2. Adult Development Home – licensed by DES (Department of Economic Security) – up to three adults (18 years or older) in the home
3. Adult Therapeutic Foster Home – for behavioral health members only – up to three adults in the home
4. Behavioral Health Level II (Residential Treatment Center) – licensed by ADHS – 24-hour supervision and counseling or other therapeutic activities for individuals who do not require the intensity of treatment services or onsite medical services found in a Level 1 behavioral health facility
5. Behavioral Health Level III (Residential Treatment Center) – licensed by ADHS – 24-hour supervision and supportive protective oversight, behavior management or psycho-social rehabilitation. They help assure members receive required

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medications, obtain needed treatment and have transportation to outside treatment agencies if necessary. Life skills training, social and recreational activities may be provided directly or by referral to outside treatment agencies.

6. Child Development Foster Home – licensed by DES – up to three children in the home.
7. Group Home for Developmentally Disabled – licensed by DES – up to six adults in the home.
8. Rural Substance Abuse Transitional Agency
9. Traumatic Brain Injury Treatment Facility – licensed by ADHS.
10. Member/Resident Options When a NF or Alternative HCBS Setting Contract is Terminated – Affected members residing in a NF and/or alternative HCBS setting at the time of a contract termination may keep living in that facility until their open enrollment period. At that time, members must either choose an available contractor who works with the facility or move to a setting that works with their current contractor. For more information, refer to the AHCCCS Contractor Operations Manual (ACOM), Chapter 400, Policy 421.

Therapeutic leave and bed hold

UnitedHealthcare Community Plan members living in SNFs may receive up to 12 days per AHCCCS contract year (beginning October 1) while the member is hospitalized or otherwise not occupying a bed in the skilled nursing facility and is expected to return, based on our Therapeutic Leave/Bed Hold Policy. Of the 12 days allowed, no more than nine are for therapeutic leave. The case manager must prior authorize all requests for Therapeutic Leave/Bed Hold payment days.

Our members younger than 21 years may use any combination of Therapeutic Leave/Bed Hold per AHCCCS contract year with a limit of 21 days per year. The total days may include days in multiple facilities.

Medical/acute care-only services

Acute care-only services may be available if members decline to use LTC services or while awaiting disenrollment from the ALTCS EPD or have not received LTC services for more than 30 days. These members do not qualify for full LTC benefits. Services provided will be only those allowable under the auspices of AHCCCS ambulatory plans and case management services (e.g., DME, medically necessary transportation, physician services, prescriptions, laboratory, X-rays, behavioral health, outpatient services, inpatient acute services). These services do not include nursing facility placement, assisted living placement or HCBS.

Medical supplies included in FFS home health nursing visits

The following supplies are included in your agreement. This list is not all-inclusive and is for a general reference only.

- Adhesive spray or tape
- Antiseptics
- Bandage, cling type 6”
- Colostomy care
- Cotton balls, sterile or non-sterile
- Diabetic daily care
- Diabetic diagnostics and tape, cloth 2’’x10yds
- Dressing, N-Adhering with adhesive 2x3”
- Dressing, transparent
- Gauze bandage roll 1”x10yds Tape, cloth 2”x10yds
- Gauze pads, sterile and 4”x4”
- Gauze pads, sterile with gel 1/2”x72”
- Gauze pads, sterile with gel 6”x36”
- Gauze sponges, non-sterile 4”x4”
- Gloves, plastic disposable
- Glucose care starter kit
- Glucose reagent strips
- Hydrogen peroxide
- Iodoform packing 1/2’’x5yds
- Isopropyl alcohol swabs
- Lancets
- Lubricating jelly, 1oz
- Packaging gauze, plain 1/4”x5yds
- Petroleum jelly, 1oz
- Petroleum jelly gauze 1”x8”
- Syringes/needles
- Tape, paper 1”x5yds
- Tape, plastic 1”x5yds

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- Tape, standard adhesive 2”x5yds or 11/2”x10yds
- Tape, waterproof adhesive 1”, 1”x5yds or 11/2”x5yds
- Urine test strips
- Wood applicator with cotton tips

Non-covered services

Services not covered by ALTCS EPD include:

- DME (not ordered by the member’s PCP)
- Services provided by non-approved care providers
- Services or items furnished solely for beauty or cosmetic reasons
- For members 21 years or older: hearing aids, eye exams for glasses/lenses and other services, unless deemed medically necessary and approved by the medical director
- Services defined by AHCCCS as experimental or provided solely for the purpose of research according to A.A.C. R9-22-203
- **Gender reassignment surgeries**
- Reversal of self-requested sterility
- Care not deemed medically necessary by AHCCCS, UnitedHealthcare Community Plan or the care provider, and/or care not covered under ALTCS EPD
- Medical services provided to an enrollee who is an inmate or who is in the care of a state mental health center
- Man-made hearts or xenografts
- Organ transplants, except those identified under the “Covered Services” chapter of this manual or stated in ALTCS benefits
- Services provided in a center or facility in an area of a center or facility that is not Medicare/Medicaid-certified for such services
- R&B in adult foster care (AFC), an assisted living home (ALH), an assisted living community (ALC) or other alternative residential settings
- HCBS not approved by the UnitedHealthcare Community Plan case manager

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Chapter 7: Workforce development

Workforce Development common to all lines of business

This following information applies to care providers contracted with UnitedHealthcare Community Plan or the Arizona Health Care Cost Containment System (AHCCCS), AHCCCS Complete Care (ACC), Regional Behavioral Health Authority (RBHA), Arizona Long Term Care Services (ALTCS) Elderly/Physically Disabled (E/PD), and/or Developmental Disability (DD)]. It discusses the requirements, expectations and recommendations in developing the workforce. The initiatives align with Workforce Development (WFD) Policy ACOM 407 & ACOM 407 Attachment A.

UnitedHealthcare Community Plan's Workforce Development Operation (WFDO) implements, monitors and regulates care provider WFD activities and requirements. In addition, UnitedHealthcare Community Plan evaluates the impact of the WFD requirements and activities to support care providers in developing a qualified, knowledgeable and competent workforce.

In collaboration with AHCCCS, the ACC, ALTCS and DD Arizona's Workforce Development Alliance's (AWFDA's), ensure that all course content is culturally appropriate, has a trauma-informed approach and is developed using adult learning principles and guidelines. Additionally, it is aligned with company guidelines and WFD industry standards, the Substance Abuse and Mental Health Services Administration (SAMHSA) core competencies for WFD, federal and state requirements and the requirements of several agencies, entities and legal agreements.

Workforce groups

ALTCS Workforce Development Advisory Council is organized by AHCCCS and includes members from the four ALTCS managed care organizations (MCOs), community stakeholders and LTC advocacy groups. The purpose of this group is to share resources, develop strategies and support state-wide initiatives in LTC that are aligned with Arizona's Plan for an Aging Population: Aging 2020 and AHCCCS Policies:

- ACOM 429 and ACOM 407: Direct Care Worker Training and Testing Program. Additionally, this committee will offer advice and recommendations on initiatives set by the MCOs.

ACC, ACC-RBHA Workforce Development Advisory Committee is comprised of leaders, stakeholders and experts who provide guidance and direction on strategic items important to the ongoing partnership and success around the use of Relias solutions and services, as well as Workforce Development initiatives. This committee is responsible for maintaining a working relationship and alignment with statewide goals and objectives, as well as providing input to AHCCCS on policies and initiatives related to Workforce Development.

Arizona Association of Health Plans (AzAHP) unites the companies that provide health care services to the almost two million people that are members of the AHCCCS. AzAHP offers valuable training programs through our ACC, ACC-RBHA AzAHP Workforce Development Alliance, and supplies assistance and resources to enhance the long-term care workforce through the ALTCS Arizona Workforce Development Alliance.

Arizona Workforce Development Coalition (AWFDC) is organized by the WFD Department at AHCCCS, the AzAHP and members from the eight MCOs. This group represents ACC, ALTCS, DCS CHP, DES/DDD and RBHA lines of business. Together, the coalition helps ensure initiatives across Arizona align with all lines of business..

Arizona Workforce Development Alliance (AWFDA) is the name given to the WFD Administrators from each contractor that jointly plans and conducts WFD activities for a particular line of business.

The four AWFDAs are:

- **AWFDA—ACC, ACC-RBHA** includes the WFD administrators from ACC, RBHA, and DCS CHP contractors. In addition to conducting joint WFD planning, the ACC, ACC-RBHA/DCS CHP AWFDA collectively manage the contract between the AzAHP and the Learning Management System (LMS) vendor
- **AWFDA—ALTCS** includes WFD administrators from the DDD and ALTCS E/PD contractors

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- **AWFDA—DD** includes WFD administrators from the DD and E/PD contractors.
- **AWFDA—DCS CHP** includes WFD administrators from AHCCCS, DCS and Mercy Care.

Definitions

Competency is defined as worker's demonstrated ability to perform the basic requirements of a job intentionally, successfully and efficiently multiple times, at or near the required standard of performance.

Competency development is a systematic approach for ensuring that workers are adequately prepared to perform the basic requirements of their jobs. Competency-based WFD.

Workforce capability is the interpersonal, cultural, clinical/medical and technical competence of the collective workforce or individual worker.

Workforce capacity is the number of qualified, capable and culturally representative personnel required to sufficiently deliver services to members.

Workforce connectivity is the workplace's linkage to sources of potential workers, information required by workers to perform their jobs and technologies for connecting to workers and/or connecting workers to information.

Workplace culture is developing a shared vision of the integrated health care process from a member's perspective. This includes philosophy, experience, and delivery

Workforce development is an approach to improve outcomes by enhancing the knowledge, skills and competencies of the workforce to create, sustain and retain a viable workforce. It aids in changes to culture, attitudes and people's potential to influence outcomes.

Training/compliance requirements

Prevention of abuse and neglect

- The care provider workforce shall have access to and be compliant with all workforce training and/or competency requirements specified in federal and state law, AHCCCS policies, guidance documents, manuals, contracts, plans (such as network development), quality improvement, corrective action, special initiatives, etc.
- Care providers shall have processes for documenting training, verifying the qualifications, skills, and knowledge of personnel and retaining required training and competency transcripts and records.

Residential care (24-hour care facilities) annual requirements

- Crisis prevention/de-escalation employee training for all member-facing employees prior to serving members. For facilities where restraints are approved, a nationally approved restraint training for all member-facing employees is required. This curriculum should include non-verbal, verbal and physical de-escalation techniques.

Division of licensing services (DLS) required training.

- DLS agencies must be aware of all training requirements to be completed and documented based on all additional licensing or accrediting licensing agencies. This includes the Bureau of Medical Facilities Licensing (BMFL) / Bureau of Residential Facilities Licensing (BRFL), Joint Commission, grant requirements and other entities, as applicable.

Community service agencies (CSAs)

- CSAs must submit documentation as part of the first and annual CSA application. The documentation must show that all direct service employees and volunteers have completed CSA training before providing services to members. For a list of all required CSA-specific training, see the AMPM Policy 961-C – Community Service Agencies.

Child and adolescent level of care utilization system (CALOCUS)

- Employees completing the CALOCUS assessments are required to have training in CALOCUS prior to using the assessment tool with members when assessing for the determination of which children may require high-needs case management. Ongoing competency assessments are also required to evaluate a staff member's knowledge and skills.
- Any other trained specialty care provider (PCP, specialty, etc.) working with children and adolescents is also able to conduct the CALOCUS assessment, and trained care providers can coordinate with the health care home to share the assessment results for care coordination purposes.
- To ensure the proper identification of children and adolescents with complex needs and appropriate levels of care, AHCCCS has contracted with Deerfield Behavioral Health (Deerfield) to license the CALOCUS and Level of Care Utilization

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System (LOCUS) software, as well as access to online training for those who have familiarity with instruments that measure level of service acuity instruments. The agreement includes the licensing of both CALOCUS/LOCUS online, though AHCCCS is currently only requiring the use of the CALOCUS. This also includes licensing of the integrated Electronic Health Record (EHR) products, with the intent that care providers include the assessment in their data feeds into the Health Information Exchange (HIE).

- Care providers can implement LOCUS/CALOCUS in one of two ways:
  - The first is via the web-based version, which can be accessed at locus.azahcccs.gov.
  - The second is via an EHR integration.
- Regardless of which option you choose, you must first reach out to Deerfield and sign their end user license agreement as soon as possible. There is no cost associated with this agreement. Matthew Monago will be your contact at Deerfield, and his email is mmonago@journeyhealth.org. Please be sure to identify your organization as an AHCCCS care provider when emailing.

- Per AHCCCS communication on 10/8/21: "Due to discussions between AHCCCS, UnitedHealthcare Community Plan (WFD) Administrator, members of the American Academy of Child and Adolescent Psychiatry (AACAP) and American Association of Community Psychiatrists, it has been determined that individuals who have previously taken the CASII training, will also need to complete the CALOCUS training. This will ensure consistent alignment with AHCCCS contractual requirements for CALOCUS training, establish a baseline level of CALOCUS understanding for those that administer the tool, and enhance efforts to maintain fidelity to CALOCUS administration."
  - For care providers serving children in the Department of Child Safety Comprehensive Health Plan, UnitedHealthcare Community Plan asks to prioritize the completion of the CALOCUS for youth that are either living in a DCS funded Qualified Residential Treatment Program (QRTP) or are being considered to go into a QRTP.
  - If there are questions regarding CALOCUS training requirements related to the AHCCCS contract, care provider agencies should be instructed to reach out to the Contract Compliance Officer at the contracted Health Plan.

Monitoring process

- All Health Plans will monitor the CALOCUS certification process. Each Health Plan will run Relias reports to monitor those who have completed, as well as have not completed, the requirement in the 30-day time frame. These reports will then be compared to the Deerfield completion report, ensuring fidelity to this AHCCCS requirement. Employees must also meet the 2.5-hour minimum time commitment when attending the training through Deerfield.

*It is suggested that those who have completed the Deerfield CALOCUS training prior to July 1, 2022, also be enrolled and marked complete in the training plan for monitoring, tracking and record transferability.

Care provider agency requirements

- All child and adolescent care provider agencies who meet the requirements for the CALOCUS training will need to do the following:
  - Enroll employees who are required to take the Deerfield CALOCUS training in the *AZAHP – CALOCUS Training Requirement (30 Days) training plan in Relias.
  - Once the employee has been enrolled and completes the CALOCUS training through Deerfield, the care provider agency's supervisor/administrator will mark them complete in the Relias CALOCUS Training Requirement module.
  - Once all steps have been completed, the employee will have met the requirements for CALOCUS certification.

Network workforce data collection

It is the responsibility of the contractor to produce a Network Workforce Development Plan for each line of business UnitedHealthcare Community Plan. A portion of this data will be supported by the Care Provider Workforce Development Plan [as applicable to line of business (LOB)], the AZ Healthcare Workforce Goals and Metrics Assessment and any additional means that are identified.

AZ Healthcare Workforce Goals and Metrics Assessment (AHWGMA)

UnitedHealthcare Community Plan requires that all contracted care provider types listed on our website

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complete the AZ Healthcare Workforce Goals and Metrics Assessment annually to fulfill the requirements from ACOM 407 & ACOM 407 Attachment A. To meet this requirement, all Health Plans and LOBs have collaborated extensively to create a single care provider survey that will be disseminated from one source. Refer to the **website** for the most up-to-date information, including a list of required care provider types and a link to the assessment.

AHWGMA Webpage: **azahp.org/azahp/ahwdfc/az-healthcare-workforce-goals-and-metrics-assessment/**

ADHOC initiatives

UnitedHealthcare Community Plan will promote optional WFD initiatives with ACC, ALTCS, DD. These are care providers that support the growth of business practices, improve member outcomes and increase the competency of the workforce.

Workforce development technical assistance needs

The UnitedHealthcare Community Plan Workforce Development Administrator is available to provide technical assistance for various workforce development related needs. Technical assistance needs could include:

- WFDP Guidance
- Recruitment Assistance
- Competency Review
- Workforce Development Goal Review
- Career Path Development
- Training Needs
- Metrics Review
- Relias
- Technology Assistance
- Network Capacity Review
- Cultural Competency
- Diversity/Equity/Inclusion Support
- Community Resources
- Other

For additional information on the P-WFDP requirement, training plans and the care provider forums or to discuss technical assistance needs, please reach out to our WFDO Layla Bishop at **Layla_Bishop@uhc.com**.

Behavioral Health ACC Care Providers: Please refer to the ACC Addendum for ACC BH specific Workforce Development information.

ACC, ACC-RBHA Behavioral Health Addendum

Training/compliance requirements

Relias Learning Management System

The ACC, ACC-RBHA AWFDA Care Providers, under the care provider types listed at the following link, ensure that all employees who work in programs that support, oversee or are paid by the Health Plan contract have access to Relias and are enrolled in the AzAHP Training Plans listed in this addendum. This includes, but is not limited to, full-time/part-time/on-call, direct care, clinical, medical, administrative, leadership, executive and support employees.

Care provider types:

azahp.org/azahp/azahp-accrhba-awfda/resources-2/

Exceptions:

- Any employee(s) hired for temporary services working less than 90 days is required to complete applicable training at the discretion of the care provider.
- Any employee(s) hired as an intern is required to complete applicable training at the discretion of the care provider.
- Any independent contractor (IC) is required to complete applicable training at the discretion of the care provider.
- Behavioral health hospitals
- Federally qualified healthcare care providers (FQHCs) may request exemption from their contracted Health Plan(s). Exemptions may be granted on a case-by-case basis and will consider the following: Portion of AHCCCS members enrolled in the network and served by that care provider, geographic area serviced, and number of other service care providers in the surrounding area.
- Housing care providers

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- Individually contracted practitioners
- Prevention care providers
- Transportation care providers

Agencies must manage and maintain their Relias Learning portal. This includes activating and deactivating users as well as enrollment and disenrollment of courses/events.

To request access to Relias, please contact your UnitedHealthcare Community Plan's WDA for further assistance. The request should include the following information:

- Care provider agency name
- Contract start date
- Address
- Key WFD contact
  - Name
  - Phone number
  - Email address
- Contract type (ACC, ACC-RBHA)
- Care provider type (GMH/SU, Children's, Integrated Health Home, etc.)
- Number of users (# employees at the agency who need Relias access)
- List of Health Plans care provider is contracted with (if known)

Behavioral health care provider agencies with 20 or more users will be required to purchase access to Relias Learning for a one-time fee of $1,500 for full-site privileges. A full site is defined as a site in which the agency may have full control of course customizations and competency development.

Care provider agencies with 19 or fewer users will be added to AzAHP Relias Small Provider Portal at no cost with limited-site privileges. A limited site is defined as one in which the courses and competencies are set-up according to the standard of the plan with no customization or course development provided. Contact workforce@azahp.org to do so.

Care provider agencies that expand to 20 or more users will be required to purchase full-site privileges to Relias Learning immediately upon expansion.

*Fee is subject to change if a provider requires additional work beyond a standard sub-portal implementation.

AzAHP core training plans

AzAHP–Core Training Plan (90 Days)

The following training plan is set to auto-enroll all NEW Relias users in your system who have been assigned one (or more) of the 7 Health Plans under the "Plan" field in their user profile. If the employee hired has a previous account under another agency, please ensure that you have their transcripts transferred (there is a job aid available at azahp.org).

1. *AHCCCS –Health Plan Fraud (0.75hrs)
2. *AHCCCS –NEO –Rehabilitation Employment (0.5hrs)
3. *AzAHP –AHCCCS 101 (2.0hrs)
4. *AzAHP –Client Rights, Grievances and Appeals (1.25hrs)
5. *AzAHP –Cultural Competency in Health Care (1.0hrs)
6. *AzAHP –Quality of Care Concern (1.0hr)
7. Corporate Compliance: The Basics (0.5hrs)
8. HIPAA: The Basics (0.5hrs)
9. Integrating Primary Care with Behavioral Healthcare (1.25hrs)

AzAHP–core training plan (annual)

The following training plan is set to auto-enroll all Relias users in your system who have been assigned one (or more) of the 7 Health Plans under the "Plan" field in their user profile.

1. HIPAA: The Basics (0.5hrs) Due: January 31
2. Abuse and Neglect: Preventing, Identifying and Responding to Abuse and Neglect (1.0hrs) Due: April 30
3. Corporate Compliance: The Basics (0.5hrs) Due: May 31
4. *AzAHP –Cultural Competency in Health Care (1.0hrs) Due: July 31
5. *AHCCCS –Health Plan Fraud (0.75hrs) Due: October 31
6. *AzAHP –Quality of Care Concern (1.0hr) Due: December 31

Quarterly reports

The ACC, ACC-RBHA AWFDA will run Quarterly Learner/Course Status Reports on the two AzAHP Training Plans: *AzAHP – Core Training Plan (90 Days) & *AzAHP – Core Training Plan (Annual). The goal for care

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providers is to hold a 90% (or higher) completion rate for this group of courses, within the specified reporting period. Reporting time frames for this initiative follow:

- 01/01-03/31 – ACC, ACC-RBHA AWFDA will run this report on 4/30
- 04/01-06/30 – ACC, ACC-RBHA AWFDA will run this report on 7/31
- 07/01- 09/30 – ACC, ACC-RBHA AWFDA will run this report on 10/31
- 10/01-12/31 – ACC, ACC-RBHA AWFDA will run this report on 1/31

If any of the reporting dates fall on a weekend or holiday, the ACC, ACC-RBHA AWFDA reserves the right to run the report on the following business day.

Care provider agencies who fall at 75% or below on the previous completion reports will be required to have at least 1 Relias Administrator/Supervisor from their agency complete the course titled: **AzAHP – Navigating & Managing Your Relias Portal*.

Care provider agencies falling below 90% on the previous completion reports may be subject to corrective action and/or sanctions (including suspension, fines or termination of contract) by their contracting Health Plan(s).

Child and Family Team initiatives

The statewide Child and Family Team (CFT) Facilitator Course initiative and the two associated Train-the-Trainer (TtT) courses are for care providers who serve children and adolescents in the Children's System of Care (CSOC) **and** have employees who facilitate CFTs.

Initiative 1: CFT Facilitators Course

- The CFT Facilitator Course is 2 days in length, is intended for in-person delivery and meets all AHCCCS and Health Plan training requirements for individuals who will be leading/facilitating CFT sessions.
- It is expected that care provider agencies be prepared to train this course in-house, which enables providing complimentary agency-specific processes, procedures and protocols, thus creating a robust learner-centric experience for attendees and future CFT facilitators.
- Once an agency has an employee who has become a "CFT Champion," by successfully completing the TtT session (see following section), the requirement is for the CFT Champion to train the 2-day course to newly hired employees at a care provider agency. Employees who already meet the existing CFT Facilitator training requirement need not attend the new course; however, each care provider agency may make their own determination otherwise.
- All care provider agencies shall cease the utilization of their CFT curriculum no later than December 31, 2022, and utilize the AHCCCS-approved training curriculum (ACOM 220, Section F # 2), which will be made available to the CFT Champion upon completion of their CFT TtT session.

Initiative 2: CFT Facilitator Train the Trainer

- The CFT Facilitator TtT session is approximately six hours in length and is delivered via virtual instructor-led training. TtT sessions are offered throughout the year for the new 2-day CFT Facilitator Course. These sessions are intended for employees who will be delivering the 2-day CFT training course in-house in their own agency. These identified employees will be known as CFT Champions"
- CFT Champions who participate in the TtT session must be seasoned employees who possess skills equivalent to lead training sessions and must have completed CFT training requirements already in place and be competent in CFT facilitation. It is left to the discretion of each care provider agency to verify trainer competency. Presumption will be that participants have been internally vetted as competent by their care provider agency prior to enrollment.

Initiative 3: CFT Supervisor Training

- The CFT Supervisor Training Course is approximately five hours in length, is intended for in-person delivery and is for leaders who supervise employees who facilitate CFTs. The CFT Supervisor Training course will be required for all new **and** existing leaders at the agency once the agency has a CFT Champion who successfully completes the Supervisor TtT session. The training will provide guidance related to identified competency measurements.

Initiative 4: CFT Supervisor Facilitator Train the Trainer (TtT)

- The CFT Supervisor TtT session will be approximately 2.5 hours in length and will be delivered via virtual instructor-led training. CFT Supervisor TtT sessions will be offered throughout the year. These sessions are intended for employees who will be training the CFT Supervisor Training

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Course in-house within their own agency. These identified staff will be the **same** CFT Champions that took the CFT Facilitator TtT.

AzAHP – CFT Champion Certification Process

- An **AZAHP- CFT Champion Certification* training plan has been created in Relias for the identified CFT Champions meeting the previous requirements.
  - Agency leadership will need to enroll the identified CFT Champion in the training plan.
  - Within the training plan there are three module requirements:
    - The *AzAHP- CFT Overview (a self-paced course expected to be completed before attending the TtT session)
    - *AZAHP- CFT Facilitator TtT
    - *AZAHP- CFT Supervisor Facilitator TtT
- If the identified CFT Champion has taken CFT Overview in the last two years, they will not have to take it again and will be given credit automatically in Relias.

Initiative 5: Triannual CFT Collaborative Sessions

- In addition to CFT Champions attending a TtT Facilitator Courses, delivering the 2-day CFT Facilitator Training and **CFT Supervisor Training**, CFT Champions are required to attend triannual CFT Collaborative Sessions. During these sessions, CFT Champions will meet with Health Plan trainers and leaders to discuss, as a group, best practices, challenges and opportunities for growth and development regarding CFT administration and implementation.

Training and Supervision Expectations

- Care provider agencies who have employees that are designated to facilitate/lead CFTs shall be trained in the elements of the CFT Practice Guide, complete and in-person, AHCCCS-approved CFT facilitator curricula and demonstrate competency via the Arizona Child and Family Team Supervision Tool. The CFT Supervision Tool must be completed within 90 days, and facilitators must maintain or enhance proficiency within six months as attested to by a supervisor, and annually thereafter (**AMPM 220 (F), Attachment C & D**).

Monitoring Process

- CFT Champion Certification
  - All agencies who are required to have CFT Champion will be tracked in Relias.
  - Workforce Development will maintain a list of all CFT Champions and their care provider agencies.

Arizona Child and Family Team Supervisions Tool

- The Supervision Tool requirements will be tracked in Relias for all employees who facilitate/lead CFTs.

CFT Facilitator Training Hardship Waiver

- In the event the 2-day CFT training becomes a barrier or hardship for an organization, care provider organizations may request a CFT Facilitator Training Hardship Waiver. Within the waiver, care providers will need to identify why delivering the course as originally designed presents a hardship. They must also supply a detailed plan of what changes they will make to the 2-day CFT Facilitator training while still meeting all the elements of the training. The plan will be submitted to the Workforce Development Team at **workforce@azahp.com**. Care provider organizations must obtain approval before the training occurs.

General mental health (GMSH)/Substance use (SU)

Employees completing assessments of substance use disorders and subsequent levels of care must complete the American Society of Addiction Medicine (ASAM) criteria-specific training. This training is required before staff may use the assessment tool with members. They must also complete any approved substance use/abuse course every year. The assessment should align with the most recent ASAM criteria.

Network workforce data collection

Care provider workforce development plan (P-WFDP)

The purpose of the P-WFDP is to encourage care provider organizations to work together and ensure members receive services from a workforce that is qualified, competent and sufficiently staffed. The P-WFDP shall include a description of organizational goals, objectives, tasks and timelines to develop the workforce. The overall approach and philosophy to Workforce Development is to ensure a comprehensive, systematic and measurable structure that incorporates best practices at all levels of service delivery and utilizes Adult/Children's Guiding Principles, Adult Learning Theories/Methods, Trauma-informed Care, Equitable Services and Culturally Competent practices. All training

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initiatives, action steps and monitoring procedures outlined in the P-WFDP are to include targeted efforts for all employees (e.g., direct care providers, supervisors, administrators and support staff) who are paid by, partially paid by or support an agency's Health Plan contract(s).

The ACC, ACC-RBHA Care Providers, under the care provider types listed at the following link, complete the annual P-WFDP. The P-WFDP template is provided for this deliverable by the ACC, ACC-RBHA AWFDA to care providers. P-WFDPs will be submitted between 2/1 – 2/28, annually. Early and late submissions will not be accepted unless an extension was received and granted by the deadline, determined by the ACC, ACC-RBHA AWFDA.

- **Extension Requests**: Must be submitted to **workforce@azahp.org** before the date specified by the ACC, ACC-RBHA AWFDA for each year. Non-submittals are subject to contracted health plan policies as it pertains to the P-WFDP deliverable.
- **Exemption Requests**: FQHCs may request an exemption from their contracted Health Plan(s). Exemptions may be granted on a case-by-case basis and will consider the following:
  - Portion of AHCCCS Members enrolled in the network and served by that Care provider
  - Geographic area serviced
  - Number of other service care providers in the surrounding area.c
  - Exemption requests must be submitted on/before December 31st and will be reviewed by the Alliance.

Required ACC, ACC-RBHA care provider types can be found at **azahp.org/wp-content/uploads/2022/07/AZAHP-Website-All-LOB-Provider-Types-Requirements-Tracker-2022-1.xlsx**

Failure to submit your completed annual P-WFDP deliverable by the annual due date may result in corrective action and/or sanctions (including suspension, fines or termination of contract).

ACC, ACC-RBHA AWFDA Care Provider Forums

The ACC/RHBA AWFDA consists of representatives from the AzAHP, Relias and the Workforce Development Administrators from all seven ACC Health Plans. Care providers are encouraged to attend the virtual ACC, ACC-RBHA AWFDA care provider forum on the second Thursday of each month for up-to-date information on WFD-related topics, including:

- WFD initiatives
- Professional development
- Training
- Relias
- Opportunities to receive technical assistance.

To review previous forums, you may access the recordings at **azahp.org/azahp/azahp-accrhba-awfda/resources-2/**

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Chapter 8: Value-Added Services

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com**	• ALTCS EPD: **1-800-377-2055** • ACC/DD: **1-800-445-1638**
Healthy First Steps Rewards	**UHChealthyfirststeps.com** UHCprovider.com/azcommunityplan > **Provider Forms, Programs and References** > General Forms > Pregnancy Notification Form	**1-800-599-5985**
Value Add services	**UHCcommunityplan.com/AZ** View plan details	• ALTCS EPD: **1-800-293-3740** • ACC/DD: **1-800-445-1638**

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call Provider Services at **1-800-445-1638** unless otherwise noted.

OB homecare nursing services

Preterm Birth Prevention Program for Preterm Labor and History of Spontaneous Preterm Birth:

- Makena® or 17HPC Administration Nursing and Care Management service is designed to improve weekly injection adherence and reduce pre-term delivery

Nausea and Vomiting Management – Continuous antiemetic therapy utilizing micro-infusion pump with pharmacist and nursing support

Diabetes in Pregnancy – for members with gestational diabetes or existing Type 1 or Type 2 diabetes

- Home-based assessment, counseling, and monitoring of non-insulin or insulin managed care by RN and CDE, including visits as needed to assure stable glycemia

To refer a patient to OB case management or if you have questions about our maternity program, please call Healthy First Steps at **1-800-599-5985**.

Chronic condition management

We use educational materials and newsletters to remind members to follow positive health actions such as immunizations, wellness, and EPSDT screenings. For those members with chronic conditions, we provide specific information, including recommended routine appointment frequency, necessary testing, monitoring, and self-care through our disease management (DM) program. All materials are based upon evidence-based guidelines or standards. All printed materials are written at a fifth grade reading level. They are available in English as well as other languages. The materials are designed to support members as they begin to take responsibility for their health. They provide information necessary to successfully manage their condition and live a healthy lifestyle.

Members at highest risk with conditions such as asthma, CHF, diabetes, COPD and depression receive more intense health coaching. Resources and tools are available to support members and caregivers with conditions common to children with special health care needs and help them manage their illness.

Identification – The health plan uses claims data (e.g. hospital admissions, ER visits, and pharmacy claims) to identify members with gaps in care and/or chronic conditions.

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Early Intervention program

Early Intervention promotes the development of infants and toddlers with developmental challenges and delays. It also covers certain disabling conditions. The program provides services to eligible children from birth to 3 years old and their families.

Foster care

Peer support specialist

We have a foster-care peer support specialist working with youth in the foster care system and their families. The specialist works with the member and the family to define the member's recovery goals. The specialist helps the member develop life skills and provides phone and/or face-to-face communications to members. The member and foster family receive support and help improve the member's overall physical and behavioral health. This benefit can also help to reduce hospitalizations and ER visits related to behavioral conditions in youth in foster care services.

Health4Me

Our **Health4Me** app enables users to review health benefits, access claims information and locate in-network providers. It is available at no charge to our members.

Healthy First Steps Rewards

Healthy First Steps™ (HFS) is a specialized care management program designed to provide assistance to all pregnant members, those experiencing an uncomplicated pregnancy, as well as additional medical, behavioral, and social risks. The goal is improving birth outcomes and lowering NICU admissions by managing prenatal and postpartum care needs of pregnant members. Care management staff are board-certified in maternal and neonatal medicine.

Members self-enroll on a smartphone or computer. They can go to UHChealthyfirststeps.com and click on "Register" or call **1-800-599-5985**.

How it works

Care providers and UnitedHealthcare Community Plan reach out to members to enroll them. Members enter information about their pregnancy and upcoming appointments online. Members get reminders of upcoming appointments and record completed visits.

How you can help

- Identify UnitedHealthcare Community Plan members during prenatal visits.
- Share the information with the member to talk about the program.
- Encourage the member to enroll in Healthy First Steps Rewards.

NurseLine

NurseLine is available at no cost to our members 24 hours a day, seven days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the ER or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **1-866-351-6827** to reach a nurse.

Peer and family support resources

Peer-run organizations are owned, managed, and staffed by people who have received mental health services. As a result, these individuals help make all decisions for their organization. Peer-run organizations offer a range of services to adult members: They include:

- Peer support.
- Living skills.
- Vocational skills.
- Re-entry support.
- Veterans' services.
- Entrepreneurship skills.

We contract with the following peer-run organizations:

- Recovery Empowerment Network (REN).
- Helping Ourselves Pursue Enrichment (HOPE), inc.
- Northern Arizona Consumers Advancing Recovery by Empowerment (NAZCARE).

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- Center for Health Empowerment Education Employment Recovery Services (CHEERS).
- Stand Together and Recover (STAR) Centers.
- Hope Lives/Vive La Esperanza.
- Coyote Task Force – Our Place Clubhouse (Accredited)/Café 543 and Truck 54.

We also contract with family-run organizations. These organizations are governed by family members of children with mental health challenges. They serve families with children with behavioral, emotional and mental health challenges by offering:

- Family support
- Respite services
- Wellness and living skills
- Youth support
- Vocational skills

UnitedHealthcare Community Plan contracts with the following family-run organizations:

- MIKID.
- Family Involvement Center.
- Caring Connections for Special Need.
- Reach Family Services/Alcanza Services de Familia.

Arizona Smoker's Helpline (AshLine)

Arizona Smoker's Helpline (AshLine) provides support and resources for members trying to quit smoking. English-speaking members may call 1-800-784-8669. Spanish speakers may call 1-855-335-3569 or fax 1-800-261-6259. Or you may go to AshLine.org > **Healthcare Professionals**.

AshLine offers a web-based cessation program, online forums, coaching chat, and email and text support. It also provides 24/7 live coaching by phone.

Both HIPAA-covered entities and non-covered entities can refer people to the ASHLine. Only HIPAA-covered entities will receive feedback from the ASHLine about their referrals.

Referrals

Participating providers can refer patients to the ASHLine either by phone or completing an online form. Please share these forms with all clinical staff, as the current paper referral forms do not have the most up-to-date content.

Find the registration platform and fax referral form at **azdhs.gov/ashline/#patient-referrals**.

SUD recovery support

Our SUD (Substance Use Disorder) recovery support team works with members to develop coping skills. Skills include encouragement, safety and a sense of responsibility for their own recovery. This benefit also emphasizes support to those with a behavioral health diagnosis while working through SUD treatment and recovery.

Eligible members are identified through predictive modeling and claims data, a health risk assessment (HRA) or your referral. The program has no age limitation.

An anonymous SUD helpline is available at 1-855-780-5955 or by live chat at **liveandworkwell.com/recovery**. This is not an insurance benefit but a resource for all community members.

UHC Latino

Latino | UnitedHealthcare (uhc.com), our award-winning Spanish-language site, provides more than 600 pages of health and wellness information and reminders on important health topics.

State-funded programs

The state also has programs, such as Women, Infants, and Children Supplemental Nutrition programs (WIC) to help with nutritional needs for low income families. For more information about WIC, call 1-800-252-5942 or go to **azdhs.gov/prevention/azwic**.

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Chapter 9: Mental health and substance use

Key contacts

Topic	Link	Phone Number
Behavioral Health (including claims) /Provider Express	providerexpress.com	**1-800-888-2998**
Provider Services	UHCprovider.com/AZcommunityplan	• ALTCS EPD: **1-800-377-2055** • ACC/DD: **1-800-445-1638**
Crisis Lines	National Crisis Line: 988lifeline.org Arizona Crisis Hotline	988 1-844-534-4673

United Behavioral Health provides UnitedHealthcare Community Plan members with mental health and SUD benefits. You must have a National Provider Identification (NPI) number to see Medicaid members and receive payment from UnitedHealthcare Community Plan.

To request an ID number, go to azahcccs.gov.

How to join the United Behavioral Health (Optum Behavioral Health) network

If you want to join our behavioral health provider network through Optum, note the following steps.

1. Register with AHCCCS. Use the same specialty and demographic information you provide when starting the credentialing process.
2. Start the credentialing process by going to the "Join Our Network" section of ProviderExpress.com and following the instructions for Arizona providers.

To help ensure proper maintenance of your clinician roster, complete and submit the Roster Update Form as staffing changes occur. The form may also be used to confirm that no roster changes are required at this time.

Credentialing information is available at providerexpress.com > Clinical Resources > Guidelines/Policies & Manuals > Credentialing Plans > Optum

Covered services

UnitedHealthcare Community Plan offers covered behavioral health services for mental, emotional and substance use disorders without the requirement of a referral. A member, member's legal guardian, family member or care provider may make oral, written or electronic requests for behavioral health services. We accept behavioral health referral requests at any time. We offer care management to help members, clinicians, and PCPs using and offering behavioral health services. We provide information and tools for mental health and substance abuse diagnoses, symptoms, treatments, prevention and other resources in one place.

liveandworkwell.com, accessed through a link on myUHC.com, includes mental health and well-being information, articles on health conditions, addictions and coping, and provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.

For member resources, go to providerexpress.com. Go to the Live and Work Well (LAWW) clinician center. Locate Health Condition Centers at the Clinical Resources tab. The Provider Express Recovery and Resiliency page includes tools to help members addressing mental health and substance use issues.

Benefits include:

- Behavioral health inpatient services
- Behavioral health therapeutic home care services

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- Behavioral management (behavioral health personal care, family support/home care training, self-help/peer support)
- Care coordination services
- Crisis services
- Court-ordered treatment
- Emergency and non-emergency transportation
- Behavioral health evaluation and assessment and treatment services
- Individual, group, and family therapy and counseling
- Inpatient behavioral health services (members ages 21-64 in an Institution for Mental Diseases)
- Residential treatment centers (level 1 and sub-acute facilities)
- Laboratory and radiology services for psychotropic medication regulation and diagnosis (laboratory services should be referred to Labcorp, the network laboratory provider)
- Nursing services
- Opioid agonist treatment (including medication-assisted treatment [MAT])
- Day program services (supervised day program, therapeutic day program and medical day program)
- Physician services
- Psychosocial rehabilitation (living skills training, health promotion, supportive employment services)
- Psychotropic medication, adjustments and monitoring
- Rehabilitative services
- Respite care (600 hours max benefit)
- Screening, evaluation and diagnosis
- Substance abuse (drug and alcohol) counseling
- Support services

The following services are not covered under the AHCCCS Complete Care Program but are available through the members ALTCS EPD program. The member may be referred to a RBHA for the following services if they are not enrolled in our ALTCS EPD program. Review the Referral section in this chapter as well as the ALTCS EPD chapter for more information.

- Supported employment (LTC)
- Traditional healing (LTC-Non Title XIX benefit for members who are SMI)
- Supported housing (LTC-Non Title XIX benefit for members who are SMI)

Acupuncture for SUD (LTC-Non Title XIX benefit for members who are SMI)

DD members who are designated SMI have the following Non Title 19 services and may be referred to the RBHA. The services included are:

- Auricular acupuncture
- Traditional healing services

Eligibility

The service delivery system for behavioral health services involves:

- **AHCCCS Complete Care –** An integrated program that joins physical and behavioral health services to treat all aspects of our members' health care needs under UnitedHealthcare Community Plan.
- **Developmental Disabilities/DD –** An integrated program that joins physical, behavioral and special health care needs services to treat all aspects of our members' health care needs under UnitedHealthcare Community Plan.
- **Children in Foster Care –** Children in foster care not enrolled in one of our health plans will be covered by the CHP for physical health services.
- **ALTC EPD –** Members evaluated and enrolled in the LTC Program will receive their medically necessary physical and behavioral health services within an integrated program provided by UnitedHealthcare Community Plan. SMI members assigned to the LTC program will receive their behavioral health services through the LTC network.
- **Serious Mental Illness Program –** Members with a serious mental illness (SMI) who are enrolled with the DDD will receive integrated physical and behavioral health services through UnitedHealthcare Community Plan. Members enrolled in Complete Care and are then determined to be SMI have their physical and behavioral health services transitioned to the RBHA in their county. A member with SMI may opt out from receiving physical health services from the RBHA and enroll in an AHCCCS Complete Care plan for their physical health services. If you are involved with DD SMI members, identify and submit notification within five business days to the Office of Human Rights members who meet the criteria for Special Assistance based on A.A.C. R9-21-101 et seq. Submit a notification whether or not the member's Special Assistance needs will be met by an involved guardian/designated representative, family member or friend.

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Use the [320-R, Attachment A Form].

Verify the UnitedHealthcare Community Plan member's Medicaid eligibility before treating them. View eligibility online on the Eligibility and Benefits application on the Provider Portal at [UHCprovider.com] or [AHCCCSOnline].

Authorizations

Members may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; ABA intensive treatment program; day treatment; or partial, inpatient or residential care. Help ensure prior authorizations are in place before rendering non-emergent services. Get prior authorization by going to [UHCprovider.com/paan], or by calling Provider Services.

Pre-petition screening, court-ordered evaluation and court-ordered treatment

Court-ordered treatment (COT) is the civil commitment process laid out in A.R.S. Title 36, Chapter 5, Article 4 and 5. It states that when there is a belief that, due to a person's mental disorder and their unwillingness to engage with treatment, they are a:

- Danger to self (DTS).
- Danger to others (DTO).
- Persistently or acutely disabled (PAD)
- Gravely disabled (GD).

Information about these screenings and court-ordered treatments can be found on the AHCCCS website in the [AMPM Policy 320-U - Pre-Petition screening, Court Ordered Evaluation, and Court Ordered Treatment].

When you submit inpatient claims on a UB-04 claim form for court-ordered evaluations, end the bill type with a "0." This indicates zero payment and/or the service is informational only.

If you submit outpatient UB-04 or CMS 1500 claim forms, include modifier 32 on the court-ordered evaluation (COE) for mandated service. Members may seek a voluntary evaluation at any screening agency available statewide.

During the COE and COT process, members may agree to a voluntary evaluation. A voluntary evaluation occurs after a pre-petition screening is filed but before a COE is filed. It requires the person's informed consent.

Court-ordered evaluation and court-ordered treatment

Court-ordered evaluation (COE) and court-ordered treatment (COT) are designed to help people who are unwilling to or incapable/unable of providing consent to receive behavioral health services and who meet legal criteria for the State of Arizona to step in and compel (mandate or order) them to receive treatment.

Court ordered evaluation

In Arizona, COE is a process in which two behavioral health medical professionals each complete a detailed analysis of an individual identified as potentially meeting one or more of the four criteria.

The court-ordered evaluation may include firsthand (observed by the professional completing the evaluation) or remote or secondary observations from others (by family, friends, social or community supports, or other treatment care providers) that describe, in detail, the individual's:

- Danger To Self (DTS)
- Danger To Others (DTO)
- Persistently or Acutely Disabled (PAD) and/or Gravely disabled (GD)

If it is determined that the individual meets 1 of the 4 criteria for court-ordered treatment, the medical professionals who completed the evaluation will submit their findings to the superior (county) court where the individual resides or where they received the evaluation. A judge will hear the case and determine whether the individual meets the criteria to be ordered into treatment.

Court ordered treatment

In Arizona, COT is behavioral or mental health treatment that is ordered by a superior (county) court according to the Arizona Revised Statute Title 36 processes.

An individual can be ordered by the court to undergo mental health treatment if, because of a mental disorder, the individual is determined to be a danger to themselves, a danger to others, is persistently or acutely disabled, or is gravely disabled.

In Arizona, a mental disorder is defined as: a substantial disorder of the person's emotional processes, thought, cognition, or memory. Individuals living with substance abuse disorders, intellectual/developmental disabilities, or disorders that are a result of lifelong and deeply ingrained antisocial behavior patterns are not eligible

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for COT, unless these behavior patterns are the result of a different mental disorder that meets the legal criteria according to the statute.

If you believe an individual is in immediate need of assistance due to being a danger to themselves or others, call 911, 988, 1-844-534-4673 (HOPE) or local crisis hot line in your county or www.azahcccs.gov.

If you believe the situation is not immediately urgent but you would like to start the process of 'Pre-petition Screening' to see if a person is appropriate for a COE, contact your local/county screening provider or LTC Case Manager, if applicable, who can assist you with the paperwork and start the process of evaluation.

Emergency situations

When a member is an immediate safety risk for themselves or others due to their inability or unwillingness to seek voluntary mental health treatment, they may apply for emergency evaluation and admission (attachments 1 and 2) in person.

If the screening agency approves the application, it issues a pick-up order to law enforcement in the region where the member is located, requesting the member be delivered to the screening agency for evaluation.

Non-emergency situations

When members are not a danger to themselves or others but could be if their behavioral health issues remain untreated, a non-emergent application can be filed through any of the following agencies.

County	Agency	Contact
Apache	Changepoint	1-928-587-3435 mychangepoint.org
Cochise	Community Bridges	1-877-931-9142 communitybridgesaz.org
Coconino	The Guidance Center	1-877-756-4090 tgcaz.org
Gila	Community Bridges	1-877-931-9142 communitybridgesaz.org
Graham	Community Bridges	1-877-931-9142 communitybridgesaz.org
Greenlee	Community Bridges	1-877-931-9142 communitybridgesaz.org
La Paz	Horizon Health and Wellness	1-833-431-4449 hhwaz.org
Maricopa	Connections AZ Urgent Psychiatric Center (UPC)	1-602-416-7600 connectionsarizona.com
	Community Bridges Community Psychiatric Emergency Center (CPEC)	1-877-931-9142 communitybridgesaz.org
	Empact (outpatient screenings for persistently/ acutely disabled or gravely disabled only) Non-Emergent	lafrontera-empact.org
	Community Bridges	1-877-931-9142 communitybridgesaz.org
	Recovery Innovations International — Recovery Response Center (RRC)	1-602-636-4380 riinternational.com
Mohave	Southwest Behavioral Health Services	1-928-753-9387 sbhservices.org/kingman-outpatient

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County	Agency	Contact
Navajo	Change Point Integrated Health	1-928-587-3435 mychangepoint.org
Pima	Crisis Response Center (CRC)	1-520-301-2284 connectionsarizona.com
Pima	Community Bridges	1-877-931-9142 communitybridgesaz.org
Pinal	Horizon Health and Wellness	1-480-983-0065 hhwaz.org
Santa Cruz	Community Bridges	1-877-931-9142 communitybridgesaz.org
Yavapai	StoneRidge	1-855-593-2231 stoneridgecenters.com
Yuma	Horizon Health and Wellness	1-866-495-6735 hhwaz.org

Communication with us

All agencies providing COE screening or evaluation must send a daily inpatient census of our members under COE to COT_COE@uhc.com.

You must submit all documents filed with the court within five days of the paperwork being filed or the conformed copy being received from the court. This includes all notifications of judicial review, status reports, affidavits of evaluators, amendment letters, tolling requests and notice of closure letters as well as other documents that may be filed with the court.

You must also submit a monthly report to us by the fifth of the month with data from the prior calendar month. Members are included on the report if they were assigned to you during the reporting month. See the Monthly COT Report for a blank report template. Submit the report to COT_COE@uhc.com.

The following attachments are in the AHCCCS Medical Policy Manual:

- Application for Involuntary Evaluation (320U-A) – Filed by applicant
- Application for Emergency Admission (320U-B) – Filed by applicant
- Petition for Court Ordered Evaluation (320U-C) – Filed by screening agency
- Petition for Court Ordered Treatment (320U-D) – Filed by evaluating agency
- COE Affidavit (320U-E) – Filed by evaluating agency
- Application for Voluntary Evaluation (320U-G) – Filed by either screening or evaluating agency
- UnitedHealthcare Community Plan Monthly COT Report (available from court liaison)

Treating a member in crisis

Provider Services is here all day, every day, to help you treat our members.

When you're treating a member after hours, UnitedHealthcare Community Plan of Arizona has live representatives available any time at **1-800-445-1638**. We help behavioral health care providers get important benefit and coverage information on members who are categorized as either having a serious mental illness (SMI) or receiving court-ordered treatment (COT).

In addition, we can give you the SMI member's outpatient clinic name and phone number. We can also provide information about whether a member is receiving COT with their start date.

Outreach, engagement and re-engagement

Outreach

You must reach out to vulnerable populations, establish an inviting and non-threatening environment, and re-establish contact with members who have become temporarily disconnected from services based on AMPM Policy 1040. UnitedHealthcare Community Plan provides outreach activities to inform the public of the benefits and availability of behavioral health services and how to access them. We disseminate this information to the general public and through our community partners, to care providers, and other interested parties. Outreach activities may include but are not limited to:

- Participation in local health fairs or health promotion activities.
- Involvement with local schools.

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- Development of homeless outreach programs.
- Development of outreach programs to members who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved.
- Publication and distribution of informational materials.
- Liaison activities with local and county jails, county detention facilities, and local and county DCS offices and programs.
- Contact with pregnant women/teenagers who have a substance use disorder when identified through our maternity program, such as Healthy First Steps.
- Development and implementation of outreach programs that identify persons with co-morbid medical and behavioral health disorders and those who have been determined to have a SMI.
- Provision of information to mental health advocacy organizations.
- Development and coordination of outreach programs to American Indian Tribes in Arizona to provide services for Tribal members.

Engagement

UnitedHealthcare Community Plan and our subcontracted behavioral health care providers actively engage the following in the treatment planning process:

- The person and/or person's legal guardian or designated representative.
- The person's family/significant others, if applicable and amenable to the member.
- Other agencies/providers as applicable.
- The person's assigned ALTCS DDD Support Coordinator, if applicable.
- The member, guardian, designated representative, advocate or other individual designated to provide Special Assistance for members with SMI who are receiving Special Assistance (see AMPM Policy 320-R).

Behavioral health care providers must provide services in a culturally competent manner based on our Cultural Competency Plan. See Chapter 1 for more information and resources.

Re-engagement

Participating behavioral health care providers attempt to re-engage members who have withdrawn from treatment, refused services or failed to appear for a scheduled service. Try to re-engage the member by doing the following:

- Communicating in the member's preferred language.
- Contacting the member, guardian or designated representative by phone when the member may reasonably be available.
- Attempting in-person contact when possible if you cannot reach the member by phone.
- Sending a letter to the most recent address requesting contact. If all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues, note safety or confidentiality concerns in the progress notes section of the clinical record. Include a copy of the letter sent in the comprehensive record.
- Contacting the person designated to provide special assistance for their involvement in re-engagement efforts for members determined to have SMI who are receiving special assistance.

If the person appears to meet clinical standards as a danger to self or others, or they are persistently and acutely disabled or gravely disabled, the care provider must determine whether to attempt to engage the person to seek inpatient care voluntarily. If this is not a viable option, and the clinical standard is met, the care provider may initiate the pre-petition screening or petition for treatment process for court-ordered evaluation, and court-ordered treatment.

Follow-up after significant and/or critical events

Document all follow-up activities, including the post-event call, in the medical record, within the following time frames and in the following circumstances:

- Member is discharged from inpatient services based on the discharge plan and within seven days per AMPM 1040 of their release. This helps ensure member stabilization and medication adherence. It also helps avoid re-hospitalization.
- Member is involved in a behavioral health crisis within time frames based on their clinical needs, but no later than seven days per AMPM 1040.
- Member refuses prescribed psychotropic

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medications within time frames based on their clinical needs and individual history.
- Member needs a change in the level of care.

Out-of-state placements for behavioral health treatment

A child or young adult may need out-of-state placement to meet their clinical needs. Placing members in out-of-state (OOS) placements for behavioral health care happens after the Child and Family Team (CFT) and the Adult Recovery Team (ART) have reviewed all other in-state options.

Meet the following documentation requirements before making a referral for an OOS placement:

- At least three in-state facilities have declined to accept the member.
- The CFT or ART has been involved in the service planning process and is in agreement with the OOS placement.
- The CFT or ART has documented how it will remain involved in service planning once the OOS placement has occurred.
- A service plan has been developed.
- All applicable prior authorization requirements have been met.

The Arizona Department of Education helps ensure that the educational program in the OOS placement meets its academic standards and the member's specific educational needs as applicable:

- All other state agencies and/or contractors involved with the member are coordinated. This includes notifying the appropriate medical director when the member is enrolled with either DDD or CHP.
- The member's PCP, the contractor, and the TRBHAs develop a plan for the provision of any necessary, non-emergency medical care. All care providers should be AHCCCS-registered providers.

You must notify AHCCCS and the Division of Health Care Management (DHCM) before or as a member goes into an OOS placement. You must also complete the AHCCCS Out of State placement form **Attachment A**. Using this form, submit updates every 30 days while the member remains in OOS placement. All OOS providers must meet the reporting requirements of all incidents of injury/accidents, abuse, neglect, exploitation, health care-acquired conditions, and injuries from seclusion/restraint implementations as described in AMPM Policy 960.

Please refer to the AMPM Policy 450 for more information and guidelines.

Medication management

In addition to treating physical health conditions, PCPs may treat behavioral health conditions within their scope of practice. For purposes of medication management, it is not required that the PCP be the member's assigned PCP. PCPs who treat members with these behavioral health conditions may provide medication management services. This includes prescriptions and other diagnostic tests needed for diagnosis and treatment. However, the following conditions must be met:

- PCP feels comfortable in managing members' psychotropic medications.
- Treatment is within the care provider's scope of practice and expertise.
- PCP may request these medications for continuity of care by submitting a completed UnitedHealthcare Pharmacy Prior Authorization Form indicating step therapy has been completed. The member needs to continue on current medication and dosage for stabilization unless the medical condition changes. PDL medications requiring step therapy are covered only after a sufficient trial of an indicated first-line agent has failed.
- Before sending the completed Pharmacy Prior Authorization Form with documentation, indicate on the Pharmacy Prior Authorization Form: "Request for Step Therapy Medication." To prevent any lapse in medication coverage, or for help, call UnitedHealthcare Pharmacy at **1-800-310-6826**.

The UnitedHealthcare Pharmacy Prior Authorization Form is at **UHCprovider.com**.

When a PCP has started managing a member's medication to treat a behavioral health disorder, such as an SUD, and the PCP determines the member should be transferred to a behavioral health provider for evaluation and/or continued medication management services, the care provider must coordinate the transfer of care. Refer to AMPM 520 for more information.

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Psychotropic medication management

PCPs may provide psychotropic medication management under the following conditions.

- PCP feels comfortable managing member's psychotropic medications.
- These conditions are within the care provider's scope of practice.

PCPs may request these medications for continuity of care management by submitting a completed Pharmacy Prior Authorization Form. The form should note step therapy has been completed, and the member needs to continue on current medication and dosage for stabilization, unless the medical condition has changed. Preferred drugs requiring step therapy are routinely covered only after the first-line agent has been adequately tried and failed. Before sending the completed Pharmacy Prior Authorization Form with documentation:

- Request the Step Therapy medication, and
- State if the request is expedited or routine.

If the medication is not listed on the AHCCCS Drug List or the AHCCCS Behavioral Health Drug List, more information may be required when obtaining prior authorization. To prevent lapse in coverage, or for help, contact UnitedHealthcare Pharmacy at 1-800-310-6826.

The PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the MAT model and coordinate care with the behavioral health provider. Find a network psychologist or behavioral health provider using the provider directory. A referral is not necessary.

Informed consent must be obtained from the member/guardian/designated representative for each psychotropic medication prescribed. The clinical record must include documentation of the essential elements for obtaining informed consent. Information about these elements are in Attachment A of the AMPM, Chapter 300, Policy 310-V.

Behavioral health screenings

The PCP should screen members for behavioral health needs during routine or preventive visits. Based on the behavioral health screening and assessment, Best Practice Guidelines, and Evidence-Based-Medicine (EBM), a member may benefit seeing a behavioral health professional. While a referral is not required, the PCP must refer the member to an in-network behavioral health care provider and consult with the behavioral health provider about the member's treatment plan. Our online Provider Directory can provide a list of care providers in our network. After finishing a behavioral health assessment, a service plan following a health home model as specified in AMPM Policy 320-O should be completed.

Serious mental illness determination

Per AMPM Policy 320, the determination of SMI requires both the qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis.

The licensed psychiatrist, psychologist, or NP of the determining entity (either the authorized AHCCCS designee or a TRBHA authorized to make the final determination) designates must make a final determination about whether the person meets the SMI status eligibility requirements based on:

- A face-to-face assessment or a qualified clinician's review of a face-to-face assessment (AMPM Policy 950), and
- A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians.

Functional criteria for SMI determination

A member must have, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the following four areas for most of the past 12 months. Or it must last for most of the past six months with an expected duration of at least six months:

- Inability to live in an independent or family setting without supervision
- A risk of serious harm to self or others
- Dysfunction in role performance
- Risk of deterioration.

Solari will send the member a Notice of Decision letter by mail informing them of the final decision regarding their SMI determination. This letter will include information about their rights and how to appeal the decision.

Any person may file an SMI grievance or request an investigation. The request may be verbal or written. It

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must be initiated no later than one year after the alleged rights violation or condition requiring investigation. AHCCCS addresses SMI grievances related to physical or sexual abuse or death and requires grievances be filed within seven days of when the issue occurred. Submit grievances to:

AHCCCS Office of Grievance and Appeals
801 East Jefferson, MD-6200
Phoenix, AZ 85034

Phone: 1-602-364-4575

The appropriate RBHA or ALTCS/EPD contractor handles all other grievances.

Any person age 18 or older may file an appeal related to services applied for or services currently being received.

Include the following with a SMI Grievance and Appeal:

- Person's name filing the SMI grievance/request for investigation or appeal.
- Person's name receiving services, if different.
- Mailing address and phone number.
- Date of issue being appealed or incident requiring investigation.
- Brief description of issue or incident.
- Resolution or solution desired.

For either process, the member may represent themselves, designate a representative or use legal counsel. Call the State Protection and Advocacy System, the Arizona Center for Disability Law at 1-800-922-1447 in Tucson and 1-800-927-2260 in Phoenix. Calls can also be made to the Office of Human Rights (OHR) at 1-602-364-4585 or 1-800-421-2124 in Phoenix. In Flagstaff, call OHR at 1-928-214-8231 or 1-877-744-2250. In Tucson, call OHR at 1-520-770-3100 or 1-877-524-6882.

If your complaint relates to a licensed behavioral health agency, write to:

Bureau of Medical Facilities Licensing Office
150 N. 18th Ave., Suite 450
Phoenix, Arizona 85007

Phone: 1-602-364-3030

Availability of services

If you cannot meet or locate a member's need in a timely basis, complete the Unmet Needs Report by emailing our Healthcare Administration team at **azcapacityreports.com**.

Transition to adulthood

Start transitioning a child's behavioral health care into adulthood when an adolescent is 16 years old. For those individuals who may benefit from SMI services, participating behavioral health care providers can complete the SMI evaluation when the member is 17 years old. If an adolescent is determined to have a SMI, a transition meeting will occur with the future SMI health home. See the **AMPM 520** – Member transitions or review the **AHCCCS Transition to Adulthood Practice tool** on azahcccs.gov for more information.

Member with co-occurring substance abuse

For psychotic diagnoses (e.g., bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder and psychotic disorder NOS), functional impairment is presumed to be due to the qualifying psychiatric diagnosis.

For other major mental disorders (e.g., bipolar disorders, major depression, obsessive compulsive disorder), functional impairment is presumed to be due to the psychiatric diagnosis. The exceptions are:

- If the symptom severity, frequency, duration or characteristics contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis; or
- The assessor can demonstrate the functional impairment is present only when the member is abusing substances or experiencing withdrawal from substances.

For all other mental disorders, functional impairment is presumed to be due to the co-occurring substance use unless:

- The symptoms contributing to the functional impairment cannot be attributed to the SUD; or
- The functional impairment is present during at least the next 30 days following stopping the substance use; or
- The functional impairment is present during a period of at least 90 days of reduced use unlikely to cause the symptoms or level of dysfunction.

Information about referral, evaluation and determination of SMI can be found on **azahcccs.gov** under AMPM Policy 320-P Serious Mental Illness Eligibility Determination.

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All members must be evaluated for SMI eligibility by a qualified assessor, and have an SMI eligibility determination made by Solari, if the person either:

- Requests an SMI determination or has a guardian or legal representative make a request on their behalf.
- Has an order from an Arizona Superior Court saying they must undergo an SMI evaluation/determination.
- Is at least 17.5 years old. (Also refer to the AHCCCS Transition to Adulthood Practice Tool 8.0.)
- Has qualifying SMI diagnosis.

Any ALTCS EPD members asking whether they have been determined SMI should contact their UnitedHealthcare Community Plan case manager. This helps ensure SMI determinations and services are provided as specified in Title 9, Health Services, Chapter 21 AHCCCS Behavioral Health Services for Persons with a Serious Mental Illness (R9-21). For members already determined to be SMI, the case manager informs them of their grievance and appeal rights about their services as specified in R9-21.

An appeal of a denial of SMI determination goes through the AHCCCS-selected SMI Determination Agency and the case manager. The SMI coordinator assists the member with this process if needed (R9-21). The case manager informs the member of their rights to obtain special assistance from the Office of Human Rights as specified in R9-21.

During the member's initial ALTCS EPD assessment and all reassessments, the case manager completes a screening. They check if the member has any of the qualifying diagnoses determined as SMI. If they do, the case manager discusses with the member or their legal guardian the SMI determination process to see if this is something they want to pursue.

Behavioral health referral and intake

A referral may be made directly by the member, prospective member, their health care decision-maker, PCP, the health plan or another care provider, hospital, treat and refer provider, jail, court, probation or parole office, school or other government or community agency as specific in A.R.S § 8-512.01 and ACOM Policy 449.

Help ensure an effective referral and intake process is in place for members seeking behavioral health services. These includes general mental health and substance use services. The referral and intake process should include:

- Engaging the member, their health care decision-maker or designated representative
- Communicating the referral process and keeping that information or documents associated with the referral confidential and protected
- Collecting sufficient information about the member to determine the urgency of the situation

For ALTCS EPD members, the provider is encouraged to use the assistance of the assigned long-term care case manager to make referrals and obtain behavioral health services. Find more information about this process in the AHCCCS Medical Policy Manual (AMPM), policy 580.

PCP coordination of care responsibilities

The PCP helps ensure a member-specific medical record is established when behavioral health documentation is received from the T/RBHA or behavioral health provider on an assigned member. Even if you have not seen the member, a record must be created.

The PCP will respond to behavioral health provider or T/RBHA information requests within 10 business days of receiving the request. The response should include current diagnoses, medications, laboratory results, last PCP visit and recent hospitalizations.

PCPs may contact an in-network behavioral health provider or T/RBHAs and request a phone consultation with a psychiatrist regarding the medication management, transition of care and treatment options for a member with a behavioral health diagnosis with co-morbidities.

If a transfer is recommended, PCPs receive notice of the member's enrollment status. If you do not receive notice, contact the T/RBHA to speak to a liaison or behavioral health coordinator.

Non-behavioral health care provider responsibilities

Non-behavioral health care providers receive correspondence from the case manager about psychotropic medications the member is prescribed. The PCP should establish a separate record for behavioral health information.

UnitedHealthcare Community Plan performs random

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Behavioral Health Record Reviews (BHRR) yearly on care providers with 10 or more members actively receiving behavioral health services, or in which the PCP is prescribing and/or managing member's medications for the treatment of ADHD, anxiety or depression.

Provider parent and youth partner requirements

UnitedHealthcare Community Plan requires contracted providers to educate members and their families on the availability of Parent Peer Partner/Youth Partners at first contact and each meeting thereafter. Refer to AMPM Behavioral Health Practice Tool 240 for more information.

Peer and recovery support specialist and trainer qualifications

To comply with CMS requirements for delivering peer support services, the AHCCCS Office of Individual and Family Affairs (OIFA) has established training requirements and credentialing standards for peer recovery support specialists (PRSS) and parent family support specialists. Review the AHCCCS Medical Policy Manual (AMPM) Policies 963 and 964 for more information about:

- PRSS and CPFSS trainer qualifications
- Peer and parent/family support employment training program approval process and curriculum standards

Individuals seeking credentialing and employment as a peer recovery support specialist or as a parent/family support specialist must pass a competency exam with a minimum score of 80% upon completion of required training. Individuals credentialed in another state must submit their credentials to AHCCCS/OIFA through UnitedHealthcare Community Plan or the employing provider. Agencies must keep documentation of required qualifications and credentialing for PRSS.

AHCCCS OIFA asks all agencies training peer and parent/family support specialists to complete Attachments B and C in policies 963 and 964. These documents are rosters of individuals who have graduated your peer and/or family training. The documents should be completed immediately after training graduation. Email Attachment C for Peer Support and Attachment B for parent/family support to oifa@azahcccs.gov and our OIFA at Dawn_McReynolds@uhc.com.

Our OIFA contacts all agencies employing peer support specialists and parent/family support specialists to complete the attachments. It also requests a contractually required audit of employment records and supervision logs of all employed credentialed peer and family support specialists.

In accordance with the AHCCCS and Division of Developmental Disabilities (DDD) Policies 963 and 964 and UnitedHealthcare Community Plan's contractual obligations, the OIFA conducts audits of agencies that employ or train individuals to become peer and/or family support specialists. The following outlines the information and process in which the audits are performed.

1. OIFA requested a list of all peer and/or family support specialists employed at each provider site. Once it receives the list, UnitedHealthcare Community Plan and OIFA will conduct the file review. Each employee file must contain the following evidence:
   - At least 4 hours for PRSS and 16 hours for CPFSP (Certified Parent Family Support Partners).
   - At least 1 hour bi-weekly of Behavioral Health Professional (BHP) or Behavioral Health Technician (BHT) supervision
   - Employee credential certification
   - Documentation of yearly ongoing peer or family support-focused learning opportunities
2. OIFA requests evidence of inclusion of member and/or family member voice and choice in service delivery and decision-making procedures. Random samples of how providers are operationalizing these items may be solicited within the audit notification communication.

Rehabilitative services/ vocational rehabilitation

UnitedHealthcare Community Plan supports competitive integrated employment for working age youth and adults with disabilities. We have a designated vocational rehabilitation administrator who is the statewide point of contact for members requesting employment

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services. The administrator helps refer members interested in employment to the Rehabilitative Services Administration/Vocational Rehabilitation (RSA/VR) program and coordinates with peer-run organizations that offer vocational skills to members. In addition, the administrator provides education and support for providers offering employment services or those who would like to begin this process.

Based on AHCCCS ACOM, Chapter 400, Policy 447, you are expected to refer members interested in employment to the RSA/ VR program and document the member's care plan. You are also required to submit RSA/ VR referral data monthly to us using our VR Referral Monthly Deliverable form. Submissions must include health care professional name, site/location, member name, AHCCCS ID and referral date. Send your monthly submission of the VR Referral Monthly Deliverable or questions to **vocrehab@uhc.com**.

Diabetic members admitted to Arizona State Hospital

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

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

If the member's mental status renders them incapable or unwilling to manage their condition, and that condition requires ongoing medical care, UnitedHealthcare Community Plan will coordinate with the RBHA, member guardian, and AzSH to get the appropriate care.

Behavioral health toolkits

AHCCCS has developed a set of clinical toolkits to assist PCPs in assessing the needs of children/adolescents (8-17 years old), and adults (18 years and older). They also help PCPs determine the need and type of medication and if a behavioral health referral is indicated.

The toolkits are online at **UHCprovider.com** under Guides, Toolkits and Resources. They can also be found on **azahcccs.gov** in the Medical Policy Manual, Appendix E (Child and Adolescent Behavioral Health Tool Kits) and F (Adult Behavioral Health Tool Kits).

Centers of Excellence

Centers of Excellence (COEs) are specialized care programs for people with complex medical and behavioral health conditions. The types of conditions addressed are set by AHCCCS.

UnitedHealthcare Community Plan works with carefully selected community partners to support COEs. Each one delivers proven service in:

- Choice of care delivered
- Clinical excellence
- Member satisfaction

Learn more about COEs at **UHCCommunityPlan.com/az/coe**.

Portal access

Website: **UHCprovider.com**

Access the Provider Portal, the gateway to UnitedHealthcare Community Plan's online services, on this site. Use online services to verify eligibility, review electronic claim submission, view claim status, and submit notifications/prior authorizations.

Also view the Prior Authorization list, find forms and access the care provider manual. Or call Provider Services to verify eligibility and benefit information.

Website: **providerexpress.com**

Update your practice information, review guidelines and policies, and view the national Optum Network Manual. Or call Provider Services at 1-866-815-5334.

Website: AHCCCS **azahcccs.gov**

Website: Arizona DES/DDD **des.az.gov**

Integrated Health Plan Contact Information

azweb.statemedicaid.us

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Member appeals and grievances

Call Member Services at **1-800-348-4058** (TDD **711**) or **1-800-293-3740** for ALTCS EPD Member Services, and a representative will assist you with the Member Appeals and Grievances process. You may file an appeal with written consent from the member within 60 calendar days of the notice of adverse benefit determination. Find more information in Chapter 14 of this manual.

Send written requests to:

UnitedHealthcare Community Plan Member Appeals and Grievance
1 East Washington, Suite 900
Phoenix, AZ 85004

Claims

Submit claims using the 1500 Claim Form (v 02/12) or UB-04 form, whichever is appropriate. Use applicable coding, including ICD diagnosis code(s), CPT, Revenue and HCPCS coding. Include all necessary data to process a complete claim. Find out more about filing claims in Chapter 13.

Monitoring audits

We conduct routine on-site and virtual audits. These audits focus on the physical environment, policies and procedures, and quality record documentation. UnitedHealthcare Community Plan will request documentation, reports and tracking to support fidelity monitoring based on contractual and/or state policy requirements.

Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction. We engage in strategic community relationships and approaches for special populations with unique risks, such as pregnant women and infants. We use our robust data infrastructure to identify needs, drive targeted actions, and measure progress. Finally, we help ensure our approaches are trauma-informed and reduce harm where possible.

Brief summary of framework

- Prevention:
  - Prevent SUDs before they occur through pharmacy management, care provider practices, and education.
- Treatment:
  - Access and reduce barriers to evidence-based and integrated treatment.
- Recovery:
  - Support care management and referral to person-centered recovery resources.
- Harm reduction:
  - Access to Naloxone and facilitating safe use, storage, and disposal of opioids.
- Strategic community relationships and approaches:
  - Tailor solutions to local needs.
- Enhanced solutions for pregnant mom and child:
  - Prevent neonatal abstinence syndrome and supporting moms in recovery.
- Enhanced data infrastructure and analytics:
  - Identify needs early and measure progress.

Increasing education and awareness of opioids

You must stay up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep SUD-related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/SUD assessments and screening resources, and other important state-specific resources.

Pain Management Toolkits are also available. They provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, “The Role of the Health Care Team in Solving the Opioid Epidemic,” and “The Fight Against the Prescription Opioid Abuse Epidemic.” While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing and key resources.

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Access these resources at UHCprovider.com > Resources > Drug Lists and Pharmacy. Click “Opioid Programs and Resources - Community Plan” to find a list of tools and education.

Prevention

We are invested in reducing the abuse of opioids, while facilitating the safe and effective treatment of pain. Preventing SUDs before they occur through improved pharmacy management solutions, improved care provider prescribing patterns, and member and care provider education is central to our strategy.

UnitedHealthcare Community Plan has implemented a 90 MED supply limit for the long-acting opioid class. The prior authorization criteria coincide with the CDC’s recommendations for the treatment of chronic non-cancer pain. Prior authorization applies to all long-acting opioids. The CDC guidelines on long-acting opioids are available online at cdc.gov > More CDC Topics > Injury, Violence & Safety > Prescription Drug Overdose > CDC Guideline for Prescribing Opioids for Chronic Pain.

Medication-assisted treatment

UnitedHealthcare Community Plan PCPs can treat our members with MAT for SUDs.

PCPs providing MAT must meet all regulatory requirements established for the medication type administered. MAT is both medication management with FDA-approved medication for SUD in conjunction with psychological and behavioral therapies. Care providers who provide the medication management alone for SUDs must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the MAT model and coordinate care with the behavioral health provider.

Find more information in the AMPM Policy 510.

Refer to the Pharmacy Program on UHCprovider.com for the Preferred Drug List Search and AHCCCS/Medicaid Preferred Drug List.

Opioid treatment programs (OTPs) that employ mid-level practitioners are required to complete the Mid-Level Exemption Request Process, as described in AMPM 660 to allow those practitioners to dispense opioids within a MAT setting for individuals with OUD. You must continuously monitor and abide by the federal guidelines for OTPs.

Members cannot be excluded from behavioral health residential facilities if they are on or pursuing MAT.

Opioid Treatment Program reporting requirements

Pursuant to A.R.S. §36-2907.14, in addition to all state or federal licensing and registration requirements, any OTP (including new and existing OTP sites) receiving reimbursement from AHCCCS or its contractors must develop and submit plans as specified in statute, and any relevant documentation, for review and approval by AHCCCS. Existing OTP sites are also required to submit an annual report no later than November 15 of each year. The submitted plans will be posted to the AHCCCS website for public comment for 30 days. AHCCCS will make a determination on the acceptability of the submitted documentation within 30 days of the close of the public comment period. If AHCCCS determines there is a deficiency in any of the submitted documentation, the OTP will be provided 30 days, from day of notification, to correct the deficiency or AHCCCS will suspend reimbursement for OTP providers until deficiency is remediated. UnitedHealthcare Community Plan is required to suspend payment to OTPs who do not receive AHCCCS approval.

Plans required for submission from the OTPs include a:

- Detailed security plan
- Neighborhood engagement plan
- Comprehensive plan to demonstrate how the OTP ensures that appropriate medication-assisted standards of care are met
- Community relations and education plan
- Current diversion control plan.

Refer to the AHCCCS website for detailed information regarding expectations and submission requirements. Hospitals, jails, and OTPs on Tribal lands are exempt from the previous requirement.

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Guest dosing for members transitioning from home opioid treatment program

Guest dosing follows the ASAM's guidance for medication safety and recovery support. An individual may be administered daily dosing from an OTP center other than their home OTP center when they cannot travel to the home OTP center or when traveling outside the home OTP center's area. Guest dosing may also be approved outside Arizona when the member's health would be endangered if travel were required back home (42 CFR § 431.52). Members may ask their home OTP to coordinate with the guest OTP for the needed doses.

Duty to warn/report

A.R.S. § 36-517.02 states that no cause of action or legal liability may be held against behavioral health care providers for breaching a duty to prevent harm to a person caused by a patient. The exception is if both the following occur:

- The member has told the behavioral health care provider that they plan to seriously harm or kill a clearly identifiable victim, and the member has the intent and ability to carry out the threat, and
- The mental health care provider fails to take reasonable precautions.

This statute says a behavioral health care provider's duty to take reasonable precautions to prevent a member from causing harm is discharged when the behavioral health care provider:

- Shares the threat to all identifiable victims, when possible;
- Notifies a law enforcement agency where the member or any potential victim lives;
- Takes reasonable steps to hospitalize the member either voluntarily or involuntarily based on AMPM Policy 320-U, if appropriate; or
- Takes precautions a reasonable, prudent behavioral health care provider would take under the circumstances.

All care providers, regardless of specialty, must protect others against a member's potential danger to themselves or others. When you determine, or reasonably should have determined, that a patient poses a serious danger to self or others, you have a duty to protect others against imminent danger.

Reporting seclusions, restraints, emergency responses, incidents, accidents or death

AHCCCS Medical Policy Manual (AMPM) Section 962 requires all facilities to report seclusions, restraints and emergency responses. This applies to all state-licensed behavioral health inpatient facilities, mental health agencies, out-of-state facilities and ADHS treating members with ACC, DD and ALTCS EPD coverage. Types of restraint and seclusion include:

- Chemical restraint: Pharmacological restraint that is not standard treatment. It helps manage the member's behavior or restrict their movement to lower the safety risk to themselves or others.
- Mechanical restraint: Any device, article, or garment attached or next to a member's body that restricts the member's movement and is not easily removed. This lowers the safety risk to themselves or others.
- Seclusion: Involuntary confinement in a room or an area from which the member cannot leave.

How to report seclusion, restraint or emergency response

Based on AHCCCS AMPM Policy 962: Reporting Seclusion and Restraint and Emergency Response, licensed behavioral health programs authorized to use seclusion and restraint must report to us each occurrence of seclusion, restraint or Emergency Response and information on the debriefing within five business days of the occurrence if less than 23 hours and 59 minutes. If the incidence happened after that time frame, send to us immediately. Submit the individual reports on the Seclusion and Restraint Reporting form, AHCCCS AMPM Policy 962, Attachment A. Behavioral Health Inpatient Facilities (BHIFs) and Mental Health Agencies shall report incidents of seclusion and restraint (SAR) that result in an injury or complication requiring medical attention to the contractor within 24 hours in accordance with AMPM Policy 961.

If using seclusion and restraint requires face-to-face monitoring, attach a report with details on the Seclusion

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and Restraint Reporting form. The form must include the requirements as per 42 CFR § 482.13, 42 CFR §§ 483 Subpart G, R9-20-602 and R9-21-204, outlined in Seclusion and Restraint Monitoring Requirements. Submit reports by:

- For less than 23 hours and 59 minutes: Send completed form to Optum within 5 days of Seclusion and/or restraint to:
  - Fax: **888-821-5101**
  - Email: specialcare_UB2@optum.com
- For more than 23 hours and 59 minutes: Send completed form to Optum immediately to:
  - Fax: **1-844-675-0296**
  - Email: az_seclusion_restraint_escalated@optum.com

We submit individual reports received from care providers involving enrolled children and adults to AHCCCS on a monthly basis. We also submit summary and redacted reports as required to AHCCCS for submission to the Independent Oversight Committee (IOC).

Incident, accident or death

Per AHCCCS Policy 961, the following types of incidents must be reported to UnitedHealthcare Community Plan within 24 hours of the incident using the Incident, Accident, Death Report electronic form (also referred to as an IAD) and submitted through the AHCCCS QM portal:

- Allegations of abuse, neglect or exploitation of a member
- Death of a member
- Delays or difficulties in accessing care (e.g., outside of the timeline specified in ACOM Policy 417)
- Healthcare-acquired conditions and other provider-preventable conditions (refer to AMPM Policy 960 and AMPM Policy 1020)
- Serious injury
- Injury resulting from the use of a personal, physical, chemical or mechanical restraint or seclusion (refer to AMPM Policy 962)
- Medication error occurring at a licensed residential provider site including: Behavioral Health Residential Facility (BHRF), DDD Group Home, DDD Adult Developmental Home, DDD Child Developmental, Assisted Living Facility (ALF), SNF, Adult Behavioral Health Therapeutic Home (ABHTH) or Therapeutic Foster Care Home (TFC), and any other alternative HCBS setting as specified in AMPM Policy 1230-A
- Missing person from a licensed BHIF, BHRF, DDD Group Home, ALF, SNF, ABHTH or TFC
- Member suicide attempt
- Suspected or alleged criminal activity
- Any other incident that causes harm or has the potential to cause harm to a member

Sentinel IADs include:

- Member death or serious injury associated with missing person,
- Member suicide, attempted suicide or self-harm that results in serious injury while being cared for in a healthcare setting,
- Member death or serious injury associated with a medication error,
- Member death or serious injury associated with a fall while being cared for in a healthcare setting,
- Any stage 3, stage 4, and any unstageable pressure ulcers acquired after admission or presentation to a healthcare setting,
- Member death or serious injury associated with the use of seclusion and/or restraints while being cared for in a healthcare setting,
- Sexual abuse/assault on a member during the provision of services.
- Death or serious injury of a member resulting from a physical assault that occurs during the provision of services, and
- Homicide committed by or allegedly committed by a member.

Reporting incident, accident and death

You are required to register for the AHCCCS portal and receive their login and password information. IADs cannot be emailed to UnitedHealthcare Community Plan, and all care providers must use the portal at qmportal.azahcccs.gov.

IAD is reportable for:

- Allegations of abuse, neglect, or exploitation of a member
- Death of a member
- Delays in accessing care
- Health care-acquired conditions
- Serious injury
- Injury resulting from restraint or seclusion
- Medication error

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- Missing person from licensed behavioral health facility
- Suicide attempt
- Criminal activity within 2 business days

Report Sentinel IADS (AMPM Policy 961) within 1 business day.

UnitedHealthcare Community Plan is responsible for reviewing all IADs to determine if there is a quality of care concern. If determined to be a quality of care concern, UnitedHealthcare Community Plan will reach out to care providers for records and necessary documentation or perform member and staff interviews as needed to complete a timely investigation. We submit all completed quality of care reports to AHCCCS and complete tracking and trending on these items within required time frames.

Demographics, social determinants and outcomes

AHCCCS has developed a plan to help care providers collect and report demographic and SDOH data. This plan reduces the number of data points care providers must report. It involves using:

1. **Alternative data sources.** AHCCCS has identified current demographic elements in other AHCCCS data systems and other source agreements.
2. **SDOH ICD-10 Diagnosis codes.** These diagnosis codes reported on claim submissions began April 1, 2018.
3. **Demographic Portal.** For those social determinant/demographic/outcome elements with no identified alternative data source or Social Determinate diagnosis identifier, AHCCCS created an online portal (DUGless) accessed directly by care providers to collect applicable identified data elements for members. All care providers who typically provide these types of data will provide the required information through DUGless.

The requirements, definitions, and values for submission of the identified data elements are specified in the AHCCCS DUGless Portal Guide (DPG). Required information is collected by AHCCCS health care providers. Data and information are recorded and reported to MCOs to assist in monitoring and tracking. For more information please see the DUGless portal guide at azahcccs.gov/PlansProviders/GuidesManualsPolicies/index.html#DUGless.

For more information, review the Demographics, Social Determinants and Outcomes page on azahcccs.gov.

Housing requirements for behavioral health providers

AHCCCS and UnitedHealthcare Community Plan believe safe, stable and affordable housing, matched with a member's behavioral health, medical and other supportive services consistent with the member's needs and goals in the least limiting community setting, is critical for an individual's overall well-being. These services may be necessary if they help members get and keep permanent housing.

Subcontracted behavioral health providers must comply with all ACOM Policy 448 requirements related to assisting members in getting and keeping housing as part of their independent living goals. For additional programmatic and operational processes for AHCCCS Housing Programs, review the AHCCCS Guidebook AHCCCSHousingProgramGuidebook.pdf at azahcccs.gov. You must confirm that all members have information about, and assistance securing, available housing resources including market rate, mainstream subsidy and AHCCCS-subsidized housing programs.

You are responsible for assisting and supporting members to secure and maintain housing as part of overall physical and behavioral health service provision. This includes coordination with the AHCCCS Housing Administrator for AHCCCS Housing Programs (AHP), if eligible, as well as other community-based housing and programs (e.g., Housing Choice Vouchers, HUD CoC programs).

Arizona Behavioral Health Corporation (ABC Housing) and HOM, Inc., function as the state-wide Housing Administrator for the AHP. Program elements will be managed by ABC Housing and funded by Arizona State funding sources, Non-Title XIX/XXI SMI Housing General Fund and Non-Title XIX/XXI Supported Housing General Fund (Refer also to AMPM Policy 320-T2).

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Behavioral health providers will ensure identification, assessment, screening and documentation of members who have housing needs including homelessness, housing instability or lack of adequate and appropriate setting at discharge from residential, crisis or inpatient facility. This process may also include administration of any AHCCCS-approved standardized assessment tools that include housing evaluation. You are required to coordinate with the UnitedHealthcare Community Plan Housing Coordinator and ABC Housing to identify and refer members identified with high need for housing that meet the AHP eligibility requirements listed in ACOM 448 Section E.

For instructions on how to submit referrals for the AHCCCS Housing program, go to: AHCCCS Housing Programs (AHP) – Arizona Behavioral Health Corporation.

Housing-related supportive service coordination requirements

Provider staff is required to have knowledge of federal and state funding regulations. Housing-related supportive service coordination requirements include the following:

- Behavioral health care providers will assist members to identify, apply and qualify for housing options they may be eligible for. This includes AHP subsidies and supports, as well as other local and/or federal housing programs. This ensures a range of housing settings and programs are available and consistent with the member's recovery goals, service plan and choice. The goal is to offer the least restrictive environment necessary to support the member. Shelters, hotels and similar temporary living arrangements do not meet this expectation.
- Whenever possible, behavioral health providers will not actively refer or place members in a homeless shelter, licensed supervisory care homes, unlicensed board and care homes or other similar facilities upon discharge from an institutional setting.
- Behavioral health providers, including a member's treatment team or care coordinator, are required to participate and support AHP and other mainstream housing processes. This includes assistance in securing eligibility documentation, attending housing briefings to ensure the member understands housing rights, duties and processes, assisting in the housing search and lease-up process and help with move-in and ongoing requirements.
- For members enrolled in AHP, behavioral health provider clinical teams will coordinate with the AHCCCS Housing Administrator and housing provider (landlord, property management company or property owner) to ensure members receive appropriate housing-related supportive services to confirm housing stability and progress towards case plan goals. This may include delivery of services within the member's housing placement as appropriate.
- Behavioral health providers are required to maintain enough dedicated housing professionals with knowledge, expertise, experience and skills to coordinate with the AHCCCS Housing Administrator to expedite housing processes. Behavioral health providers may be required to demonstrate they can capably conduct and use any AHCCCS-required current or emerging standardized assessment tool for assessing and documenting housing needs, such as the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) or other AHCCCS approved acuity tool.

Housing for individuals determined to have SMI

Refer a member determined to have SMI and experiencing homelessness or in imminent risk of homelessness to the AHCCCS Housing Program and other mainstream housing resources available in the community. The assigned behavioral health provider is required to support the member in the housing search and retention process according to the housing-related service coordination requirements outlined above.

The AHCCCS Housing Program ensures a variety of housing options and supportive services are available to assist these members live as independently as possible. Recovery often starts with safe, decent and affordable housing so that members can live, work, learn and participate fully in their communities. Safe, stable and familiar living arrangements are critical to a member's ability to benefit from treatment and supportive services.

For members determined to have SMI who can live independently, the AHCCCS Housing Program has several programs to support independent living, such as

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scattered site rent subsidy programs and supportive housing programs, community living programs, bridge to permanency programs as well as eviction prevention and housing support programs.

UnitedHealthcare Community Plan believes in permanent supportive housing and has adopted the SAMHSA model for permanent supportive housing programs. The 12 key elements of the SAMHSA Permanent Supportive Housing Program are:

1. Tenants have a lease in their name, and, therefore, they have full rights of tenancy under landlord-tenant law, including control over living space and protection against eviction.
2. Leases do not have any provisions that would not be found in leases held by someone who does not have a psychiatric disability.
3. Participation in services is voluntary and tenants cannot be evicted for rejecting services.
4. House rules, if any, are like those found in housing for people who do not have psychiatric disabilities and do not restrict visitors or otherwise interfere with a life in the community.
5. Housing is not time-limited, and the lease is renewable at tenants' and owners' option.
6. Before moving into permanent supportive housing, tenants are asked about their housing preferences and are offered the same range of choices as are available to others at their income level in the same housing market.
7. Housing is affordable, with tenants paying no more than 30% of their income toward rent and utilities, with the balance available for discretionary spending.
8. Housing is integrated. Tenants can interact with neighbors who do not have psychiatric disabilities.
9. Tenants have choices in the supportive services they receive. They are asked about their choices and can choose from a range of services, and different tenants receive different types of services based on their needs and preferences.
10. As needs change over time, tenants can receive more intensive or less intensive supportive services without losing their homes.
11. Supportive services promote recovery and are designed to help tenants choose, get and keep housing.
12. The provision of housing and the provision of supportive services are distinct.

Coordinated entry access points for members who report as homeless

Refer members experiencing homelessness or risk of homelessness to the HEARTH Continuum of Care (CoC) program through the local Coordinated Entry system in their community. The following links give more information about the services available in each region.

- **Arizona Balance of State CoC** The Arizona Department of Housing serves as the Collaborative Applicant and Homeless Management Information System (HMIS) lead agency for the CoC for the 13 non-metro counties in the state. **Locate community access points by county here**.
- **Tucson/Pima County CoC** Tucson Pima Collaboration to End Homelessness (TPCH) is a coalition of community and faith-based organizations, government entities, businesses and individuals committed to the mission of ending homelessness and addressing the issues related to homelessness in our community. **Locate community access points here**.
- **Phoenix/Mesa/Maricopa County Regional CoC** This is staffed by the Maricopa Association of Governments. More than 40 homeless assistance programs in 13 different agencies are supported. **Locate community access points here**.

For additional training on the COC and coordinated entry system:

- **Homeless Services in Arizona: Continuum of Care & Coordinated Entry System (chameleoncloud.io)** *(This link takes you to a self-paced training on Coordinated Entry System and Continuum of Care.)*

Additional affordable community-based housing resources

Utilize the resources listed below to assist members in identifying and accessing housing opportunities appropriate to their needs in their local area. You can share these resources with the member and help them navigate the eligibility and application processes as needed.

Income-based housing:

- **Subsidized apartment search**

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Chapter 10: Member rights and responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	UHCCommunityPlan.com/AZ > Medicaid Plans	• ALTCS EPD: **1-800-293-3740** • ACC/DD: **1-800-348-4058**
Member Handbook	UHCCommunityPlan.com/AZ > Medicaid Plans	• ALTCS EPD: **1-800-293-3740** • ACC/DD: **1-800-348-4058**

- Public Housing Authorities
- Housing Choice Vouchers (Section 8)
- Section 202 Supportive Housing for the Elderly
- Section 811 Supportive Housing for Persons with Disabilities

Sober living housing are facilities that provide safe housing and supportive, structured living conditions for people exiting drug rehabilitation. Members pays independently for the rent amount. You can share sober living housing with the member.

- AZ Recovery Housing Association Certified Sober Living Communities

Eviction prevention resources:

- Emergency Rental Assistance
- HUD Approved Housing Counseling Agencies

Department of Housing & Urban Development subsidized apartment search tool:

- https://resources.hud.gov/

To receive additional information regarding these programs, contact member services at 1-800-348-4058.

Our Member Handbook has a section on member rights and responsibilities. In it, we ask that members treat you with respect and courtesy. If they do not, please call Provider Services and ask to speak with the member's care manager.

Privacy regulations

HIPAA privacy regulations offer full federal protection to protect member health care information. These regulations control the internal and external uses and disclosures of such data. They also create member rights.

Access to PHI

Members may access their medical records or billing information either through you or us. If their information is electronic, they may ask that you or we send a copy in an electronic format. They may also ask that a copy of their information be provided to a third party.

Amendment of PHI

Our members have the right to ask that you or we change information they believe to be inaccurate or incomplete. The member request must be in writing and explain why they want the change. You or we must act on the request within 60 days, or may extend another 30 days with written notice. If denying the request, provide certain information to the member explaining the denial reason and actions the member must take.

Disclosure of member information

Information obtained while providing a member with covered health services is confidential. It may only be disclosed according applicable federal and state law. If an unauthorized use/disclosure of unsecured PHI occurs, the covered entity responsible for the breach must notify all affected persons. Medical records must be maintained based on written protocols related to their care, custody, and control as mandated by the AHCCCS program.

Before disclosing PHI, consult the specific citation to HIPAA and state law. Also consult with legal counsel.

To prevent breaches, maintain a list of every person or organization that inspects a currently or previously enrolled person's records other than the clinical team.

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Also track how the information is used. The access list must be placed in the member's record and be made available to them, their guardian or designated representative. Retain consent and authorization medical records as noted in A.R.S. § 12-2297.

Right to request restrictions

Members have the right to ask you to restrict the use and disclosures of their PHI for treatment, payment and health care operations. For example, members may request to restrict disclosures to family members or to others who are involved in their care or payment. You may deny this request. If you approve restriction, document the request and restriction details. You will be required to abide by the restriction.

Right to request confidential communications

Members have the right to request communications from you or us be sent to a separate location or other means. You must accommodate reasonable requests, especially if the member states disclosure could endanger them. Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Member rights and responsibilities

The following information is in the Member Handbook. You may obtain copies of the Member Handbook at UHCprovider.com or by calling Provider Services.

American Indian/Alaska Native access to care

American Indian/Alaska Native members can access care to Tribal clinics and Indian hospitals without approval.

Member rights

Based on 42 CFR § 438.100 and 42 CFR § 457.1220, members have the right to:

- Request information on advance directives.
- Be treated with respect, dignity and privacy.
- Receive courteous and prompt treatment.
- Receive cultural assistance, including having an interpreter during appointments and procedures. This also includes the right to refuse care from specified providers.
- Receive information about us, their rights and responsibilities, their benefit plan and which services are not covered.
- Learn how to get AHCCCS-covered services not offered or available through the health plan. Also learn how to get family planning services from an appropriate AHCCCS-registered provider.
- Receive information about how the health plan evaluates new technology for inclusion as a covered benefit.
- Know the qualifications of their care provider.
- Give their consent for treatment unless unable to do so because life or health is in immediate danger.
- Discuss any and all treatment options with you.
- Refuse treatment directly or through an advance directive. They may also refuse care from a specific care provider.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Receive medically necessary services covered by their benefit plan.
- Receive information about in-network care providers, and choose one from our network.
- Change care providers contracted with us up to three times per year per 42 CFR § 438.52(d) and 42 CFR § 438.14(b)(3).
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response.
- Tell us their opinions and concerns about services and care received.
- Register grievances or complaints concerning the health plan or the care provided.
- Appeal any payment or benefit decision we make.
- Review or request a copy of their medical records you keep and request changes and/or additions to any area they feel is needed.
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, alternative

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treatment options, and talk with you when making decisions about their care.
- Be informed of medical alternatives and other types of care and how they access care.
- Get a second opinion with an in-network care provider.
- Expect care providers are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage.
- Make suggestions about our member rights and responsibilities policies.
- Get more information upon request, such as on how our health plan works and a care providers incentive plan, if they apply.
- Know if they need stop-loss insurance for very large claims.
- Know how we compensate you.
- Exercise their rights and that the exercise if those rights shall not adversely affect service delivery to the member.
- Request a summary of the member survey results.

Member responsibilities

Members should:

- Read their Member Handbook so they can understand their benefits and get the most value from them.
- Show you their Medicaid member ID card.
- Prevent others from using their ID card.
- Understand their health problems and give you true and complete information.
- Ask questions about treatment.
- Work with you to set treatment goals.
- Follow the agreed-upon treatment plan.
- Get to know you before they are sick.
- Keep appointments or tell you when they cannot keep them.
- Treat your staff and our staff with respect and courtesy.
- Get any approvals needed before receiving treatment.
- Use the ER only during a serious threat to life or health.
- Notify us of any change in address or family status.
- Make sure you are in-network.
- Follow your advice and understand what may happen if they do not follow it.
- Give you and us information that could help improve their health.
- Give a copy of their living will to their PCP.

Our member rights and responsibilities help uphold the quality of care and services they receive from you. The three primary member responsibilities as required by the National Committee for Quality Assurance (NCQA) are to:

- Supply information (to the extent possible) to AHCCCS, UnitedHealthcare Community Plan and to you that is needed for you to provide care.
- Follow care to which they have agreed.
- Understand their condition and take part in developing mutually agreed-upon treatment goals, to the degree possible.

Change of contractor

AHCCCS ACOM policy 401 sets guidelines, criteria and time frames for how, when and by whom insurance contractor change requests are processed for AHCCCS members outside of contractor choice offered upon initial enrollment and the Annual Enrollment Choice (AEC) period. This affects:

- The member.
- The member’s current/relinquishing contractor.
- The receiving contractor.
- AHCCCS.

Criteria for change of contractor outside of initial enrollment or AEC period

Contractor change requests outside these periods are granted if certain conditions are met per 45 CFR § 155.410. These conditions are:

- **Administrative Actions That May Merit a Contractor Change**
  - A member was entitled to freedom of choice but was not sent an auto-assignment/freedom of choice notice.
  - A member was entitled to participate in an AEC but:
    - Was not sent an AEC notice, or
    - Was sent an AEC notice but could not take part

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due to circumstances beyond the member's control.

- Family members were inadvertently enrolled with different contractors through the auto-assignment process. Upon receipt of AHCCCS notification, the member who was wrongly enrolled will be disenrolled from the contractor of assignment and enrolled in the contractor where the other family members are enrolled. Other family members may not change to the contractor to which the new member was auto-assigned. This process does not apply if a member was afforded an enrollment choice during their AEC period.
- A member who was enrolled with a contractor, lost eligibility and was disenrolled, then was subsequently redetermined eligible and reenrolled with a different contractor within 90 days from the date of disenrollment. In this case, the member will be reenrolled with the contractor they were enrolled with prior to the loss of eligibility. If this does not occur, AHCCCS, upon notification, will enroll the member with the correct contractor.
- Newborns will automatically be assigned to the mother's contractor. If the mother is Title XIX or Title XXI-eligible, she will be given 90 days from notification to select another contractor for the newborn. Newborns of Federal Emergency Services (FES) mothers or newborns born ineligible for a comprehensive health plan (CHP) will be auto-assigned, and the mother will be given 90 days to select another contractor.
- Adoption subsidy children will be auto-assigned, and the guardian will be given 30 days from notification to select another contractor.
- A Title XIX-eligible member who is entitled to freedom of choice but becomes eligible and is auto-assigned prior to having the full choice period of 30 days will be allowed to request a contractor change following auto-assignment. The member will be given 30 days to request a contractor change. A member who does not make a selection within 30 days will remain with the auto-assigned contractor.

- **Medical Continuity of Prenatal Care**
  A pregnant member enrolled with a contractor through auto- assignment or freedom of choice but who is receiving or has received prenatal care from a provider who is affiliated with another contractor may be granted a medical continuity contractor change if the medical directors of both contractors agree. If other individuals in the pregnant member's family are also AHCCCS-eligible and enrolled, they may remain with the current contractor or transition to the new one if the medical continuity plan change is granted. The member may not return to the original contractor or change to another after the medical continuity contractor change has been granted except during the AEC period.
  - Members who transition to a new contractor or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS- registered care provider, regardless of contractual status, to help ensure continuity of care.
- **Medical Continuity of Care**
  AHCCCS has standards for network composition that result in uniform availability and accessibility of services from all contractors serving a specific geographic area. In unique situations, contractor changes may be approved on a case- by-case basis to help ensure the member has access to care.

  A plan change for medical continuity is not an automatic process. The member's PCP, or other care provider, must provide documentation to both the receiving and relinquishing contractors that supports the need for a contractor change. The contractors must be reasonable in the request for documentation.

  However, the burden of proof that a contractor change is necessary rests with the member's medical provider. The contractor change must be approved by both contractor medical directors.

  When the medical directors of both contractors cannot agree, the relinquishing contractor will submit the request to the AHCCCS chief medical officer (CMO) or designee. The AHCCCS Acute Care Change of Contractor Form (Attachment A) and the supporting documentation must be sent to the AHCCCS DHCM/ Medical Management Manager within 14 business days from the date of the original request.

  The results of the review will be shared with both medical directors. The relinquishing contractor must issue a final decision to the member. If the member request is denied, the relinquishing contractor will send the member a Notice of Adverse Benefit Determination.

  The member must be transitioned within the requirements and protocols in ACOM Policy 402 and in AMPM Chapter 500.

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Contractor responsibilities when a contractor change is not warranted

The current contractor must promptly address the member's concerns regarding availability and accessibility of service and quality of care or delivery issues that may have caused a contractor change request. These issues include but are not limited to:

- Quality of care delivery.
- Care management responsiveness.
- Transportation convenience and service availability.
- Institutional care issues.
- Care provider preference.
- Care provider recommendation.
- Care provider office hours.
- Timing of appointments and services.
- Office waiting time.
- Network limitations and restrictions.

When the member raises quality of care and delivery of service issues that cannot be solved through the normal care management process, call the health plan Member Services number on the member's ID card to report concerns.

The current contractor must also explore all options available to the member, such as transportation problems, care provider availability issues, allowing the member to choose another PCP or care provider, if appropriate.

The delivery of covered services remains the responsibility of the current contractor if a contractor change for medical continuity of prenatal or other medical care is not approved. The current contractor must notify the member, in writing, that a Contractor change is not warranted. If the contractor change request was the result of a member concern, as defined in Section III A (2) or A (3) of this policy, the notice must include the contractor's resolution. The notice must also advise the member of the AHCCCS and contractor grievance policy and include timeframes for filing a grievance.

Contractors may reach an agreement with an out-of-network provider to care for the member on a temporary basis, for the members' period of illness, and/or pregnancy to provide continuity of care.

Relinquishing contractor, receiving contractor and AHCCCS administration responsibilities when a contractor change is warranted

- **Relinquishing Contractor Responsibilities**
  If a member contacts the current contractor, verbally or in writing, and states the plan change request is due to situations defined in Section A(1) of this policy, the relinquishing contractor will tell the member to call the AHCCCS Verification Unit at 1-602-417-7100 or 1-800-334-5283 for AHCCCS to process the change.

  If the member contacts the relinquishing contractor, verbally or in writing, to request a plan change for medical continuity of care as defined in III A (2) or A (3) of this policy, the following steps must be taken:

  - The relinquishing contractor will contact the receiving contractor. If a plan change is needed for medical continuity of care, the AHCCCS Contractor Change Request Form (Attachment A) must be completed. All affected members are added to the form, which the medical directors or physician designees of both contractors sign. The form is then submitted to the AHCCCS CMO.
  - To facilitate continuity of prenatal care, contractors will sign off and forward the AHCCCS Contractor Change Request Form to the AHCCCS CMO within two business days of the change request. The timeframe for other continuity of care issues is 10 business days.
  - The AHCCCS CMO will review the contractor change documentation and forward to the Communications Center for processing.
- **Receiving Contractor Responsibilities**
  The member must be transitioned within the requirements and protocols in ACOM Policy 402 and in AMPM Chapter 500.
- **Member Responsibilities**
  The member will request a change of contractor directly from AHCCCS only for situations defined in Section III A (1) of this policy. The member should direct all other contractor change requests to the member's current contractor.
- **AHCCCS Responsibilities**
  AHCCCS will process change of contractor requests that are listed in ACOM Policy 401 and send notification through the daily recipient roster to the relinquishing and receiving contractors. The contractor must identify members from the daily recipient roster who are leaving the contractor.
  If AHCCCS denies a Section III A (1) change of contractor request, AHCCCS will send the member a denial letter. The member will be given 60 days to file a grievance.

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If AHCCCS receives a letter or verbal request from a member requesting a contractor change, for reasons defined in Section A(1) of this policy, and notes other problems, that information will be sent to the current contractor. If AHCCCS receives a letter or verbal request from a member requesting a contractor change for reasons listed in Section III A (2) or A (3), the information will be forwarded to the current contractor.

The AHCCCS Acute Care Change of Contractor Form is located in the AHCCCS Contractor Operations Manual, Chapter 400.

ALTCS EPD members

Members have the rights and responsibilities to:

- Use services.
- Ask questions if they do not understand their rights or plan of treatment.
- Keep their appointments.
- Cancel appointments in advance when you cannot keep them.
- Contact their PCP first for non-emergency medical needs.
- Understand when they should and should not go to an ER.
- Know who to call if they need a ride to the doctor or for other covered services.
- Treat care providers and health plan staff with respect and dignity.
- Be in charge of their planning meeting.
- Ask anyone I want to come to my planning meetings.
- Choose their goals to work on and what is in their plan.
- Schedule their person-centered planning meeting at a time and place when the people they want to attend are available.
- Agree to the services they want from the choice of services they may have.
- Pick an available provider they want to give them services.
- Know that they may need help from their guardian, family and/or friends to make good choices.
- Tell their PCP and case manager about their health and changes to it.
- Tell Member Services and/or their case manager about changes in their Medicare, Medicare HMO or private insurance, includes adding or ending other insurance.
- Talk to their care providers and case manager about their health care. Ask questions about the ways their health problems can be treated.
- Notify their case manager and AHCCCS if their family size changes, if they move or if their income changes.

With the help of their DES/DDD support coordinator, members must also:

- Keep their ALTCS eligibility predetermination appointments.
- Select a PCP within 10 days of notification of plan enrollment.
- Coordinate all necessary covered medical services through their PCP.
- Go to their well visits with their PCP to help them stay healthy. Their PCP will help prevent infections by giving immunizations.
- Notify the DES/DDD support coordinator if any address, phone number or private insurance changes.
- Arrive on time for appointments or call ahead if they can't make it.
- Provide their PCP with all the information they request.
- Notify their DDD support coordinator and UnitedHealthcare Community Plan with all the information, including changes in private and public insurance, third-party liability, financial assistance or other benefits they receive.
- Pursue eligibility with Children's Rehabilitative Services (CRS). CRS is a special health care program that helps with certain health conditions.
- Direct any complaints or problems to DES/DDD, Health Care Services, Member Services or the UnitedHealthcare Community Plan DD Liaison as soon as possible.
- Participate in family-centered team planning meetings at the request of UnitedHealthcare Community Plan, the support coordinator or other personnel.

Members may call their DDD support coordinator at 1-844-770-9500, ext. 1, if they have questions.

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Chapter 11: Medical Records

Medical record charting standards

UnitedHealthcare Community Plan and AMPM, Chapter 900, Policy 940 require you to keep complete and orderly medical records, in paper or electronic format, which fosters efficient and quality member care. If a PCP has not yet seen the assigned member, keep the health information in an appropriately labeled file. Associate it with the member's medical record as soon as one is established. Members or their representative are entitled to one free copy of their medical record. Additional copies may be available at member cost. Medical records are generally kept for a minimum of five years unless federal requirement mandate a longer time frame (i.e., immunization and tuberculosis records required for lifetime).

You are subject to our periodic quality medical record review. You must also keep medical records based on written protocols related to their care, custody and control as mandated by the state of Arizona AHCCCS program and as prescribed in A.R.S. § 12-2297. The review could include any of the following items to determine compliance:

Topic	Contact
Confidentiality of Record	Office policies and procedures exist for: • Privacy of the member medical record. • Initial and periodic training of office staff about medical record privacy. • Release of information. • Record retention. • Availability of medical record if housed in a different office location including medical records managed by a third-party care provider. • Process for notifying UnitedHealthcare Community Plan upon becoming aware of a patient safety issue or concern. • Coordination of care between medical and behavioral care providers.
Record Organization and Documentation	• Have a policy that provides medical records upon request. Urgent situations require copies be provided within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing Medical records. • Release only to entities as designated consistent with federal requirements. • Keep in a secure area accessible only to authorized personnel.

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<table>
<tr><th>Topic</th><th>Contact</th></tr>
<tr><td>Procedural Elements</td><td>Medical records are readable in blue or black in or typewritten*
• Sign and date all entries.
• Member name/identification number is on each page of the record.
• Corrections made with a line drawn through the incorrect information, a notation, the date the correction was made, and the initials of the person altering the record. Correction fluid or tape is not allowed
• If a rubber-stamp signature authenticates the entry, the individual whose signature the stamp represents is accountable for the use of the stamp.
• Document language or cultural needs.
• Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member's first language is something other than English.
• Procedure for monitoring and handling missed appointments is in place.
• An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives.
• Include a signed and dated acknowledgment of informed consent of proposed treatment from the member or member's legal guardian/custodian.
• Include a list of significant illnesses and active medical and behavioral health conditions.
• Include a list of prescribed and over-the-counter medications. Review it annually.*
• Document the presence or absence of allergies or adverse reactions.*
• Obstetric care providers must also complete a risk assessment tool for obstetric patients (i.e., Mutual Insurance Company of Arizona Risk Assessment Tool [MICA] or ACOG). Lab screenings for members requiring obstetric care must also conform to ACOG guidelines.
• Documentation that physician or other care provider has notified each member of reproductive age verbally or in writing of the family planning services available.
• Documentation of review of the CSPMP database prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances.
• If assistants are allowed to provide services, the member's record must contain documentation indicating supervision by a licensed professional authorized by the licensing authority to provide the supervision.</td></tr>
</table>

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<table>
<tr><th>Topic</th><th>Contact</th></tr>
<tr><td>History</td><td>An initial history (for members seen three or more times) and physical is performed. The initial history for members younger than 21 years should also include prenatal care and birth history. It should include:

Medical, dental, laboratory, behavioral and surgical history* that includes disabilities, immunizations and serious accidents.
A family history that includes relevant medical and behavioral history of parents and/or siblings
A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance abuse use/history beginning at age 11
Current and history of immunizations of children, adolescents and adults which must be maintained in a separate immunization record.

For all adult members 21 years and older, the record must show the member’s immunization status for Tb.
For all female members of childbearing age, the record must show blood titer and/or immunization status for rubella.
For members 65 years and older, include immunization status for influenza and pneumococcal.
For at-risk DD/ALTCS EPD members, include immunization status for influenza and pneumococcal.
For all high-risk members 21 years and older, include immunization status for influenza pneumococcal and/or hepatitis B.
For members younger than 21 years, include immunizations given according to CDC recommendations. If no record is available, include documentation about immunization status. For example, state who reported the status and that the copy was requested for the medical records.

Screenings of/for:

Recommended preventive health screenings/tests
Depression
High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit
Medicare members for functional status assessment and pain
Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

PCPs, pediatricians, and OB/GYN care providers should utilize standard validated screening instruments to assess for:

Behavioral health needs
Trauma
Social determinants of health (SDOH)
</td></tr>
</table>

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Topic	Contact
Problem Evaluation and Management	Documentation for each visit includes: • Appropriate vital signs (Measurement of height, weight, and BMI annually) - **Chief complaint*** - **Physical assessment*** - **Diagnosis*** - **Treatment plan*** • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines. • Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT). • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets. • Treatment plans are consistent with evidence-based care and with findings/diagnosis: - Timeframe for follow-up visit as appropriate - Appropriate use of referrals/consults, studies, tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review. • There is evidence of care provider follow-up of abnormal results. • Unresolved issues from a previous visit are followed up on the subsequent visit. • There is evidence of coordination with behavioral health care provider. • Education, including lifestyle counseling, is documented. • Member input and/or understanding of treatment plan and options is documented. • Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented.

***Critical element**

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Medical record maintenance

Medical records shall be maintained by the care provider who generates the record. Retain the original or copies of member medical records as follows:

- **Adult:** for at least six years after the last date the adult member received care services
- **Child:** either for at least three years after the child's 18th birthday or for at least six years after the last date the adult member received care services, whichever occurs later.

Sharing medical records and information

You must comply with the following standards:

- Appropriate and confidential exchange of member information among care providers, including behavioral health care providers to help ensure:
  - A care provider making a referral transmits necessary information to the care provider receiving the referral.
  - A care provider furnishing a referral service reports appropriate information to the referring care provider.
- You must request information from other treating care providers as necessary to provide appropriate and timely care.
- Sharing medical records and information may be requested by any health plan representative, such as quality management, case management or medical management, at no additional charge.
- Information about services provided to a member by a non-network care provider (e.g., emergency services, behavioral health) is transmitted to the member's PCP.
- When a member chooses a new PCP within the network, the member's records are transferred to the new care provider within 10 working days of the change continuity of care, or if a member subsequently enrolls with a new health plan, sharing of member information is accomplished in a manner to keep it confidential while promoting continuity of care.
- Information form, or copies of records may be released only to, authorized individuals. You must help ensure unauthorized individuals cannot gain access to, or alter, member records.
- Original medical records must be released only based on federal or state laws, AHCCCS policy and contracts, compliance with the Health Insurance Portability and Assurance Act (HIPAA) requirements and 42 CFR § 431.300 el seq.
- Confidentiality of member information must be protected by the policy and/or procedures as required by law. There must be documentation that office staff are informed of and agree to confidentiality standards.
- Records for members transitioning to a new contractor must be shared in a way that keeps it confidential while promoting continuity of care.

Health information exchange

Health information exchange (HIE) connects care providers' electronic health record (EHR) systems, helping you securely share patient information and better coordinate care. Health Current is Arizona's health information exchange organization.

EHR benefits for care providers include:

- Better access to patient information.
- More efficient workflow.
- Improved clinical support.

Members benefit with:

- Better quality care.
- Improved patient safety.
- A more private and secure environment for storing member health data.

For more about EHRs, go to contexture.org

Medical record review

On an ad hoc basis, we conduct a review of our members' medical records. You must respond to information requests within 10 business days. We expect you to achieve a passing score of 85% or better. To achieve this score, the medical records you maintain should contain an initial health assessment, including a baseline comprehensive medical history. This assessment should be completed in less than two visits, with ongoing physical assessments occurring on

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following visits. It should also include:

- Problem list with:
  - Biographical data with family history.
  - Past and present medical and surgical intervention.
  - Significant medical conditions with date of onset and resolution.
  - Documentation of education/counseling regarding HIV pre- and post-test, including results.
- Entries dated and the author identified.
- Legible entries.
- Medication allergies and adverse reactions (or note if none are known).
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen three or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record.
- Tobacco habits, alcohol use and substance abuse (12 years and older).
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one.
- History of physical examination (including subjective and objective findings).
- Unresolved problems from previous visits addressed in subsequent visits; diagnosis and treatment plans consistent with finding.
- Lab and other studies as appropriate.
- Member education, counseling and/or coordination of care with other care providers.
- Notes regarding the date of return visit or other follow-up.
- Consultations, lab, imaging and special studies initialed by PCP to indicate review.
- Consultation and abnormal studies including follow-up plans.

Member hospitalization records should include, as appropriate:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- Documentation of appropriate preventive screening and services
- Documentation of behavioral health assessment (CAGE-AID, TWEAK AND PHQ-9)

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Chapter 12: Quality management program and compliance information

Key contacts

Topic	Link	Phone Number
Credentialing	Medical: • Network Management Support Team and chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. • CAQH: **caqh.org** Chiropractic: **myoptumhealthphysicalhealth.com** Behavioral Health: **providerexpress.com** > Join Our Network	**1-877-842-3210**
Fraud, Waste and Abuse (Payment Integrity)	**UHC.com/fraud**	**1-800-455-4521**

What is the Quality Improvement program?

UnitedHealthcare Community Plan's comprehensive Quality Improvement program falls under the leadership of the CEO and the chief medical officer. A copy of our Quality Improvement program is available upon request.

The program consists of:

- Identifying the scope of care and services given
- Developing clinical guidelines and service standards
- Monitoring and assessing the quality and appropriateness of services given to our members based on the guidelines
- Promoting wellness and preventive health, as well as chronic condition self-management
- Maintaining a network of care providers that meets adequacy standards
- Striving for improvement of member health care and services
- Monitoring and enhance patient safety
- Tracking member and care provider satisfaction and take actions as appropriate

As a participating care provider, you may offer input through representation on our Quality Improvement Committees and your care provider services representative/provider advocate.

Cooperation with quality-improvement activities

You must comply with all quality-improvement activities. These include:

- Providing requested timely medical records.
- Cooperating with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.

Care provider satisfaction

Every year, UnitedHealthcare Community Plan conducts care provider satisfaction assessments as part of our quality improvement efforts. We assess and promote your satisfaction through:

- Annual care provider satisfaction surveys.
- Regular visits.
- Town hall meetings.

Our chief concern with the survey is objectivity. That's why UnitedHealthcare Community Plan engages the independent market research firm Center for the Study of Services (CSS) to analyze and report findings.

Survey results are reported to our Quality Management Committee. It compares the results year over year as well as to other UnitedHealthcare Community Plan plans across the country. The survey results include key strengths and improvement areas. Additionally, we carry out improvement plans as needed.

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Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. You are encouraged to visit the following website to view the guidelines, as they are an important resource to guide clinical decision-making.

UHCprovider.com/cpg

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable AHCCCS statutes and the NCQA. As a participant of the Arizona Association of Health Plans (AzAHP), we also use the Council for Affordable Quality Healthcare (CAQH) Universal Provider Data Source. The following items are required to begin the credentialing process:

- A completed credentialing application, including Attestation Statement
- A completed Request for Participation Form from the National Credentialing Center
- Current medical license
- Current Drug Enforcement Administration (DEA) certificate
- Current professional liability insurance

We verify information from primary sources regarding licensure, education and training. We also verify board certification and malpractice claims history.

Credentialing and recredentialing process

UnitedHealthcare Community Plan's credentialing and recredentialing process determines whether you are a good fit for the UnitedHealthcare Community Plan provider network. You must go through the credentialing and recredentialing process before you may treat our members. New and existing care providers are re-credentialed with the AzAHP credentialing process.

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- MDs (Doctors of Medicine)
- DOs (Doctors of Osteopathy)
- DDSs (Doctors of Dental Surgery)
- DMDs (Doctors of Medical Dentistry)
- Affiliated Practice Dental Hygienists
- DPMs (Doctors of Podiatric Medicine)
- ND or NMD (Naturopaths)
- NP (Nurse Practitioners)
- PA (Physician Assistants)
- DCs (Doctors of Chiropractic)
- CNMs (Certified Nurse Midwives) acting as PCPs, including prenatal care/delivering care providers
- Psychologists
- Optometrists
- Certified Registered Nurse Anesthetists
- Occupational Therapists
- Speech and Language Pathologists
- Physical Therapists
- Independent Behavioral Health professionals who contract directly with UnitedHealthcare Community Plan, including Licensed Clinical Social Workers (LCSW)
- LPC (Licensed Professional Counselor)
- LMFT (Licensed Marriage/Family Therapist)
- LISAC (Licensed Independent Substance Abuse Counselor)
- BCBAs (Board Certified Behavioral Analysts)
- Any non-contracted certified or licensed care provider that is rendering services and sees 50 or more of UnitedHealthcare Community Plan's members per contract year
- Covering or substitute oral health care providers that provide care and services to UnitedHealthcare Community Plan's members while providing coverage or acting as a substitute during an absence of the contracted care provider (covering or substitute oral health care providers should indicate on the claim form that they are the rendering care provider of the care or service)

Excluded from this process are practitioners who:

- Practice only in an inpatient setting,
- Hospitalists employed only by the facility; and/or
- NPs and PAs who practice under a credentialed UnitedHealthcare Community Plan care provider.

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Cooperation with quality-improvement activities

You must comply with all quality-improvement activities. These include:

- Providing requested timely medical records.
- Cooperating with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.

Care provider satisfaction

Every year, UnitedHealthcare Community Plan conducts care provider satisfaction assessments as part of our quality improvement efforts. We assess and promote your satisfaction through:

- Annual care provider satisfaction surveys.
- Regular visits.
- Town hall meetings.

Our chief concern with the survey is objectivity. That's why UnitedHealthcare Community Plan engages the independent market research firm Center for the Study of Services (CSS) to analyze and report findings.

Survey results are reported to our Quality Management Committee. It compares the results year over year as well as to other UnitedHealthcare Community Plan plans across the country. The survey results include key strengths and improvement areas. Additionally, we carry out improvement plans as needed.

Care providers subject to credentialing and recredentialing

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- Hospitalists employed only by the facility; and/or
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Health facilities

Facility care providers such as hospitals, home health agencies, skilled nursing facilities and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements.

Facilities must meet the following requirements or verification:

- State and federal licensing and regulatory requirements and NPI number.
- Have a current unrestricted license to operate.
- Have been reviewed and approved by an appropriate accrediting body as specified by CMS.
- Have malpractice coverage/liability insurance that meets contract minimums.
- Agree to a site visit if not accredited by the Joint Commission (JC) or other recognized accrediting agency.
- Have no Medicare/Medicaid sanctions

UnitedHealthcare Community Plan does not make credentialing and recredentialing decisions based on race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes.

The National Credentialing Center (NCC) completes these reviews. Find applications on the CAQH website.

Go to **UHCprovider.com/join** to submit a participation request. For chiropractic credentialing, call **1-800-873-4575** or go to **myoptumhealthphysicalhealth.com**.

Submit the following supporting documents to CAQH after completing the application:

- Curriculum vitae
- Medical license
- DEA certificate
- Malpractice insurance coverage
- IRS W-9 Form

Peer review

Provider Advisory Committee

The Provider Advisory Committee (PAC) evaluates and monitors quality, continuity, accessibility, availability, utilization and medical care, The committee also monitors peer review activities, reviews and accepts the National Credentialing Plan and regulatory requirements and provides oversight by the Credentialing Committee for credentialing and recredentialing. It also monitors performance on clinical indicators such as Quality of Care investigations, AHCCCS and DD performance measures — and makes recommendations as appropriate.

Credentialing process

A peer review committee reviews all credentialing applications and makes a final decision. The decisions may not be appealed if they relate to mandatory criteria at the time of credentialing. We will notify you of the decision in writing within 60 calendar days of the review. In addition, we take part in the Arizona Association of Health Plans (AzAHP), which uses the CAQH Universal Provider Data Source for all practitioner credentialing and re-credentialing applications.

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every three years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website. Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have three chances to answer the request before your participation privileges are terminated.

Performance review

As part of the recredentialing process, UnitedHealthcare Community Plan looks in its Quality Management database for information about your performance. This includes member complaints and quality of care issues.

Applicant rights and notification

You have the right to review information you submitted to support your credentialing/recredentialing application. This excludes personal or professional references or

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peer review protected information. You have the right to correct erroneous information you find. Submit updated information directly to your CAQH credentialing application. If the NCC finds erroneous information, a representative will contact you by phone or in writing. You must submit corrections within 30 days of notification by phone, or in writing to the number or address the NCC representative provided.

You also have the right to receive the status of your credentialing application, please Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page.

Confidentiality

All credentialing information collected during the review process is kept confidential. It is only shared with your approval or as required by law with those involved in the credentialing process.

HIPAA compliance – your responsibilities

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 aims to improve the efficiency and effectiveness of the United States health care system. While the Act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have had the greatest impact on how the health care industry works. UnitedHealthcare Community Plan is a "covered entity" under these regulations. So are all health care professionals who conduct business electronically.

Transactions and code sets

If you conduct business electronically, submit claims using the standard formats adopted under HIPAA. Otherwise, submit claims using a clearinghouse.

Unique identifier

HIPAA also requires unique identifiers for employers, health care professionals, health plans and individuals for use in standard transactions.

National Provider Identifier

The NPI is your standard unique identifier. It is a 10-digit number with no embedded intelligence that covered entities must accept and use in standard transactions. While HIPAA only requires you to use the NPI in electronic transactions, many state agencies require it on FFS claims and on encounter submissions. For this reason, UnitedHealthcare Community Plan requires the NPI on paper transactions.

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES). Share it with all affected trading partners, such as care providers to whom you refer patients, billing companies and UnitedHealthcare Community Plan.

Privacy of individually identifiable health information

The privacy regulations limit how health plans, pharmacies, hospitals and other covered entities can use members' medical information. The regulations protect medical records and other identifiable health information. This includes electronic, paper or spoken data.

They enhance consumers' rights by giving them access to their health information and controlling its inappropriate use. They also improve health care delivery by extending the privacy efforts of states and health systems to a national level.

Security

Covered entities must meet basic security measures:

- Help ensure the confidentiality, integrity and availability of all electronic PHI the covered entity creates,
- Protect against any reasonably anticipated threats, uses or disclosures of information not permitted or required under the Privacy Regulations, and
- Help ensure compliance with the security regulations by the covered entity's staff.

UnitedHealthcare Community Plan expects you to comply with all HIPAA regulations.

Find additional information on HIPAA regulations at **cms.hhs.gov**.

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Ethics and integrity

UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with you, members, suppliers and government officials and agencies. Making sound decisions as we interact with you, other health care care providers, regulators and others is necessary for our continued success and that of our business associates. It's also the right thing to do.

Compliance program

As a segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Community Plan Compliance 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 educating employees.
- Assessing compliance by monitoring and auditing.
- Responding to allegations of violations.
- Enforcing policies and disciplining confirmed misconduct or serious neglect of duty.
- Reporting mechanisms for workers to alert management and/or the Ethics and Integrity program staff to violations of law, regulations, policies and procedures, or contractual obligations.

UnitedHealthcare Community Plan has compliance officers for each health plan. In addition, each health plan has a compliance committee consisting of senior managers from key organizational areas. The committee provides program direction and oversight.

Reporting and auditing

Report any unethical, unlawful or inappropriate activity by a UnitedHealthcare Community Plan employee to a UnitedHealthcare Community Plan senior manager or directly to the Compliance Office.

Call the health plan Member Services number on the member's ID card to report a member issue, such as a quality of care concern. Quality of care concerns include, but are not limited to, abuse, neglect, opioid abuse and attempted suicide.

To facilitate the reporting process of questionable incidents involving members or care providers, call our **Fraud and Abuse line** or go to **UHC.com/fraud**.

Please refer to the Fraud, Waste and Abuse section of this manual for additional details about reporting waste and abuse.

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews to help ensure compliance with law, regulations and policies/contracts. When informed of potentially inappropriate or fraudulent practices within the plan or by you, UnitedHealthcare Community Plan will conduct an investigation. You must cooperate with the company and government authorities. This means giving access to pertinent records (as required by your applicable Care Provider Agreement and this manual) as well as access to office staff. If we establish activity in violation of law or regulation, we will advise appropriate governmental authorities.

If you become the subject of a government inquiry or investigation, or a government agency requests documents relating to your operations (other than a routine request for documentation), you must provide UnitedHealthcare Community Plan with the details. You must also reveal what triggered the inquiry.

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the State of Arizona to perform "individual and corporate extrapolation audits." This may affect all programs supported by dual funds (state and federal funding) as well as state-funded programs, as requested by AHCCCS.

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least three years after the child's 18th birthday or for at least six years after the last date the member received services from you, whichever date occurs later. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under

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review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

If any litigation, claim, negotiation, audit or other action involving the records has been started before the 10-year period ends, you agree to keep the records until one year after the resolution of all issues that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your Care Provider Agreement.

To help ensure members receive quality services, you must also comply with requests for on-site reviews conducted by the state. During these reviews, the state will address your capability to meet Arizona program standards.

You must cooperate with the state or any of its authorized representatives, the AHCCCS, the CMS, the Office of Inspector General, or any other agency prior-approved by the state, at any time during your Care Provider Agreement.

These entities may, at all reasonable times, enter your premises. You agree to allow access to and the right to audit, monitor and examine any relevant books, documents, papers and records to otherwise evaluate (including periodic information systems testing) your performance and charges.

We will perform reviews and audits without delaying your work. If you refuse to allow access, this will constitute a breach of your Care Provider Agreement.

Delegating and subcontracting

If you delegate or subcontract any function, the delegate or subcontractor must include all requirements of your applicable Care Provider Agreement and this manual.

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of care (QOC) and services concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated.

We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all PCP office sites to help ensure facility quality.

UnitedHealthcare Community Plan requires you and your facilities meet the following site standards:

- Clean and orderly overall appearance.
- Available handicapped parking.
- Handicapped accessible facility.
- Available adequate waiting room space
- Adequate exam rooms for providing member care.
- Privacy in exam rooms.
- Clearly marked exits.
- Accessible fire extinguishers.
- Post file inspection record in the last year.

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Criteria for site visits

The following table outlines the criteria used to require a site visit. When the threshold is met, we conduct a site visit according to UnitedHealthcare Community Plan policy.

QOC Issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	1 complaint
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	2 complaints in 6 months
Other	All other complaints concerning the office facilities	3 complaints in 6 months

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Chapter 13: Billing and Submission

Key contacts

Topic	Link	Phone Number
Claims	**UHCprovider.com/claims** **UHCprovider.com/azcommunityplan** > Contact Us	• ALTCS EPD: **1-800-377-2055** • ACC/DD: **1-800-445-1638**
National Plan and Provider Enumeration System (NPPES)	**nppes.cms.hhs.gov**	1-800-465-3203
EDI	**UHCprovider.com/EDI**	• ALTCS EPD: **1-800-377-2055** • ACC/DD: **1-800-445-1638**
Chat support	Available 7 a.m.–7 p.m. CT, Monday–Friday, Chat support can help with claims, prior authorizations, credentialing and member benefits.	

Our claims process

For claims, billing and payment questions, go to **UHCprovider.com**.

We follow the same claims process as UnitedHealthcare. See the Claims Process chapter of the Administrative Guide for Commercial, Medicare Advantage and DSNP on **UHCprovider.com/guides**.

Claims: From submission to payment

1. You submit EDI claims to a clearinghouse or paper claims to us. We scan paper claims.
2. All claims are checked for compliance and validated.
3. Claims are routed to the correct claims system and loaded.
4. Claims with errors are manually reviewed.
5. Claims are processed based on edits, pricing and member benefits.
6. Claims are checked, finalized and validated before sending to the state.
7. Adjustments are grouped and processed.
8. Claims information is copied into data warehouse for analytics and reporting.
9. We make payments as appropriate.

Claims reconsideration and appeals

If you think we processed your claim incorrectly, please see the Claims Reconsiderations, Appeals and Grievances chapter in this manual for next steps.

Your clean claims must include your NPI and federal TIN.

General billing guidelines

We only consider reimbursing claims if you met billing and coverage requirements. Submitting a referral does not guarantee we will pay you. Payment depends on the member's coverage on the date(s) of service, medical necessity, plan rules about limitations and exclusions, and UnitedHealthcare Community Plan policies. We don't reimburse excessive, inappropriate, experimental or non-covered charges. To comply with applicable standards, policies and law, we may adjust previous payments for services and audit claims. We may seek reimbursement for overpayments or offset future payments as allowed by law.

Payment for care providers

UnitedHealthcare Community Plan will not pay a claim initially submitted outside of the timely filing guidelines documented in this manual, or stated in your Agreement. Non-participating care providers have up to 180 days to submit an initial claim. Please review the Timely Filing information provided in Chapter 13 of this manual.

Fee schedule

Reimbursements also depend on the fee schedule, your Agreement and the procedure performed.

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AHCCCS rate codes

The rate codes found on member rosters refer to the member's eligibility category. Each member is eligible for a rate code that indicates their eligibility type, benefits and whether they are eligible for Medicare. Prior Period Coverage is indicated by a rate code ending in an alpha character. If you are a capitated PCP, the rate codes determine your per-member capitation payment. Updated AHCCCS rate codes can be found at azahcccs.gov in the AHCCCS Enrollment Rate Codes and Values.

Behavioral and physical health services financial responsibility

For members not enrolled in an integrated line of business:

Payment for covered behavioral health and physical health services is determined by the principal diagnosis on the claim, except in limited circumstances as described in attachment A of the AHCCCS Contractor Operations Manual (ACOM), Chapter 432.

If physical health services are listed on a claim with a principal diagnosis of behavioral health, the member's behavioral health program pays for covered physical health services as well as behavioral health services, regardless of the setting.

If behavioral health services are listed on a claim with a principal diagnosis of physical health, the member's medical/physical health program pays for covered behavioral health services as well as physical health services, regardless of the setting.

Payment responsibility for professional services associated with an inpatient stay is determined by the principal diagnosis on the claim. Payment responsibility for the inpatient facility claim and the associated services is not necessarily the same program.

Payment for an emergency department facility claim of an acute care facility is the responsibility of the member's insurance carrier, regardless of the principal diagnosis. Payment responsibility for professional services associated with the emergency department visit is determined by the principal diagnosis on the professional claim. Payment responsibility of the emergency department visit and the associated services is not necessarily the same program.

PCPs may treat a member's behavioral health condition if it falls within their scope of practice.

The MCO Capped Fee Schedule pays for physical and behavioral health services claims provided by an IHS or a Tribally owned and/or operated facility to Title XIX members whether enrolled in managed care or FFS.

Principal Diagnosis: The condition established to be chiefly responsible for the admission or care (as indicated by the Principal Diagnosis on a UB-04 claim form or the first listed diagnosis on a CMS 1500 claim).

The principal diagnosis is not the admitting diagnosis or any other diagnoses on the claim. Neither the admitting diagnosis nor other diagnoses should be used to assign payment responsibility.

Refer to the AHCCCS Contractor Operations Manual (ACOM), and the AdSS Operations Manual, Policy 432, for more information.

FQHC/RHC payment and billing information

UnitedHealthcare Community Plan pays the lesser of all-inclusive visit PPS rate or billed charges on a per claim basis. This replaces the previous reimbursement capped FFS fee schedule.

This affects AHCCCS Complete Care and Developmental Disabilities members. AHCCCS has established a care provider type for FQHCs, 638-FQHCs, FQHC Look-alikes (LAs) (C2), (C5) and RHCs (29). AHCCCS requires all FQHCs, FQHC LAs, and RHCs to reregister under the applicable care provider types. It also requires each clinic covered by the CMS FQHC, FQHC LA, or RHC designation to obtain a unique NPI not already associated with another active AHCCCS care provider ID.

FQHC/RHC locations

The FQHC/RHC location is the address attached to your AHCCCS NPI and care provider type C2, C5 or 29. The PPS rate will apply to services submitted at that address and NPI. Any services not provided at that location will be billed according to the AHCCCS FFS Care Provider Manual.

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FQHC/RHC billing and procedure codes

All FQHC, FQHC-LAs, and RHC visits must be billed using the CMS Form 1500 or the ADA Form. For reimbursements, AHCCCS has adopted HCPCS code T1015 for reporting physical health, behavioral health and dental visits. FQHC/RHC services should be reported on either a CMS 1500 claim form or an ADA claim form. A claim for an FQHC, 638-FQHC, FQHC-LA, or RHC visit must include all appropriate covered procedure codes describing the services rendered plus visit code T1015.

The following participating care provider information is required for all FQHC/RHC claim submissions:

- CMS 1500 Claim Form: Box 19
- ADA Claim Form: Field 35
- 837 Professional (Electronic Claim): Loop 2300 NTE.

A visit's reimbursement will be applied to the HCPCS code T1015. All underlying, covered services reported on the same claim will be bundled into the visit and valued at $0 with reason code CO 45.

Case management (T1016) is not an FQHC/RHC visit to be reimbursed at the all-inclusive per visit PPS rate. Case management is reimbursed at the MCO Capped Fee Schedule when provided by a care provider within their scope of practice. Excluding case management, the services of a Behavioral Health Technician (BHT) may qualify as a FQHC/RHC visit only when those services meet the requirements of 42 CFR Part 405, Subpart X. Behavioral health group therapy and/or any other services provided to a group do not satisfy the requirements of a face-to-face encounter and are not reimbursable at the all-inclusive per visit PPS rate.

Telehealth and telemedicine may qualify as a FQHC/RHC visit if it meets the requirements as specified in AMPM Policy 320-I.

Further billing instructions and examples regarding the referring care provider requirements are in the AHCCCS FFS Care Provider Manual, Chapter 10 FQHC/RHC addendum and AHCCCS Medical Policy Manual, Policy 670.

When billing Dual Complete or Dual Complete One, you must use the appropriate designated G-codes from CMS guidelines to receive the PPS payment. Submit the AHCCCS-required T1015 to the Medicaid secondary carrier with the primary EOB for processing and payment of the remaining PPS amount based on AHCCCS guidelines.

School billing guidelines

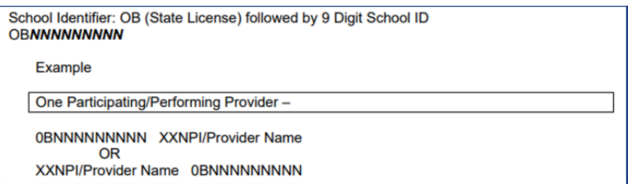
AHCCCS requires the place of service of the member for all services. The AHCCCS updated their **Fee-for-Service Provider Billing Manual Chapter 10 Addendum** for billing school place of service. Care providers using the CMS 1500 claim form (including those using digital billing) should follow these new guidelines or the state may deny claims.

The updated billing requirements include medical and dental services:

- List the clinic or RHC/FQHC as the rendering provider.
- List the 0B qualifier (indicates a state license) followed by:
  - The 9-digit **AHCCS County, Type, District, School (CTDS) identifier**
  - Do not put a space or other separator between 0B and the CTDS number
  - The XX qualifier and participating care provider NPI number and name

  Examples:

To report **1** participating health care professional


School Identifier: OB (State License) followed by 9 Digit School ID
OB***NNNNNNNNN***

Example

One Participating/Performing Provider –

0BNNNNNNNNN XXNPI/Provider Name
OR
XXNPI/Provider Name 0BNNNNNNNNN

To report **2** participating health care professionals

School Identifier: OB (State License) followed by 9 Digit School ID
OB***NNNNNNNNN***

Example

Two Participating/Performing Providers –

0BNNNNNNNNN XXNPI/Provider Name XXNPI/Provider Name
OR
XXNPI/Provider Name XXNPI/Provider Name 0BNNNNNNNNN.

AHCCCS-approved codes, units and values

Use valid and approved AHCCCS codes when submitting claims. This includes:

- Place of service codes.
- HCPCS codes.
- Revenue codes.
- CPT codes.

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- Modifiers.
- ICD-10 codes.

Additional requirements may apply to UB claims. See National Uniform Billing Manual (NUBC) for the UB-04.

We apply AHCCCS and DD billing and payment requirements to all claims submitted. For example, this applies to max-unit guidelines, age/gender guidelines, place of service/procedure combinations, duplicate claim billing, duplicate line-item, and revenue/procedure/modifier combination guidelines.

AHCCCS electronic visit verification

Based on Section 1903 of the Social Security Act, also known as the 21st Century Cures Act, AHCCCS implements EVV for the following services:

- Attendant care services
- Companion care
- Habilitation
- Home health services (services provided by the home health provider in a member's residence)
- Nursing
- Home health aid
- Physical therapy
- Occupational therapy
- Respiratory therapy
- Speech therapy
- Private duty nursing services
- Homemaker
- Personal care
- Respite services

EVV is mandatory as of Jan. 1, 2021.

Submit the attestation for services that **do not** require prior authorization through the AHCCCS online portal. Learn more at **azahcccs.gov/AHCCCS/Initiatives/EVV/**. To check if services require prior authorization, go to UHCprovider.com/azcommunityplan > **Prior Authorization and Notification**.

The AHCCCS-approved Statewide Closed-Loop Referral System (CommunityCares) is the preferred method for properly referring members to CBOs that provide services to address social risk factors of health. See Chapter 2 for more information.

EVV hard edit

The EVV hard edit will result in a claim denial for any in-scope claims not meeting the EVV requirements with dates of service beginning Jan.1, 2023. We encourage all care providers and agencies to review the **EVV Hard Edit Interactive Guide** at UHCprovider.com/AZcommunityplan > **Electronic Visit Verification** with their staff. Take any necessary steps to help ensure compliance with all EVV requirements to prevent unnecessary claim denials.

Gaps in direct care worker (DCW) reporting

The case manager will educate the member on how to work with the care provider to develop a contingency plan and report any gaps to their service provider or UnitedHealthcare Community Plan when the member experiences a short, late or missed visit. The development of the contingency/back-up plan is the responsibility of the care provider and member. The case manager will work with the member to develop a contingency/back-up plan for those receiving self-directed attendant care services.

Find more information about EVV in the **AMPM Policy 540**. This includes guidelines about:

- Paper timesheets
- EVV modalities
- EVV prior authorizations and service confirmation portal guidelines
- Contingency/back-up plan
- Reporting
- Provider requirements

Social determinants

AHCCCS has found using specific ICD-10 diagnosis codes representing SDOH is a valuable source of information that affects member health.

As appropriate, routinely screen for, and document, SDOH. Provide identified social determinant diagnosis codes on all claims for Community Plan members to comply with state and federal coding requirements beginning with dates of service on and after April 1, 2018.

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For more information about ICD-10 coding and SDOH protocol and how they apply to the members you treat, see the Specific Protocols chapter in the Administrative Guide for Commercial, Medicare Advantage and DSNP at **UHCprovider.com/guides**. You can also visit **UHCprovider.com/en/policies-protocols.html**. Under Additional Resources, choose Protocols > **Social Determinants of Health ICD-10 Coding Protocol**. Also see **azahcccs.gov** in the FFS Provider Manual.

Member ID card for billing

The member ID card has the UnitedHealthcare Community Plan member ID. UnitedHealthcare Community Plan suggests you bill with the member ID as shown on the member's ID card. UnitedHealthcare Community Plan ID cards reflect the member's Group ID number. However, this is not a required field. You may view a copy of the members ID card image using the Provider Portal online at **UHCprovider.com** while verifying member eligibility.

Acceptable claim forms

UnitedHealthcare Community Plan only processes claims submitted on CMS 1500, UB-04 claim forms as well as 837p or 837i electronic formats. For dental claims submitted on an ADA claim form or electronically submitted on 837d, see the claim information on **dbp.com**. Follow all billing guidelines and requirements.

Visit the **National Uniform Claim Committee Website** to learn more about how to complete the CMS 1500 claim form. The AHCCCS guidelines in the FFS Manual also include directions for completing the form. Refer to Chapter 5 on **azahcccs.gov**.

Use the most current claim form for ancillary services, ambulatory surgery centers and urgent care centers.

Use the UB-04 form for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other care providers.

The AHCCCS guidelines for completing the UB-04 form can be found in the AHCCCS FFS Manual, Chapter 6 on **azahcccs.gov**.

Submit claims and medical record attachments electronically, if possible. Paper claims can also be submitted to:

Medical:
UnitedHealthcare Community Plan
P.O. Box 5290
Kingston, NY 12402-5290

Behavioral:
United Behavioral Health
P.O. Box 30760
Salt Lake City, UT 84130-0760

Clean claims and submission requirements

The Arizona Revised Statutes says that a "clean claim" can be processed without obtaining additional information from the service care provider or from a third party. It does not include a claim from a provider under investigation for fraud or abuse or a claim we have selected for medical review. Network care providers must submit the initial claims submission within 90 days from the date of service or based on their contracted timely filing terms.

Submit any services completed by NPs or PAs who are part of a collaborative agreement. Use their tax ID and NPI, and we will process the claims just like other physicians'.

Non-participating care providers have 180 days from the date of service to submit an initial claim. You must submit a claim for secondary payment within 180 days from the claim's date of service, even if payment has not been received from the primary carrier. Please review the Coordination of Benefit section for more information. You have 365 days from the date of service, date of discharge or date of eligibility posting to correct and resubmit claims only if the initial submission time period has been met. Not adhering to these requirements will

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result in a denial.

We may require additional information for some services, situations or regulatory requirements.

Mail initial medical claims, medical record attachments and encounters to:

UnitedHealthcare Community Plan
P.O. Box 5290
Kingston, NY 12402-5290

Mail initial behavioral health claims, medical record attachments and encounters to:

United Behavioral Health
P.O. Box 30760
Salt Lake City, UT 84130-0760

Circumcision billing

Per the AHCCCS Medical Policy Manual (AMPM), Policy 410, AHCCCS only covers circumcision for FFS and contracted care providers as follows:

- Circumcision is only a covered service under EPSDT for male infants when it's determined to be medically necessary.
- According to A.R.S. § 36-2907, routine circumcision for newborn males isn't a covered service.
- You must submit a prior authorization request for all circumcision procedures, and UnitedHealthcare Community Plan must approve the request.

Circumcision services applies to all services billed. This includes anesthesia, medications, or evaluation and management. Please keep this in mind when preparing for circumcision procedures and submitting claims for those services.

Electronic claims submission and billing

You may submit claims by EDI. EDI offers less paperwork, reduced postage, less time spent handling claims and faster turnaround.

- Our payer ID is 03432.
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit.
- We follow the National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for CMS 1500 and UB-04 forms.

For more information, contact EDI Claims. You can also email ac_edi_ops@uhc.com or call Provider Services at **1-800-445-1638**. Or you may call ALTCS EPD Provider Services at **1-800-377-2055**.

Additional claim submission requirements for C&S Facet claims

Follow these tips for 837 formats:

1. Use the 2010AA Billing Provider loop when the billing and rendering care provider are the same.
2. Use the 2310B Rendering Provider loop when the rendering and billing care provider are NOT the same.
3. You may use the 2420A Rendering Provider Line Level when there are multiple rendering care providers. However, for claims that process on the CSP Facets system, use one rendering care provider per claim. Claims with multiple rendering care providers will have to be formatted at separate claims. Use the 2310B loop.

EDI companion documents

UnitedHealthcare Community Plan's companion documents are intended to share information within Implementation Guides (IG) adopted by HIPAA. The companion documents identify the data content requested when it is electronically transmitted. UnitedHealthcare Community Plan uses companion documents to:

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

The companion document provides general information and specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements.

The companion documents are located on UHCprovider.com/edi > Go to EDI Companion Guides.

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Clearinghouse and status reports

Software vendor reports only show the claim left your office and was either accepted or rejected. They don't confirm the claim status. Acknowledgment reports confirm the information you sent has been received. Review your reports, clearinghouse acknowledgment reports and the status reports to reduce processing delays and timely filing penalties.

For clearinghouse options, use our EDI at UHCprovider.com/edi > EDI Clearinghouse Options.

e-Business support

Call Provider Services for help with EDI: Electronic Remittance Advices (ERAs) and Electronic Funds Transfers (EFTs). For all of our claims and payment options, such as business support and EDI claims, go to Chapter 1 under Online Services.

To find more information about EDI online, go to UHCprovider.com/EDI.

UnitedHealthcare Community Plan remittance advice

All online transactions for members enrolled in ACC, DD, ALTCS, and Dual Complete/Dual Complete One will be accessible on UHCprovider.com as well as on the Provider Portal.

If you are not registered on UHCprovider.com, you may do so on the website. The following explains the fields found on the UnitedHealthcare claim remittance advice:

The box in the top right hand corner of the first page. The remit contains:

- **Payment Date:** The date the remit was issued
- **Payee Tax Number:** The TIN the claims were processed to pay under
- **Payee NPI:** The NPI of the Practice/Group
- **Payee ID:** Our internal ID associated with the Care Providers/Facility used to process the claims
- **Payee Name:** The name of the Practice/Group associated with the Care Provider/Facility used to process the claims
- **Payment Number:** The check number (if paper) or electronic reference number associated with the payment
- **Payment Amount:** The net paid amount of the remit
- **GRP ID:** The line of business associated with the processed claims on the remit
- **RA Reference ID:** The electronic reference number associated with the remit

The remit is sorted by group ID on subsequent pages. The group ID will appear. Within the remit, the claim information is listed for each member's date of service that was included on the remit. Please see the following for details regarding the information provided:

- **Patient:** The member's name (first, middle initial, last)
- **Subscriber ID:** The internal ID number assigned to this member's program with which the claim processed under. Please remember to submit claims to us with the ID number shown on the member's ID card.
- **Subscriber Name:** the name of the Subscriber (first, middle initial, last).
- **Prompt Pay Disc:** Prompt Pay Discount amount (if applicable)
- **Claim Number:** the claim number assigned. The last digit in the claim number will change as the claim is adjusted (01,02, etc.)
- **Patient Account:** The account number submitted on the claim
- **Member ID:** The member's AHCCCS ID number as shown on their card
- **Interest Amount:** The interest amount applied to qualified claims (if applicable)
- **PCP Number:** UnitedHealthcare Community Plan's internal ID number of the PCP assigned to this member
- **Remit Detail:** Indicates whether it is a Professional CMS 1500 or Institutional UB-04 claim
- **Product Desc:** Description of the product under which the claim processed
- **Servicing Prov NPI:** The rendering care provider's NPI
- **Servicing Prov NM:** The name of the rendering care provider applied to the submitted claim
- **Coverage Date:** The effective date we have listed for

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the member under this group

- **PCP Name:** The name of the PCP assigned to the member (last name, first name)
- **Billing NPI:** The pay to NPI provided on the submitted claim
- **COB Primary Ins:** The name of the member's primary insurance carrier
- **Policy Number:** The member's primary insurance policy number
- **Carrier ID:** Insurance carrier ID number

The individual line items we received on the claim image or in the electronic information provided are listed with the following processing details:

- **Date(s) Of Service:** The dates of service
- **Description of Service:** The procedure code modifier and place of service (POS). For UB-04 claims: procedure code, revenue code and bill type.
- **Units:** The number of units for each line item.
- **Billed Amt:** The billed amount for each line item.
- **Disallow Amt:** The amount that exceeds the rate. This amount is not billable to the member.
- **Discount Amt:** Calculated discount applied to qualified claims (if applicable).
- **Allowed Amt:** Amount allowed per UnitedHealthcare Community Plan agreement or non-participating rate
- **Deduct Amt:** Portion of payment for which the member may be responsible before benefit is payable.
- **Copay/Coins Amt:** A monetary amount a member may be required to pay directly to a care provider at the time a covered service is rendered. See more information in the Coinsurance section of this manual.
- **COB Pmt Amt:** (Coordination of Benefits) The amount of which other insurance has paid.
- **Withhold Amt:** Amount withheld, if any, according to the UnitedHealthcare Community Plan agreement
- **Paid to Care Provider Amt:** Amount paid after any applicable discounts, penalties or member responsibilities were applied
- **Patient Resp Amt:** The members responsibility amount
- **Auth#:** The authorization number on file used for processing the claim (if applicable)
- **RMK CD:** The Remark Code providing details regarding each lines individual processing or denial reason. These codes are explained within the same remit as shown below and are also available on our website.
- **GRP CD/RSN CD:** The Group Code or Reason Code providing details regarding each lines individual processing or denial reason. These codes are explained within the same remit as shown below and are also available on our website.
- **CARE PROVIDER TOTALS:** This includes a total of Billed amounts, Disallowed amounts, Discount Amounts, Members Not Covered Amount (from Patient Responsibility Amount), Allowed Amounts, Deduct Amounts, Copay/Coinsurance Amounts, COB Payment Amounts, Withhold Amounts, Paid to Care Provider Amounts, Authorization Number (see claim details), Interest Amounts, and Prompt Pay Discount Amounts.
- **PAYEE TOTALS:** This includes a total of Billed amounts, Disallow amounts, Discount amounts, Member Not Covered Amount (from Patient Responsibility Amount), Allowed Amounts, Deduct Amounts, Copay/Coinsurance Amounts, COB Payment Amounts, Withhold Amounts, Paid to Care Provider Amounts, Patient Responsibility Amounts, Authorization Number (see claim details), Interest Amounts, and Prompt Pay Discount Amounts.

The last few pages of the remittance advice provide more detail. Please review this information before taking action on a claim. Many denials or details about why a claim processed as it did are as follows:

- **REMARKS:** Provides details and explanation regarding the RMK Code (remark codes) listed for each line item.
- **Care Provider Communications:** A contact number for the Provider Services Center
- **National Provider Identifier Information:** Information regarding the national NPI guidelines and how you can update your NPI in our system.
- **Balance Billing:** The Arizona Administrative Code (A.A.C.) regarding billing UnitedHealthcare Community Plan members.
- **EDI, ERA, & EFT:** Contact information for our Electronic Data Interchange department. They can assist with your electronic payments and submissions.
- **UnitedHealthcare Community Plan Online Services:** Provides details on some resources available online
- **UnitedHealthcare Community Care Provider**

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Services: Provides details on some resources available

- **Corrected Claim Resubmissions and Claim Adjustments:** Definition/Explanation for Corrected Claim vs Claim Adjustment
- **COB Primary Carrier Information:** Provides information on where to review a member's primary carrier information
- **Claim Disputes:** Information regarding filing a Claims Dispute

Any recovery or overpayments applied or will be applied are listed in the Summary of Overpayments/Payments Recovered section. Only claims listed with a dollar amount in the Current Recovered column have been applied on this remit. The claims that still have an amount to recover are listed in the Remaining Amount column:

- **Overpayment Creation Date:** The date the overpayment was identified
- **Patient Last Name:** Member's last name
- **Patient First Name:** Member's first name
- **Member ID:** the internal ID number assigned to the member
- **Patient ACCT Number:** The care providers patient account number provided on the submitted claim
- **Claim Number:** The claim number assigned identified for recovery
- **Date(s) of Service:** The date of service identified for recovery
- **Original Overpayment Amount:** The total amount identified for recovery
- **Previously Deducted:** Any amount that has been previously recovered on prior remits
- **Current Recovered:** The amount recovered on this remit. This amount is subtracted from the Total Paid Amount, leaving the Net Paid Amount balance
- **Remaining Amount:** The amount flagged for overpayment that will be recovered at a later date/on another remit.
- **Total Deductions:** the total amount currently recovered
- **Total Overpayment Carried Forward:** The balance of overpayments listed in the Remaining Amount column
- **Total Paid to Care Provider:** The Net Paid Amount paid to Provider

You can view remits on UHCprovider.com and the Provider Portal.

Electronic payment solution: Optum Pay™

UnitedHealthcare Community Plan has launched the replacement of paper checks with electronic payments and will no longer be sending paper checks for payment. You will have the option of **signing up** for Automated Clearing House (ACH)/direct deposit, our preferred method of payment, or to receive a Virtual Card payment (Virtual Card). The only alternative to a Virtual Card is direct deposit. Both of these options allow you to get paid quickly and securely.

Why choose ACH/direct deposit?

- Direct deposit puts payment directly into your bank account
- Easy and fast way to get paid
- Improved financial control; no paper checks or remittance information to lose or misplace
- Ability to track information on online portal

What does this mean to you?

- If your practice/healthcare organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a Virtual Card will be automatically sent in place of paper checks.
- **To sign up** for the ACH/direct deposit option, go to UHCprovider.com/payment.
- If your practice/healthcare organization is already enrolled and receiving your claim payments through ACH/direct deposit from Optum Pay™ or receiving Virtual Cards there is no action you need to take.
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Library.
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to UHCprovider.com/payment.

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Completing the CMS 1500 claim form

Companion documents for 837 transactions are on UHCprovider.com. Click Resources, then Resource Library to find the EDI section.

Visit the National Uniform Claim Committee website to learn how to complete the CMS 1500 form. See also the AHCCCS FFS Provider Manual for submitting claims as well as the AHCCCS 837 EDI Companion Guide at azahcccs.gov.

HCBS submitted with dates of service spanning over more than one month must be split onto separate line items. See posted bulletin for more information. More information on corrected claim submission requirements and claim reconsiderations can be found in Chapter 14 of this manual.

Completing the UB-04 form

Visit CMS.gov, National Uniform Billing Committee, or the AHCCCS FFS Provider Manual, Chapter 6 for more information about how to complete the UB-04 form. Bill all hospital inpatient, outpatient and ER services using bill types and revenue codes as well as:

- Include ICD-10 diagnosis codes.
- Identify other services by the CPT/HCPCS and modifiers.

We may deny claims submitted with service dates that don't match the itemization and medical records. Inpatient claims require value codes.

Crisis and court-ordered evaluation billing requirements

When you submit a claim for crisis-related services, include a modifier ET (Emergency Treatment) and an Emergency Indicator of "Y" on Professional claims.

Court-Ordered Evaluations: Inpatient UB, Bill type ending in "0" which indicates zero payment; and/or Condition Code 04. Professional and Outpatient UB, include Modifier 32 (Mandated Service)

Court-Ordered Treatment: Inpatient UB, Admission Source/Point of Origin – 8 (Court or Law Enforcement). Professional and Outpatient UB, include Modifier H9 (Court-Ordered)

Group ID numbers

UnitedHealthcare Community Plan added a group ID number to the member ID cards. If submitting the member's group ID number, submit in box 11 of CMS 1500 claims form or box 62 of UB-04 claim form.

Claims for ALTCS EPD members will still require a Group ID number to be submitted on all claims. Review the ALTCS EPD chapter in this manual for more additional information.

Claim form reminders

- HCBS billed on a CMS 1500 claim form with dates of service that span over multiple months must be split showing separate months on separate line items or put on separate claim forms.
- Atypical providers must use their AHCCCS ID on claims forms if they do not have an NPI. If they have an NPI, the NPI is required instead of the AHCCCS ID.
- Note the attending care provider name and identifiers for the member's medical care and treatment on institutional claims for services.
- Send the referring care provider NPI and name on outpatient claims when this care provider is not the attending provider.
- Behavioral health care providers can bill using their site-specific NPIs.
- Ordering, referring, and supervising provider information may also be required in box 17 for certain services. See the AHCCCS FFS Provider Manual, Chapter 5 and 10.
- If more than one ordering or referring provider renders services, you may only list one on a paper CMS 1500 claim form. In this case, use the following priority order:
  - 1. Referring provider
  - 2. Ordering provider
  - 3. Supervising provider
  - The exception is if the services rendered **require** an ordering provider, as indicated in the AHCCCS

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FFS manual. Then the priority order would be:

- 1. Ordering provider
- 2. Referring provider
- 3. Supervising provider

AHCCCS will denies claims that include referring, ordering, prescribing or attending care providers who are not enrolled with AHCCCS. This is based on the Patient Protection and Affordable Care Act and the 21st Century Cures Act.

Coordination of benefits

Our benefits contracts are subject to coordination of benefits (COB) rules. We coordinate benefits based on the member's benefit contract and applicable regulations.

UnitedHealthcare Community Plan is the payer of last resort. Other coverage should be billed as the primary carrier. When billing UnitedHealthcare Community Plan, submit the primary payer's EOB or remittance advice with the claim.

Secondary claims must be received within six months (180 days) from the date of service, even if the primary carrier has not made payment. If the primary carrier makes payment after this time limit, a corrected claim must be resubmitted with the primary EOB. Claims are processed according to the AHCCCS requirements.

Per R9-22-1002, AHCCCS is not the payer of last resort when the following entities are the third party:

1. Indian Health Services contract health (IHS/638 Tribal plan);
2. Title IV-E;
3. Arizona Early Intervention Program (AzEIP);
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300; or
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et. seq. payer.
6. The Arizona Refugee Resettlement Program operated under 45 CFR Part 400, Subpart (G).

Per the AHCCCS FFS Provider Manual, Chapter 9; Community Plan's reimbursement responsibility is limited to the difference between the care provider's contracted rate (or the MCO Capped FFS rates for non-participating providers) and the amount of the first- or third-party liability.

An AHCCCS-registered care provider agrees to accept the contracted rate* as payment in full. If the first- or third-party coverage paid more than the provider's contracted amount*, UnitedHealthcare Community Plan makes no further reimbursement.

For example, a care provider bills $4,500 for a surgical procedure:

- The first-party plan allowed $1,388.23, paid $1,110.58 and shows a 20% coinsurance amount of $277.65.
- The care provider's contracted rate* allows $753.21 for the surgery.

UnitedHealthcare Community Plan makes no payment, as the care provider has already been paid more than their contracted* amount. The care provider must accept the $1,110.58 as payment in full. They cannot balance bill the member.

When the first-party payer is an HMO-type health plan, the same coordination of benefits process would apply. For example, a contracted HMO care provider bills $150 for an office visit.

- The HMO plan benefit has a member copay of $30, and the plan pays the contracted care provider $50.
- The care provider's contracted rate* allows $41.39 for the office visit.

UnitedHealthcare Community Plan makes no additional payment, as the care provider has already been paid more than their contracted rate*. The care provider must accept the $50 as payment in full. AHCCCS does not reimburse copays, deductibles or coinsurance amounts. If more than one coverage plan makes payment, and the total paid by the multiple coverage plans is more than the care provider's contracted rate*, there will be no payment. The care provider cannot balance bill the member for any amount.

If the first- or third-party payer denies a covered service, the care provider must follow the payer's appeal process and exhaust all remedies before we can consider the covered service. The care provider must submit a copy of plan's final appeal decision with the claim resubmission or the claim may be denied as incomplete.

*The MCO Capped FFS Schedule is used for non-participating care providers.

Medicare dual cost-sharing

Some UnitedHealthcare Community Plan members are eligible for both Medicaid and Medicare. Claims for

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dual-eligible members are paid based on the Medicare Cost Sharing for Members Covered by Medicare and Medicaid policy located in the **ACOM policy 201**. We are not responsible for cost-sharing should the payment from the primary payer be equal to or greater than what is received under Medicaid. More information is in the **Dual Complete Provider Manual**.

Hospital and clinic method of billing professional services

Hospital and clinics must bill for professional services on a CMS 1500. The servicing provider's NPI is in box 24J, their name is in box 31, and their group name is in box 33. The group NPI (if applicable) is in box 33a.

HCBS billed on a CMS 1500 claim form with dates of service that span over multiple months must be split showing separate months on separate line items or separate claim forms.

Global days

Global days include the billable period involving pre-operative visits, the procedure itself, and post-operative visits in which the care provider performs all necessary services. The visits must be performed by the same care provider or another care provider reporting the same TIN in either an inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), or physician's office.

For reimbursement, we follow CMS guidelines and the National Physician Fee Schedule (NPFS) Relative Value File to determine global days values. To learn more about billing for global days and their values, read our global days policy on UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > Reimbursement Policies for Community Plan > **Global Days Policy, Professional - Reimbursement Policy - UnitedHealthcare Community Plan**.

Correct Coding Initiative

UnitedHealthcare Community Plan performs coding edit procedures based on the Correct Coding Initiative (CCI) and other nationally recognized sources.

Comprehensive and component codes

Comprehensive and component code combination edits apply when a code pair appears to be related. These edits can be broken down to explain the bundling rationale. Some of the most common causes for these denials are:

- **Separate procedures:** Only report these codes when performed independently.
- **Most extensive procedures:** You can perform some procedures with different complexities. Only report the most extensive service.
- **With/without services:** Don't report combinations where one code includes and the other excludes certain services.
- **Medical practice standards:** Services part of a larger procedure are bundled.
- **Laboratory panels:** Don't report individual components of panels or multichannel tests separately.

Clinical Laboratory Improvements Amendments

Submit laboratory claims with the Clinical Laboratory Improvements Amendments (CLIA) number. In box 23 of the CMS 1500 claim form, enter the 10-digit CLIA certification number for laboratory services billed by an entity performing CLIA-covered procedures.

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. Laboratory service care providers who do not meet the reporting requirements and/or do not have the appropriate level of CLIA certification for the service reported may not be reimbursed. For more information about the CLIA number, call the CMS CLIA Central Office at 410-786-3531 or go to the **cms.gov**. Any claim that does not contain the CLIA ID, invalid ID and/or the complete servicing care providers demographic information will be considered incomplete. As a result, it may be rejected or denied.

Billing dental services

Send all dental service billing to UnitedHealthcare Dental using the current ADA claim form. Members cannot be billed for AHCCCS-covered services.

Members may request services from care providers AHCCCS does not cover. Those members must sign a

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release form stating that they understand the service is not covered under AHCCCS. The form must also state that members are responsible for the bill.

Submit claims through **UHCproviders.com**. Or send to:

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

Direct all dental claim inquiries to UnitedHealthcare Dental. Call **1-855-812-9208**. Check claim status at **UHCproviders.com**.

You must register using your UnitedHealthcare Dental provider ID, not with your AHCCCS ID. If you do not know your UnitedHealthcare Dental provider number, call UnitedHealthcare Dental at **1-855-812-9208**.

Billing multiple units

When billing multiple units:

- If the same procedure is repeated on the same date of service, enter the procedure code once with the appropriate number of units.
- The total bill charge is the unit charge multiplied by the number of units.

Your claim may require more information and medical records to support the units you are billing.

Billing guidelines for obstetrical services

Follow this reporting procedure when submitting obstetrical delivery claims. Otherwise, we may deny the claim. Find more information about OB Billing, including bundled and unbundled services, on **UHCprovider.com** in the Billing Resources and Reference Guides section.

- Use CPT Evaluation and Management codes (99201- 99215*) or OB visits (59425-59426) to report prenatal visits.
  - The beginning date of service is the first prenatal visit.
  - The ending date of service is the last prenatal visit prior to delivery.
  - Use one unit with the appropriate charge in the charge column.
- Use global delivery code (59400, 59519, 59610 and 59618).
- If the primary care obstetrician (PCO) provides prenatal services but does not perform the delivery, you must indicate that on the claim "Prenatal Visits Only." Or provide documentation that the care provider did not perform delivery.

*Only use CPT Evaluation and Management (E/M) Codes 99201-99215 when three or less prenatal visits are performed. Bill with up to three units.

Billing for long-acting reversible contraceptives

Effective with date of discharge on or after Oct. 1, 2016, LARC devices may be separately reimbursed outside the APR-DRG payment when billed by the hospital on a CMS 1500 claim form with the appropriate HCPCS procedure code. AHCCCS identifies LARC procedure codes as follows:

- J7297 levonorgestrel-releasing intrauterine contraceptive system, 52mg, 3-year duration
- J7298 levonorgestrel-releasing intrauterine contraceptive system, 52mg, 5-year duration
- J7300 intrauterine copper contraceptive
- J7301 levonorgestrel-releasing intrauterine contraceptive system, 13.5mg
- J7307 Etonogestrel (contraceptive) implant system, including implant and supplies

This does not apply to individuals on the Federal Emergency Services Program (FESP).

Refer to the AHCCCS FFS Provider Manual, Chapter 11 for more information.

Billing guidelines for transplants

AHCCCS covers medically necessary, non-experimental transplants as described in the Medical Policy Manual, Chapter 300, Policy 310-DD. We cover the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation.

We require transplant centers to coordinate and prepare the transplant packet containing all invoices for services related to the transplant. No invoices are to be billed outside the transplant packet by subcontractors or non-transplant department within the transplant organization. Claims not included in the packet may be denied.

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Care provider responsibilities

- Coordinate all professional services associated with the referenced transplantation services.
- Help ensure and facilitate all required referrals and evaluations needed to complete the pre-transplant evaluation process in a timely manner once the member is referred to the center as a possible candidate.
- Not providing medical documentation or obtaining prior authorization may result in denial of reimbursement.
- In a timely fashion, provide all information/ documentation requested at no additional charge.
- Help ensure subcontracted care providers do not bill the health plan directly for service reimbursed under this contract.
- Submit claims within six months of the date of service for all services provided to AHCCCS members relating to covered organ and tissue transplant services.
- Contractors are paid at the contracted rates for each covered component after the invoices for all medically necessary services relating to the at component have been submitted to AHCCCS. They must meet the clean claim criteria in A.R.S. 36-2904(H).
- Bill all medically necessary services provided to the transplant recipient related to the transplant using the appropriate diagnosis/CPT codes (see FFS Provider Manual, Chapter 24 on the AHCCCS website) and procedure/revenue codes, as appropriate to meet clean claim status:
  - **UB-04:** Submit all contracted transplant services provided by the facility, including accommodation days, organ acquisition, and related inpatient or outpatient hospital services on the UB-04 form using the proper revenue codes and bill types. Itemize services as they would be on any non-transplant encounter. Do not include physician or other non-facility services.
  - **CMS 1500**: Submit all physician and other professional services provided as part of the transplant contract, including transportation and medical supplies, on the CMS 1500 form using the proper CPT and HCPCS procedure codes. Itemize services as they would be on any non-transplant encounter.
  - **Universal Claim Form (UCF):** Submit on UCF any prescription drugs covered under the transplant contract.

Ambulance claims (emergency)

Ambulance claims must include the point of origin, destination address, city, state, and ZIP in box 32 (or its electronic equivalent) of the CMS 1500 claim form. List the accident state in box 10 (or its electronic equivalent). Non contracted ground ambulance care providers may need to submit medical records and trip tickets. See AHCCCS ACOM Policy 205.

National Drug Code

Claims must include:

- NDC and unit of measurement for the drug billed.
- HCPCS/CPT code and units of service for the drug billed.
- Actual metric decimal quantity administered.

Submit the NDC on all claims with procedure codes for care provider-administered drugs in outpatient clinical settings. The claims must show the NDC that appears on the product. Enter the identifier N4, the 11-digit NDC code, unit/basis of measurement qualified, and metric decimal quantity administered. Include HCPCS/CPT codes. View the AHCCCS NDC requirements on azahcccs.gov.

Medical necessity

UnitedHealthcare Community Plan only pays for medically necessary services. See Chapter 4 for more information about medical necessity.

Reimbursement policies

For reimbursement guidance for Community Plan members, view the current UnitedHealthcare Community Plan Reimbursement Policies and Clinical Practice Guidelines.

Place of Service codes

Go to azahcccs.gov for Place of Service codes and the AHCCCS FFS Provider Manual.

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Asking about a claim

You can ask about claims through UnitedHealthcare Community Plan Provider Services and the UnitedHealthcare Community Plan Provider Portal. To access the portal, go to UHCprovider.com. Follow the instructions to get a user ID. You will receive your user ID and password within 48 hours.

Provider Services

Provider Services helps resolve claims issues. Have the following information ready before you call:

- Member's ID number.
- Date of service.
- Procedure code.
- Amount billed.
- Your ID number.
- Claim number.

Allow Provider Services 30 days from date of contact, resubmission or reconsideration before asking about a claim. Limit phone calls to five issues per call.

UnitedHealthcare Community Plan Provider Portal

You can view your online transactions with the Provider Portal by signing in at UHCprovider.com with your One Healthcare ID. This portal offers you with online support any time. If you are not already registered, you may do so on the website.

The Provider Portal lets you move quickly between applications. This helps you:

- Check member eligibility.
- Submit claims reconsiderations.
- Review coordination of benefits information.
- Use the integrated applications to complete multiple transactions at once.
- Reduce phone calls and paperwork.

You can even customize the screen to put these common tasks just one click away.

Find Provider Portal training at UHCprovider.com/training.

Resolving claim issues

To resolve claim issues, call Provider Services, use the Provider Portal or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 5290
Kingston, NY 12402-5290

Allow up to 30 days for UnitedHealthcare Community Plan to receive payment for initial claims and 45 days to receive adjustment requests.

Chat support: Available 7 a.m.–7 p.m. CT, Monday–Friday, Chat support can help with claims, prior authorizations, credentialing and member benefits.

Timely filing

We will not pay a claim initially submitted outside the timely filing guidelines. The receipt date of the claim is the date stamp on the claim, the date electronically received or the date we received the claim. Claim submission deadlines are calculated from the claim end date of service, inpatient claim date of discharge or the effective date of eligibility posting, whichever is later.

Timely filing issues may occur if members give the wrong insurance information when you treat them. This results in receiving:

- A denial/rejection letter from another carrier.
- Another carrier's EOB.
- A letter from another insurance carrier or employer group saying the member either has no coverage or their coverage ended before the date of service.

All of these must include documentation the claim is for the correct member and the correct date of service. A submission report alone is not considered proof of timely filing for electronic claims. Please review the Valid Proof of Timely Filing section in this manual.

Submit secondary claims processed after Nov. 1, 2017 within 180 days of the date of service. This includes members with Medicare coverage. Claims are denied if they're submitted without an EOB from the primary carrier. You have 365 days from the date of service to resubmit the claim with an EOB from the primary carrier.

If a claim is rejected after submission and not processed for payment or denial, and a corrected claim is not received

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within 90 days from the date of service or based on the timely filing limits set forth in your Agreement, the claim is considered late billed. It is denied based on timely filing.

Timely filing limits can vary based on state requirements and Agreements. If you don't know your timely filing limit, refer to your Care Provider Agreement. If you are a non-participating care provider, refer to the AHCCCS FFS Care Provider Manual at azahcccs.gov for more details.

Timely Filing Proof for Paper Claims
Submit a screen shot from your billing software that shows when you submitted the claim. The screen shot must show the correct:

- Member name.
- Date of service.
- Claim date submission (within the timely filing period).

Timely Filing for Recovered Claims
The AHCCCS FFS Care Provider Manual, Chapter 4, A.R.S. § 36-2903.01 L requires us to conduct post-payment review of all claims and recover any money incorrectly paid. In some cases, We may need to recover money previously paid to a care provider.

We identify overpayments through reports, medical review, grievance and dispute decisions, internal audits and care provider-initiated recoveries.

Once the recovery is complete, the remittance advice details the action taken. If a payment is recovered for a reason other than third-party recovery (e.g., no medical documentation to substantiate services rendered), you have more time to provide justification for re-payment.

For recoupments, the time frame for submission of a clean claim differs from those described earlier in this chapter. The time allowed for resubmission of a clean claim is the greatest of:

- 12 months from date of service.
- 12 months from date of eligibility posting (for retro eligibility claim).
- 60 days from the date of the adverse action.

If the AHCCCS OIG starts the recovery as a result of identified misrepresentation, you do not have more time to resubmit a clean claim.

Billing members

If a member requests a service not covered by AHCCCS, have the member sign a release form showing they know they are responsible for all applicable charges. This form must be signed before they receive services.

A.R.S. § 36-2903.01 (K) states you cannot bill AHCCCS recipients, including QMB-only recipients, for AHCCCS-covered services or covered services denied for exceeding benefit limits. AHCCCS-registered care providers may charge AHCCCS members for services excluded from AHCCCS coverage. These services are provided in excess of AHCCCS limits, as otherwise described in A.A.C. R9-28-701.10(2).

Upon oral or written notice from the member they believe the claims are covered by the AHCCCS system, a care provider or non-provider of health and medical services prescribed in § 36-2907 should not do either of the following unless they have verified through the administration that the person has been determined ineligible, has not been determined eligible or was not eligible or enrolled at the time of services were rendered:

- Charge, submit a claim to, or demand or otherwise collect payment from a member or eligible person.
- Refer or report a member or eligible person to a collection agency or credit reporting agency for not paying charges for system covered care or services unless specifically pursuant to the statute.

QMB Dual is a person who is eligible under Article 2 of Chapter 29 of the A.A.C for QMB and acute care services provided for in 9 A.A.C. 22 or ALTCS services provided for in 9 A.A.C. 28. A QMB Dual person receives both Medicare and Medicaid services and cost-sharing help. Based on Article 2 of Chapter 29, QMB includes members defined in A.R.S. § 36-2971(5).

Copayments

Every AHCCCS member is assigned a copayment level that reflects their amount owed or not owed. Members may have nominal or mandatory copayments. Refer to the Glossary for the definition of mandatory vs non-mandatory copayments. Bill members at the time of service.

Copayments are **not charged** to the following people:

- Children younger than 19 years.
- People determined to be SMI.
- Individuals with a CRS designation.
- ACC members in nursing facilities, residential facilities such as an assisted living home, when placement is made instead of hospitalization. The exemption from copayments for ACC members is limited to 90 days in a contract year.

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- People enrolled in ALTCS EPD.
- QMB.
- Those who receive hospice care.
- Members in the Breast and Cervical Cancer Treatment Program (BCCTP).
- American Indian/Alaska Native members who are active or previous users of the Indian Health Service, Tribal health programs operated under Public Law 93-638, or urban Indian health programs.
- Individuals to whom child welfare services are made available under Part B of Title IV of the Social Security Act on the basis of being a child in foster care, without regard to age.
- Individuals to whom adoption or foster care assistance are available under Part E of Title IV of the Social Security Act, regardless of age.
- People who are pregnant and or postpartum.

These copayments are charged under Medicaid (AHCCCS). They do not mean a person is exempt from Medicare copayments.

Members must be told about any copay changes before they happen. In addition, copayments are never charged for the following services:

- Hospitalizations.
- Emergency services.
- Family planning services and supplies.
- Pregnancy-related health care and for any other medical condition that may complicate the pregnancy, including tobacco cessation.
- Services paid on a FFS basis.
- Preventive services, such as well visits, immunizations, pap smears, colonoscopies, and mammograms.
- Care provider preventable services.

Non-mandatory, nominal (low) copays for some AHCCCS programs

Most people who get AHCCCS benefits may pay the following nominal copayments for medical service:

Service	Copayment
Prescriptions (per drug)	$2.30
Outpatient services for physical, occupational, and speech therapy	$2.30
Doctor or other care provider outpatient office visits for evaluation and management of your care	$3.40

People with required copayments

Members eligible for AHCCCS through the Transitional Medical Assistance (TMA) program have mandatory copayments for the following services:

Service	Copayment
Prescriptions (per drug)	$2.30
Doctor or other care provider outpatient office visits for evaluation and management of your care	$4.00
Physical, occupational and speech therapies	$3.00
Outpatient non-emergency or voluntary surgical procedures.	$3.00

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

Members with copays will not pay more copayments once the total amount of the copays the family has made is more than 5% of the family's gross family income (before taxes and deductions) during a calendar quarter year (January through March, April through June, July through September, and October through December). AHCCCS will track each member's copayment levels by service type to identify those who have reached the 5% copayment limit.

Except for prescription drugs, only one copay may be assessed for services received during a visit. If the coding for the visit falls within more than one copayment category, the member pays the highest copayment amount.

Copayments and exceptions for other groups may change.

Prescriptions are covered at participating pharmacies. A list of participating pharmacies is at UHCprovider.com. You can also get one by calling Provider Services.

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Balance billing

Do not balance bill members if:

- The charge amount and the UnitedHealthcare Community Plan fee schedule differ.
- We deny a claim for late submission, unauthorized service or as not medically necessary.
- Services are covered and rendered during an eligible visit.
- We are reviewing a claim.

You may balance bill the member for non-covered services if the member provides written consent prior to getting the service. If you have questions, please contact your provider advocate.

To find your provider advocate, chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page.

Third-party resources

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible members. Therefore, you must bill and obtain an explanation of benefits (EOB) from any other insurance or health care coverage resource before billing UnitedHealthcare Community Plan, as required by contract. Refer to your Agreement for third-party claim submission deadlines. Once you bill the other carrier and receive an EOB, the claim may then be submitted to UnitedHealthcare Community Plan. Please attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or denial reason.

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Chapter 14: Claim reconsiderations, care provider dispute, member appeals and grievances

For claims, billing and payment questions, go to UHCprovider.com.

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your Care Provider Agreement.

These definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements.

UnitedHealthcare Community Plan and its in-network care providers may agree to more stringent requirements within Care Provider Agreements than described in the standard process. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

Denial

Your claim may be denied for administrative or medical necessity reasons.

An **administrative denial** is when we didn't get notification before the service, or the notification came in too late.

Denial for **medical necessity** means the level of care billed wasn't approved as medically necessary.

If a claim is denied for these reasons, you may be able to request a claim reconsideration or file a dispute.

Other top reasons for denial include:

Duplicate claim – This is one of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.

Claim lacks information. Basic information is missing, such as a person's date of birth; or information incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information.

Eligibility expired. Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.

Claim not covered by UnitedHealthcare Community Plan. Another claim denial you can avoid is when procedures are not covered by us. You can easily avoid this problem by using real-time verification.

Time limit expired. This is when you don't send the claim in time.

Claim correction

What is it?

You may need to update information on a claim you've already submitted. A corrected claim replaces a previously processed or denied claim submitted in error.

When to use:

Submit a corrected claim to fix or void one that has already processed. Submit corrected claims within one year from the date of service, or as otherwise stated in your Agreement.

How to use:

Use the claims submission application on the Provider Portal. To access the Provider Portal, sign in to UHCprovider.com using your One Healthcare ID. You may also submit the claim by mail with the appropriate frequency code or bill type as shown below. Allow up to 30 days to receive payment for initial claims and a response.

For medical claims, mail to:

UnitedHealthcare Community Plan
P.O. Box 5290
Kingston, NY 12402-5290

Submit corrected dental claims to:

UnitedHealthcare Community Plan
Corrected Claims
P.O. Box 481
Milwaukee, WI 53201

Additional Information:

Enter the appropriate frequency code or bill type to indicate whether the claim is a resubmission of a

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previously processed claim or a void request of a previously processed claim. Enter the Original Claim Number of the claim being corrected, replaced or voided as shown below.

When submitting a corrected electronic CMS 1500 claim, be sure to:

- **Loop 2300 (Claim Information), Segment CLM**
  - Use CLM05-3- '7' or "H" to process as a replacement claim and reverse the original claim on file.
  - Use CLM05-3- '8' to void the original claim on file. Any previous payments will be recouped.
- **REF*F8 ; must include the original claim number ID**
  - Confirm the original claim reference number (CRN) does not have additional characters. This means if the original claim ID is 22A23xxxxxxx, additional characters such as CLM 22A23xxxxxxx are incorrect.

When submitting a corrected paper CMS 1500 claim, along with the UB-04 information, be sure to include:

- **Box 22 - Claim Resubmission Code**
  - Use the appropriate resubmission code:

    1 – Original claim submission

    7 or H – Replacement

    8 – Void
- **Box 22 – Original Ref. Num. (Claim ID)**
  - Include the Original Claim Number. Do not include additional characters. This means if the original claim ID is 22A23xxxxxxx, additional characters such as CLM 22A23xxxxxxx are incorrect.

Corrected claims submitted without this information are rejected and not processed in the claims system. For a list of rejected claims, refer to the claim rejection report your clearinghouse provides.

If any previously paid lines are blanked out or removed the system will assume that those lines should not be considered for reimbursement and payment will be recouped. When submitting a corrected claim, you must resubmit any documentation that was sent with the denied or previously paid claim. See AHCCCS FFS Care Provider Manual, Chapter 4.

Resubmitting a claim

What is it?

When you resubmit a claim, you create a new claim in place of a rejected or denied one. A rejected claim has not been processed due to problems detected before processing.

When to use:

Resubmit the claim if it was rejected. Since rejected claims have not been processed yet, there is no dispute – the claim needs to be corrected through the claim reconsideration process. If submitting a corrected claim that is meant to replace a previously received and processed claim, follow the information provided in the Claim Correction section above.

Common Reasons for Rejected Claims:

Some of the common causes of claim rejections happen due to:

- Errors in member demographic data – name, age, date of birth, sex or address.
- Errors in care provider data.
- Wrong member insurance ID.
- No referring care provider ID or NPI number.
- Incorrectly submitted corrected claims either submitted with invalid frequency code or missing/ invalid original claim number.

How to use:

If a claim is originally received within 6 months, you have up to 12 months from the date of service to correctly resubmit the claim or adjust a processed claim, unless the claim involves retro-eligibility. If a claim is not clean, or is not adjusted correctly within 12 months, we are not liable for payment. Resubmit claims to:

UnitedHealthcare Community Plan
P.O. Box 5290
Kingston, NY 12402-5290

Claim reconsideration

What is it?

We are committed to improve the experience on all reconsiderations. Claim issues include overpayment, underpayment, denial, or an original or corrected claim determination you do not agree with can be addressed with a claim reconsideration. This request allows a full medical necessity review to be performed. A claim reconsideration request is the quickest way to address your concern about whether the claim was paid correctly without the need to file a formal claim dispute. When you send a reconsideration, please send additional support information.

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When to use:

Reconsiderations can be done repeatedly but should include new information each time. You have up to 12 months from the date of service to correctly resubmit the claim or adjust a previously processed claim, unless the claim involves retro-eligibility. If the claim is not clean or adjusted correctly within 12 months, we are not liable for payment.

For administrative denials:

- In your reconsideration request, please ask for a medical necessity review and include all relevant medical records.

For medical necessity denials:

- In your request, please include any additional clinical information that may not have been reviewed with your original claim.
- Show how specific information in the medical record supports the medical necessity of the level of care performed – for example, inpatient instead of observation.

How to use:

Use the claims reconsideration application on the Provider Portal. To access the Provider Portal, sign in to **UHCprovider.com** using your Optum ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

- **Electronically:** Use the Claim Reconsideration application on the Provider Portal. Include electronic attachments. You may also check your status using the Provider Portal.
- **Phone:** Call Provider Services at **1-800-445-1638** or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.
- **Mail:** Submit the Claim Reconsideration Request Form to the appropriate claims and medical record mailing address shown on the back of the member's ID card.

  This form is available at **UHCprovider.com/claims**.

Include all appropriate documentation to support the services provided when submitting the reconsideration request.

To submit a corrected claim or reconsideration, include:

- The claim.
- The remittance advice.
- Original Claim Number documented in Box 22.
- A completed Reconsideration Form with the reason for resubmitting the claim. Note any corrections. Sign and date the cover letter, and provide a contact phone number.

Send corrected claims with resubmission code 7 or bill type xx7.

Do not use this reconsideration process for DRG Outlier Payment Reconsideration. Please submit reconsiderations for DRG Outlier Payments to the address as documented on the letter received.

Tips for successful claims resolution

- Do not let claim issues grow or go unresolved.
- Call **Provider Services** if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim with the required indicators.
- File adjustment requests and claims disputes within contractual time requirements.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan. Secondary claims must be received within six months from the date of service, even if the primary carrier has not made payment. If the primary carrier makes payment after this time limit, a corrected claim must be resubmitted with the primary EOB. Claims are processed according to the AHCCCS Contractor Operations Manual (ACOM), Policy 434.
- When submitting reconsideration requests, provide the same information required for a clean claim. Explain the discrepancy, what should have been paid and why.
- Refer to your Agreement with us for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.
- Claims for dual-eligible members will be paid according

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to the ACOM Policy 201; Medicare Cost Sharing for Members Covered by Medicare and Medicaid. We are not responsible for cost-sharing should the payment to the primary payer be equal to or greater than what you would have received under Medicaid. Additional information regarding Medicare Cost Sharing is available in the Dual Complete Provider Manual.

Valid proof of timely filing documentation

What is it?

You may need to submit proof of timely filing if we have no record of receiving your claim. Proof may include:

- UnitedHealth Group correspondence (data entry send back letter) OR
- A computer-generated activity page/print screen listing the date the claim was submitted to UnitedHealthcare Community Plan. Submission must contain:
  - Member name and Identifying information
  - Date(s) of service
  - Billed amount
  - Date submitted to insurance
- Electronic Claims – Acceptance Report, must include:
  - Universal EDI acceptance code **A1:19** coding and an acceptance date within the timely filing period, OR
  - A combination of a version of the words **accepted by payer, acknowledged by payer or received by UnitedHealthcare Community Plan**
- A billing statement with the date you found out the member had UnitedHealthcare Community Plan
- Other insurance carrier Denial/Rejection EOB or letter (e.g., terminated coverage, not their member)
- A letter from an obstetrical provider indicating they could not complete all the services required to bill the global code, as the patient was no longer in their care or lost coverage.
- Primary carrier EOB showing payment. Secondary claims must be submitted within 180 days from date of service, even if primary carrier has not made payment. Once the primary carrier has paid, you may submit a reconsideration with the primary EOB within 365 days from the date of service.

A submission report is not proof of timely filing for electronic claims. It must be accompanied by an acceptance report. Timely filing denials are often upheld due to incomplete or wrong documentation submitted with a reconsideration request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use:

Submit a reconsideration request with a completed Reconsideration Form electronically, or by mail with your valid proof of timely filing from the options above.

Additional Information:

Reconsideration guidelines are available in the Reconsideration section provided previously in this chapter.

Overpayment

What is it?

An overpayment is a payment greater than amounts properly payable under applicable statutes and regulations. Notify UnitedHealthcare Community Plan of an overpayment. You may request an adjustment or a refund check.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the refund check within the time specified in your Agreement. If your payment is not received by that time, we may recover the overpayment and apply to future claim payments based on our Agreement and applicable law.

If you prefer we recoup the funds from your next payment, or you would like a repayment plan, call Provider Services.

If you prefer to mail a refund, send an Overpayment Return Check or the Overpayment Refund/ Notification form.

Also send a letter with the check. Include the following:

- Name and contact information for the person authorized to sign checks or approve financial decisions.
- Member identification number (e.g., ACC, DD, ALTCS EPD).
- Date of service.
- Original claim number (if known).
- Date of payment.

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- Amount paid.
- Amount of overpayment.
- Overpayment reason.
- Check number.

Where to send:

Mail refunds with an Overpayment Return Check or the Overpayment Refund/Notification form to:

UnitedHealthcare Community Plan
Attn: Recovery Services
P.O. Box 101760
Atlanta, GA 30392-1760

Instructions and forms are on UHCprovider.com/claims.

If you do not agree with the overpayment findings, submit a dispute within the AHCCCS-required time frame.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can file a dispute. See Dispute section in this chapter.

Sample overpayment report

***The information provided is sample data only for illustrative purposes.**
Please populate and return with the data relevant to your claims that have been overpaid.

Member ID	Date of Service	Original Claim #	Date of Payment	Paid Amount	Amount of Overpayment	Reason for Overpayment
11111	01/01/19	20A000000001	01/31/21	115.03	115.03	Double payment of claim
2222222	02/02/19	20A000000002	03/15/21	279.34	27.19	Agreement states $50, claim paid 77.29
3333333	03/03/21	21A000000003	04/01/21	131.41	99.81	You paid 4 units, we billed only 1
44444444	04/04/21	21C000000004	05/02/21	412.26	412.26	Member has other insurance
55555555	05/05/22	22F000000005	06/15/22	332.63	332.63	Member terminated

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Claims dispute

What is it?

You may file a claim dispute based on a claim denial, dissatisfaction with a claim payment, or recoupment action by UnitedHealthcare Community Plan. In agreement with AHCCCS guidelines, all claim disputes must be filed in writing within the time frame described as follows.

When to use:

If you do not agree with the outcome of the claim reconsideration decision, use the claim dispute process. All claim disputes challenging claim payments, denials or recoupments must be filed in writing with UnitedHealthcare Community Plan no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later.

How to use/file:

The dispute must state that you are filing a "dispute." To help ensure appropriate handling, do not refer to the matter as an appeal. The dispute must include the factual and legal basis for the relief requested, along with all supporting documentation. Please include a cover letter, medical records and any additional information, such as claim forms or remits. Send your information electronically or by mail. In your dispute, please include any supporting information not included with your reconsideration request.

- **Electronic claims:** Use Claims on the Provider Portal. You may upload attachments.
- **Mail:** Send the dispute to the following address.

  For Medicaid disputes:

  UnitedHealthcare Community Plan
  Attn: Claim Disputes Department
  1 East Washington, Suite 900
  Phoenix, AZ 85004

  For Dual Complete disputes: Please refer to the Dual Complete Care Provider Manual on UHCprovider.com for more information.

We deny incomplete submissions, or those which do not meet the dispute criteria. Find more on the claim dispute process in A.R.S. § 36-2903.01(8)(4), and the A.A.C. R9-34-401 et seq.

You should receive an acknowledgment letter for all claim disputes received within five business days. If you do not, please follow up with the Dispute Department.

If you disagree with our decision, you may request a hearing within 30 days of the decision. UnitedHealthcare Community Plan will forward the hearing request to AHCCCS, Office of Grievance and Appeals or DDD's Division of Administrative Review, based on the associated line of business.

Questions about your claims dispute or need a status update?

Call Provider Services for questions about your claims dispute or if you need a status update. If you filed your claims dispute online, you should receive a confirmation email or feedback through the secure Provider Portal.

Care provider grievance

What is it?

Grievances are complaints related to your UnitedHealthcare Community Plan policy, procedures or payments.

When to file:

You may file a grievance about:

- Benefits and limitations.
- Eligibility and enrollment of a member or care provider.
- Member issues or UnitedHealthcare Community Plan issues.
- Availability of health services from UnitedHealthcare Community Plan to a member.
- The delivery of health services.
- The quality of service.

How to file:

File verbally or in writing.

- **Phone:** Call Provider Services at **1-800-445-1638**
- **Mail:** Send care provider name, contact information and your grievance to:

  UnitedHealthcare Community Plan
  Medicaid Grievances
  1 East Washington, Suite 900
  Phoenix, AZ 85004

You may file a grievance regarding a peer review determination or action to the UnitedHealthcare Community Plan medical director by labeling "ATTN: Medical Director" and mailing it to the aforementioned address.

You may only file a grievance on a member's behalf with their written consent. See Member Appeals and Grievances Definitions and Procedures.

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Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses CMS definitions for member appeals and grievances.

Member appeals

What is it?

You may assist members in filing an appeal on their behalf with the member's written permission. The appeal may be filed either in writing or verbally and must be received within 60 calendar days from the date on the Notice of Adverse Benefit Determination letter. If you, on behalf of the member, believe the member's health or ability to function will be harmed unless a decision is made in the next 72 hours, the member or you can ask for an expedited appeal. For expedited appeals, call **1-800-348-4058**.

Reasons for filing an appeal include:

- The denial or limited authorization of a requested service, including the type of level of service.
- The reduction, suspension, or termination of a previous authorization.
- The denial, in whole or in part, or payment of a service.
- Not providing service in a timely manner.
- For residents of a rural area with only one health plan, the denial of the member's request to obtain services outside of the network.

You (with a member's written consent) or a member may appeal when the plan:

- Lowers, suspends or ends a previously authorized service.
- Refuses, in whole or part, payment for services.
- Fails to provide services in a timely manner, as defined by the state or CMS.
- Doesn't act within the time frame CMS or AHCCCS requires.

When to use:

You may act on the member's behalf with their written consent within 60 calendar days from the date of the Notice of Adverse Benefit Determination (NABD). You may provide medical records and certification of the appeal as appropriate.

Where to send:

You or the member may call or mail the information within 60 calendar days from the date of the Notice of Adverse Benefit Determination to:

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

Send UnitedHealthcare Dual Complete member appeals to:

UnitedHealthcare Dual Complete
Attn: Member Appeals
PO Box 31364
Salt Lake City, UT 84131-0364

Toll-free: **1-800-587-5187** (TTY **711**). For standard appeals, if you dispute by phone, you must follow up in writing, ask the member to sign the written dispute, and mail it to UnitedHealthcare Community Plan. Expedited appeals do not need to be in writing.

How to use:

Whenever we deny a service, we provide the member with UnitedHealthcare Community Plan member appeal rights. The member has the right to:

- Receive a copy of the rule used to make the decision.
- Present evidence, and allegations of fact or law, in person and in writing.
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal.
- Ask for an expedited appeal by calling 1-800-348-4058 if waiting for this health service could harm the member's health. You have two business days to represent evidence and allegations of fact or law in person and in writing.
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the care provider, you cannot ask for a continuation. Only the member may do so.

We resolve a standard appeal 30 calendar days from the day we receive it.

We resolve an expedited appeal within 72 hours from when we receive it.

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We may extend the response times up to 14 calendar days if the following conditions apply:

1. Member requests we take longer.
2. We request additional information and explain how the delay is in the member's interest.

Member consent must be included, in writing, with the submission.

An Authorization of Review (AOR) Form template is available in the General Forms section on UHCprovider.com/en/health-plans-by-state > arizona-health-plans > az-comm-plan-home > az-cp-forms-refs.

Member grievance

What is it?

A member's expression of dissatisfaction about UnitedHealthcare Community Plan and/or care provider about any matter other than an adverse benefit determination. This includes quality of care or service concerns. It includes a member's right to dispute the time UnitedHealthcare takes to make an authorization decision or dissatisfaction about anything other than a benefit determination. (See **Member Appeals**.)

They must be free from any punishment, restraint or seclusion for decisions pertaining to filing a complaint. Grievances are complaints related to UnitedHealthcare Community Plan policies and procedures.

When to use:

You may file a grievance as the member's representative with their written consent.

Where to send:

You or the member may call or mail the information anytime to:

Mailing address:

UnitedHealthcare Community Plan
Attn: Member Appeals and Grievances Unit
1 East Washington, Suite 900
Phoenix, AZ 85004

Dual Complete Member Appeals
Attn: Member Appeals Unit
P.O. Box 31364
Salt Lake City, UT 84131-0364

We will send an answer within 10 business days but no later than 90 calendar days from when you filed the complaint/grievance. Clinically urgent grievances are resolved within five business days, based on Exhibit F.1.14.

State fair hearings

What is it?

An administrative hearing available when UnitedHealthcare Community Plan does not favorably resolve a claim dispute or member appeal.

When to use:

For a claim dispute, a state fair hearing (SFH) must be filed within 30 calendar days from the receipt of the claim dispute Notice of Decision. For a member appeal, you have 120 calendar days from the receipt of the appeal Notice of Decision to file a SFH.

How to use:

Include in your request for a claim dispute hearing the claim dispute number from the Notice of Decision and the member's name. Clearly identify the request as a SFH. Include in your request for a member appeal hearing the member's name, ID number and written consent. Clearly identify the claim as a SFH. Mail the request to:

UnitedHealthcare Community Plan
State Fair Hearing Coordinator
Appeals & Claim Disputes Department
1 East Washington, Suite 900
Phoenix, AZ 85004

- If you submit SFH requests for DD members, submit according to the information provided on the Notice of Decision letter.
- AHCCCS will send the information on how the SFH will be handled, such as meeting date and time.
- AHCCCS will decide the outcome of the SFH.

Processes related to reversal of our initial decision

If the SFH outcome is to not deny, limit, or delay services while the member is waiting on an appeal, then we

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provide the services:

1. As quickly as the member's health condition requires or
2. No later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal.

If the SFH decides UnitedHealthcare Community Plan must approve appealed services, we pay for the services as specified in the policy and/or regulation.

Fraud, waste and abuse

Call the toll-free **Fraud, Waste and Abuse Hotline** to report questionable incidents involving plan members or care providers. You can also go to **UHC.com/fraud** to learn more or to report and track a concern.

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money we paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies according to state and federal law. We seek to protect the ethical and financial integrity of the company and our employees, members, care providers, government programs and the public. In addition, we aim to protect member health.

We use applicable federal and state regulatory requirements in our Anti-Fraud, Waste and Abuse Program. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we work with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

An important aspect of the Compliance Program is reviewing our operation's high-risk areas. Then we implement reviews and audits to help ensure compliance with law, regulations and agreements. You are contractually obligated to cooperate with the company and government authorities.

Find out how we follow federal and state regulations around false claims at UHCprovider.com/AZcommunityplan > **Integrity of Claims, Reports, and Representations to the Government.**

The Deficit Reduction Act (DRA) has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least $5 million in annual Medicaid payments must have written policies for entity employees and contractors. They must provide detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

This policy details our commitment to compliance with the federal and state false claims acts. It provides a detailed description of these acts and of organizational mechanisms that detect and prevent fraud, waste and abuse. It also details how whistleblowing employees are protected. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

AHCCCS has published to its DRA Training for Providers – that discusses care provider and member fraud. Any training must be appropriately documented and may be requested at any time by AHCCCS or UnitedHealthcare Community Plan. We encourage you have your staff review the **training seminar**.

In addition, based on your Agreement, you must cooperate with the review process and provide any requested medical records. This includes outreach meetings and/or written correspondence to care providers, record review and/or site audit, individual case peer-to-peer reviews, and referral for further investigation. Afterward, we monitor the practice patterns of an identified care provider to help ensure the potential fraud, waste or abuse practice pattern has been corrected.

As warranted, you will be reported to the Arizona

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Department of Insurance, licensing boards, and any other regulatory agencies based on the outcome of the investigation and as required by state and federal laws. Throughout this process, we adhere to state law, ERISA guidelines, and confidentiality standards.

Fraud and abuse policies and procedures

You must have established policies and procedures that meet AHCCCS requirements for reporting incidences of health care-acquired conditions, abuse, neglect, exploitation, injuries and unexpected death. The policies and procedures should specify the process of submitting a report of HCACs, abuse, neglect, exploitation, injuries and unexpected death.

Review our fraud and abuse policies on UHCprovider.com/azcommunityplan > Reporting Health Care Fraud, Waste and Abuse > **Integrity of Claims, Reports, and Representations to the Government**. The policy explains federal and state regulations around false claims, how we adhere to them, and how we protect whistleblowers.

Reporting fraud and abuse

If you are aware of any such actions, mail your documentation of the issue to:

UnitedHealthcare Community Plan Compliance Office
1 East Washington, Suite 900
Phoenix, AZ 85004

For Dual Complete plans and LTC, ACC and DD members, email **apipa_qualityofcare@uhc.com** with documentation. Also complete the form on the AHCCCS-OIG website at **azahcccs.gov**.

Forms from the AHCCCS and DDD websites are on **UHCprovider.com** under External Guidelines and Resources. Attach any documentation that would assist AHCCCS or the DDD in its investigation.

Submit any incidents involving UnitedHealthcare Community Plan members or non-UnitedHealthcare members directly to the AHCCCS OIG. Complete and submit the reporting form available on the **AHCCCS-OIG** website. Non-UnitedHealthcare members must be reported to the AHCCCS-OIG immediately.

All information provided to us about a potential fraud or abuse occurrence will be kept confidential based on UnitedHealthcare Community Plan's Confidentiality Policy. A copy of this policy is available upon request. Any information developed, obtained or shared among participants in an investigation of a potential fraud and abuse occurrence is maintained specifically for this purpose. HIV-related information should not be disclosed when releasing information related to fraud and abuse.

If you have questions, call the UnitedHealthcare Community Plan Compliance Office or the AHCCCS Administration.

Exclusion checks

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month. For more information or access to the publicly accessible, excluded party online databases, please see the following links:

- **Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE)**
- **General Services Administration (GSA) System for Award Management**

What you need to do for exclusion checks

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.

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Chapter 15: Care provider communications and outreach

Key contacts

Topic	Link	Phone Number
Provider Education	UHCprovider.com > Resources > Resource Library	• ALTCS EPD: **1-800-377-2055** • ACC/DD: **1-800-445-1638**
News and Bulletins	UHCprovider.com > Resources > News	• ALTCS EPD: **1-800-377-2055** • ACC/DD: **1-800-445-1638**
Provider Manuals	UHCprovider.com/guides	• ALTCS EPD: **1-800-377-2055** • ACC/DD: **1-800-445-1638**

Connect with us on social media:

Communication with care providers

UnitedHealthcare is on a multi-year effort to enhance our digital delivery channels and transition paper transactions to electronic, whenever possible. Our goal is to make it easier for you to work with us and reduce the time it takes for you to perform claim and clinical activities. We may provide electronic notice of policy, protocol and payment policy changes; news and other important updates.

Accordingly, there are a number of ways clinicians, practice managers, administrative staff, facilities and hospitals can stay up to date on items of interest from UnitedHealthcare:

- UHCprovider.com: This public website is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs:
- **UnitedHealthcare Community Plan of Arizona page**: UHCprovider.com/azcommunityplan has resources, guidance and rules specific to Arizona. Be sure to check back frequently for updates.
- **Policies and protocols:** This library includes UnitedHealthcare Community Plan policies and protocols.
- **Health plans by state:** UHCprovider.com/az is the fastest way to review all of the health plans UnitedHealthcare offers in Arizona. To review plan information for another state, use the drop-down menu at UHCprovider.com > Resources > Health Plans. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **UnitedHealthcare Provider Portal**: This secure portal is accessible from UHCprovider.com. It allows you to access patient information such as eligibility and benefit information and digital ID cards.
  You can learn more about the portal in Chapter 1 of this manual or by visiting UHCprovider.com/portal. You can also access UHCprovider.com/training > Digital Solutions for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News:** Bookmark UHCprovider.com > Resources > News. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans. You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your practice and care for patients. This includes the communication formerly known as the Network Bulletin.

Receive personalized Network News emails twice a month by subscribing at cloud.provideremail.uhc.com/subscribe. You'll get the latest news, policy and reimbursement updates we've posted on our news webpage. These email briefs include monthly notification of policy and protocol updates, including medical and reimbursement policy changes. They also include announcements of new programs and changes in administrative procedures. You can tailor your subscription to help ensure you only receive updates relevant to your state, specialty and point of care.

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Care provider education and training

To help ensure you are reimbursed accurately and patients have access to the care they need, we have developed a full range of training resources, including interactive self-paced courses and quick reference guides along with registration for instructor-led sessions. Topics include the digital solutions available on the UnitedHealthcare Provider Portal, plan and product overviews, clinical tools and state-specific training.

View the training resources at **UHCprovider.com/training**. Content is updated frequently and organized by categories to make it easy to find what you need.

Email communication – required contact information

We must have a valid email address on file to send you required notifications and important information.

Submit your email address in one of the following ways:

1. Sign up for a **One Healthcare ID**, which also gives you access to the UnitedHealthcare Provider Portal
2. **Subscribe** to Network News email briefs to receive regular email updates. Need to update your information? It takes just a few minutes to manage your email address and content.

Already have a One Healthcare ID? To review or update your email, simply sign in to the portal. Go to “Profile & Settings,” then “Account Information” to manage your email.

Care provider office visits

Provider advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a provider group to deliver face-to-face support. We do this to create program awareness, promote compliance and problem resolution.

Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for Provider Services, and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting Provider Services.

State website and forms

Find these forms on the state’s website at **azahcccs.gov**:

- **Sterilization Consent Form**
- **Hysterectomy Consent and Acknowledgment Form**
- **Provider Enrollment Application Form**

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Glossary

Abuse (by care provider)
Care provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost, or in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost, as defined by 42 C.F.R. § 455.2.

Abuse (of member)
Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S. § 46-451.

Acute Inpatient Care
Care provided to members sufficiently ill or disabled requiring:

- Constant availability of medical supervision by attending care provider or other medical staff
- Constant availability of licensed nursing personnel
- Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

Active Treatment
A current need for treatment or evaluation for continuing treatment of the qualifying condition, or it is anticipated that treatment or evaluation for continuing treatment of the qualifying condition will be needed within the next 18 months.

Advance Care Planning
Advance care planning is a billable service, a voluntary face-to-face discussion between a physician or other qualified care provider and the member to: a) teach the member and their family about the member's illness and the health care options available to them; b) develop a written plan of care that identifies the member's choices for treatment; and c) consistent with HIPAA, share the member's wishes with family, friends and their care providers.

Advance Directive
A document by which a person makes provision for health care decisions in the even that, in the future, he/she becomes unable to make those decisions.

Adverse Benefit Determination

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner, as defined by the state.
5. The failure of someone or a company to act within the time frames provided in the contract and within the standard resolution of grievances and appeals.
6. For a resident of a rural area, the denial of an member's request to exercise their right, to obtain services outside the network.
7. The denial of an member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

AHCCCS
The Arizona Health Care Cost Containment System – which is composed of AHCCCSA, contractors, and other arrangements – through which health care services are provided to eligible persons as defined by A.R.S. Title 36, Chapter 29.

AHCCCSA

The Arizona Health Care Cost Containment System Administration.

AHCCCS Benefit
AHCCCS-covered medical services.

ALTCS EPD (Arizona Long-Term Care System Elderly, Physically Disabled)
A component of AHCCCS which, in addition to medical and behavioral health services, provides long-term care services to eligible elderly and/or physically disabled (EPD) members and developmentally disabled (DD/ALTCS) members. UnitedHealthcare Community Plan provides long-term care (sometimes referred to as "ALTCS") services to DD/ALTCS members as a separate line of business.

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Ambulatory Care
Health care services that do not involve spending the night in the hospital. Also called "outpatient care". Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility
A state facility that is licensed, equipped and operated to provide surgeries and obstetrical deliveries. Members can leave the facility the same day surgery or delivery occurs.

Ancillary Provider Services
Extra health services, like laboratory work and physical therapy, which a member gets in the hospital.

Anniversary Date
The anniversary date is 12 months from the date the member is enrolled with the contractor and annually thereafter. In cases, the anniversary date will change based on the last date the member changed contractors or the last date the member was given an opportunity to change.

Annual Enrollment Choice (AEC)
The annual opportunity for a member to change their contractor. The member is offered annual enrollment choice in the 10th month following their anniversary date. If an individual member makes a timely (within the period stated on the annual enrollment choice letter) annual enrollment choice, the change in contractors will occur on the first of the month in which their anniversary date occurs.

Appeal
A member request that their health insurer or plan review a decision that denies an adverse benefit determination.

Authorization
Approval obtained by care providers from UnitedHealthcare Community Plan for a service before the service is rendered. Used interchangeably with "preauthorization" or "prior authorization."

Billed Charges
Charges you bill for rendering services to a UnitedHealthcare Community Plan member.

Capitation
A prepaid, periodic payment to providers, based upon the number of assigned members made to a care provider for providing covered services for a specific period.

Care Provider
Generally used to identify hospitals, nursing homes, home health agencies, etc., that provides medical services.

Case Manager
The individual responsible for coordinating the overall service plan for an ALTCS-eligible member in cooperation with the member, member's representative and the member's PCP.

Categorically Eligible
Individuals who are mandatorily eligible under federal law because they receive TANF or SSI benefits. These individuals are not required to complete a separate AHCCCS eligibility determination.

Centers for Medicare & Medicaid Services (CMS)
A federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and CHIP programs.

Certified Nurse Midwife (CNM)
An individual certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Arizona by the State Board of Nursing. CNMs practice independent management of care for pregnant women and newborns, providing antepartum, intra-partum, postpartum, gynecological and newborn care within a health care system that provides for medical consultation, collaborative management or referral.

CHIP (KidsCare)
Children's Health Insurance Program.

Chiropractic Services
Treatment provided by a licensed chiropractor that meets uniform minimum Medicare standards by means of manual manipulation of the spine to correct a subluxation demonstrated by X-ray. Any such services require prior authorization.

Chronic
Expected to persist over an extended period of time.

Claim Adjustment
A previously paid claim that requires additional research due to an overpayment or underpayment.

Claim Resubmission
A previously denied claim requiring additional documentation or correction (e.g., EOB, proof of timely filing, corrected CPT code, diagnosis code, care provider ID, member ID).

Clean Claim
As defined by A.R.S. § 36-2904 (H) and AHCCCS rules within A.A.C. Title 9, a claim with no defect (including lack of any required substantiating documentation) or circumstance requiring special treatment that prevents timely payment.

CMS

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Centers for Medicare and Medicaid Services, the federal regulatory agency for these programs.

Competency
A person's ability or capacity to successfully perform job duties. It encompasses workforce training and specific behavioral indicators that are demonstrated and observed.

Competency Development
A systematic approach for helping ensure that workers are prepared to perform their job's basic requirements.

Contracted Health Professionals
PCPs, specialists, medical facilities, allied health professionals and ancillary service care providers under contract with UnitedHealthcare Community Plan. These care providers deliver specific covered services to members. They represent those individuals and entities used through the UnitedHealthcare Community Plan prior authorization and referral policies and procedures.

Coordination of Benefits (COB)
A process of figuring out which of two or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

Copayment
Refers to a monetary amount, specified by the AHCCCS Director that the member pays directly to the participating care provider at the time covered services are provided.

- **Mandatory:** Care providers can deny services to members who do not pay the copayment.
- **Non-Mandatory:** Care providers are prohibited from denying the service when the member is unable to pay the copayment.

Copayment Levels
Copayment requirements will be indicated via a member specific copayment level found in all AHCCCS eligibility verification processes other than Interactive Voice Response (IVR). Every member will be assigned a copayment level which will reflect whether they are exempt from copayments, subject to optional (nominal) co-payments, or subject to mandatory copayments.

County with Choice
A county or GSA with more than one ACC, DD, or ALTCS EPD contractor.

Covered Services
The portion of a medical, dental or vision expense that a health insurance or plan has agreed to pay for or reimburse as delineated in Annex B and/or C of the provider Agreement or mentioned in AHCCCS Rules.

CRS-Designation
AHCCCS makes CRS eligibility determinations for CRS designation. A CRS covered condition is based upon meeting AHCCCS eligibility requirements as defined in A.A.C. R9-22- Article 13 and A.R.S. Title 36.

Credentialing
The verification of applicable licenses, certifications and experience. This process assures care provider status is extended only to professional, competent care providers who continually meet UnitedHealthcare Community Plan qualifications, standards and requirements.

Current Procedural Terminology (CPT) Codes
A code assigned to a task or service a care provider does for a member. Every medical task or service has its own CPT code. These codes are used by the insurer to know how much they need to pay the physician. CPT codes are created and published by the American Medical Association.

Delivery System
The mechanism by which health care is delivered to a member. Examples include hospitals, provider offices and home health care.

DES
Arizona Department of Economic Security.

DHS
Arizona Department of Health Services.

Disallow Amount (Amt)
Medical charges for which the network provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member. Examples are:

- The difference between billed charges and in-network rates.
- Charges for bundled or unbundled services as detected by Correct Coding Initiative edits.

Discharge Planning
Screening eligible candidates for continuing care following treatment in an acute care facility. It involves care planning, scheduling, arranging and steps that move a member from one level of care to another.

Disenrollment
The discontinuance of a member's eligibility to receive covered services from a contractor.

Division of Developmental Disabilities (DDD)
DDD is a part of the Arizona Department of Economic Security (DES). It provides health care services to eligible Arizonans through its role as a managed care organization in the state Medicaid system. The DD

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health plan is an integrated program for members with developmental disabilities with or without CRS conditions/designations.

UnitedHealthcare provides acute care services to these members through a separate line of business. These members are referred to as DD/ALTCS members.

Discharge Planning
Identification of the need and provision for a patient's health care requirements after discharge from the hospital.

Disenrollment
Discontinuance of a member's eligibility to receive covered services from a contractor. The member's name is deleted from the approved list of members furnished by AHCCCSA to the contractor.

Dispute
Care provider claim reconsideration: Step 1 when a care provider disagrees with the payment of a service, supply, or procedure.

Care provider appeal: Step 2 when a care provider disagrees with the payment of a service, supply, or procedure.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a care provider for everyday and extended use, for medical reasons other than convenience or comfort. DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT)
A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA Section 1905 (R) based on the AHCCCS EPSDT periodicity schedule. Covered services include a complete health history and developmental assessment; an unclothed physical exam; immunizations; laboratory tests; health education; and screenings for vision, dental, substance abuse, mental health and hearing. They also include any medically necessary services found during the preventive exam.

Electronic Data Interchange (EDI)
The electronic exchange of information between two or more organizations.

Electronic Funds Transfer (EFT)
The electronic exchange of funds between two or more organizations.

Electronic Medical Record (EMR)
An electronic version of a member's health record and the care they have received.

Eligibility Determination
Deciding whether an applicant meets the requirements for federal or state eligibility.

Emergency Care
The provision of medically necessary services required for immediate attention to review or stabilize a medical emergency.

Emergency Dental Services
Services and operational procedures required to eliminate acute infection, prevent pulpal death and related imminent tooth loss, treat injuries to teeth or supportive structures, or provide palliative therapy for pericoronitis associated with impacted teeth.

Encounter
A record of health care-related services by care providers registered with Medicaid to a patient enrolled with UnitedHealthcare Community Plan on the date of service. You are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan electronically reports these encounters to state Medicaid. The state audits encounter submission accuracy and timeliness on a regular basis.

Encounter Validation Studies

Per CMS requirements, AHCCCS conducts encounter validation studies of our encounter submissions. These validation studies compare recorded utilization information from a medical record or other source with the contractor's submitted encounter data.

Enrollee
Enrollee is interchangeable with the term member. Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber or dependent.

Enrollment
The process where a person is determined eligible to receive Medicaid or Medicare benefits becomes an enrollee or member of a health plan.

Evidence-Based Care
An approach that helps care providers use the most current, scientifically accurate research to make decisions about members' care.

Expedited Member Appeal
An an expedited review process for appeals determines that taking the time for a standard resolution could seriously jeopardize the member's life, physical or

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mental health, or ability to attain, maintain, or regain maximum function.

Fee For Service (FFS)
A method of payment to care providers on an amount-per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule.

FHC
Family Health Center

Federally Qualified Health Care Center (FQHC)
FQHCs are facilities or programs more commonly known as Community Health Centers, Migrant Health Centers and Health Care for the Homeless Programs. An entity may qualify as an FQHC if it: (1) receives a grant and funding pursuant to Section 330 of the Public Health Service Act; (2) is receiving funding from such a grant under a contract with the recipient of a grant and meets the requirements to receive a grant pursuant to Section 330 of the Public Health Service Act; (3) is determined by the Secretary of the Department of Health and Human Services (DHHS) to meet the requirements for receiving such a grant (look- alike) based on the recommendation of HRSA within PHS; or, (4) was treated by the Secretary of DHHS as a federally funded health center (FFHC) for purposes of Part B Medicare.

Fraud
A crime that involves misrepresenting or concealing information to receive benefits or to make a financial profit.

FQHC/RHC Visit

A visit defined as a face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS- covered ambulatory service is provided when that service is not incident to another service and the site of service is at an FQHC/RHC registered location.

Functionally Limiting
A restriction having a significant effect on an individual's ability to perform an activity of daily living as determined by a care provider.

General Consent
A one-time agreement to receive certain services. It is usually obtained from a member during the intake process at the initial appointment. General consent is always obtained before delivering services. It must be obtained from a member or legal guardian.

Geographic Service Area (GSA)
An area designated by AHCCCS within which a contractor of record provides, directly or through subcontract, covered health care service to a member enrolled with that Contractor of record as defined in A.A.C. R9-22-101 (B).

Grievance
a member's expression of unhappiness about the plan and/or care provider about any matter. This includes quality of care or service concerns. It does not include adverse benefit determination.

Health Home
A care provider that either provides or coordinates and monitors the provision of all primary, physical health, behavioral health, and services and supports to treat the whole person. A health home can be an outpatient behavioral health clinic, a federally qualified health center or an integrated care provider. Members may or may not be formally assigned to a health home.

Health Insurance Flexibility and Accountability Act (HIFA)
The waiver for parents of eligible SOBRA children not otherwise eligible for AHCCCS coverage.

Health Care Decision Maker
An individual authorized to make health care treatment decisions for the patient. As applicable, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions based on A.R.S. Title 14, Chapter 5, or A.R.S. §§ 8-514.05, 36-3221, 36-3231 or 36-3281.

Healthcare Effectiveness Data and Information Set (HEDIS®)
A rating system developed by NCQA that helps health insurance companies, employers, and consumers learn about the value of their health plan(s) and how it compares to other plans.

HIPAA
Health Insurance Portability and Accountability Act. A federal law that provides data privacy protection and security provisions for safeguarding health information.

Home Health Care (Home Health Services)
Health care services and supplies provided in the home, under physician's orders. Services may be provided by nurses, therapists, social workers or other licensed care providers. Home health care usually does not include help with non-medical tasks, such as cooking, cleaning or driving.

Informed Consent
An agreement to receive medical and behavioral health services before the provision of a specific treatment that

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has associated risks and benefits. Informed consent must be obtained from a member or legal guardian prior to the provision of services or procedures.

In-Network Care Provider
A care provider who has a written Agreement with UnitedHealthcare Community Plan to provide services to members under the terms of their Agreement.

Medicaid
A federal health insurance program for low-income families and children, eligible pregnant women, people with disabilities, and other adults. The federal government pays for part of Medicaid and sets guidelines for the program. States pay for part of Medicaid and have choices in how they design their program. Medicaid varies by state and may have a different name in your state.

Medical Emergency
An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention you could reasonably expect one of the following to result:

- Their health would be put in danger; or
- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body.

Medically Necessary
Medically necessary health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine according to AHCCCS.

Member
An individual who is AHCCCS-eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement.

Mid-Level Practitioner
An individual practitioner—other than a physician, dentist, veterinarian or podiatrist—who is licensed, registered or otherwise permitted by the United States or the jurisdiction in which they practice. Examples of mid-level practitioners include nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists and physician assistants.

NPI
National Provider Identifier. Required by CMS for all care providers who bill, prescribe or refer for health care services and is used on all electronic transactions. It is a single unique care provider identifier assigned to a care provider for life that replaces all other care provider identifiers. It does NOT replace your DEA number.

Out-Of-Area Care
Care received by a UnitedHealthcare Community Plan member when they are outside of their geographic territory.

Preventive Health Care
Health care emphasizing priorities for prevention, early detection and early treatment of conditions. It generally includes routine/physical examination and immunization.

Primary Care Provider (PCP)
A physician, including an MD (medical doctor) or DO (doctor of osteopathic medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the plan who provides, coordinates or helps members access a range of health care services. FQHC cannot be considered a PCP per AHCCCS AMPM.

Prior Authorization (Notification)
The process where care providers seek approval prior to rendering health care services, drugs or DME as required by UnitedHealthcare Community Plan policy.

Provider Group
A partnership, association, corporation, or other group of care providers.

QMB
Qualified Medicare Beneficiary.

Quality Management (QM)
A methodology that professional health personnel use to achieve desired medical standards and practices. The formal program includes activities to help improve and maintain quality service and care and involve multiple organizational components and committees.

Referral:

Any oral, written, faxed, or electronic request for service made by the member or member's legal guardian, family member, an AHCCCS Contractor, PCP, hospital, court, Tribe, IHS, Tribal 638 Facility, school, or other State or community agency.

Regional Behavioral Health Authority (RBHA)
The entities through which state and federally funded behavioral health services may be provided.

Rural Health Clinic
A clinic, located in a rural area, designated by AHCCCS as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics may receive enhanced payments for services

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provided to enrolled members.

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by AHCCCS.

Specialist
A care provider licensed in the state of Arizona and has completed a residency or fellowship focusing on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a care provider who has special training in a specific area of health care.

State Fair Hearing
An administrative hearing requested if the member does not agree with a Notice of Dispute Resolution from the UnitedHealthcare Community Plan Claim Dispute Department.

TANF
Temporary Assistance to Needy Families. A state program that gives cash assistance to low-income families with children.

Telehealth
Health care services delivered through asynchronous (store and forward), remote patient monitoring, teledentistry or telemedicine (interactive audio and video).

Third-Party Liability (TPL)
A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan pays claims for covered benefits and pursues refunds from the third party when liability is determined.

Timely Filing
When UnitedHealthcare Community Plan puts a time limit on submitting claims.

Title XIX
Section of Social Security Act describing the Medicaid program coverage for eligible persons.

Title XXI
Section of the Social Security Act, referred to in federal legislation as the State Children's Health Insurance Program (CHIP). The Arizona version of CHIP is referred to as KidsCare.

Tribal Regional Behavioral Health Authority
Tribal Regional Behavioral Health Authorities (TRBHAs) are Tribal entities that have an Intergovernmental Agreement (IGA) with the AHCCCS administration. The purpose of the agreement is to coordinate the delivery of comprehensive mental health services to all eligible persons assigned by the administration to the Tribal entity. Tribal governments, through an agreement with the State, may operate a TRBHA for the provision of behavioral health services to American Indian /Alaska Native members.

UnitedHealthcare Community Plan
An affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

Utilization Management (UM)
Involves coordinating how much care members get. It also determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.

Utilization Review
System of review conducted by professional health personnel of the appropriateness, quality of and need for health care services rendered to patients covered by Medicare or other third party payers, including AHCCCS.

Visit
All services received in one day from a single care provider, or components of the same service received in one day from multiple care providers, e.g. a surgery in an Ambulatory Surgical Center (ASC) where both the ASC and the surgeon provide the same service.

Whole Person Care Initiative
The Whole Person Care Initiative (WPCI) is an AHCCCS initiative launched in 2019 that invites all health care partners to move from "health care" to whole-person care. The WPCI strives to improve the overall health of the Arizonans we serve.

Workforce Capability
The interpersonal, cultural, clinical/medical and technical competence of the collective workforce or individual worker.

Workforce Capacity
The number of qualified, capable and culturally representative personnel required to sufficiently deliver services to members.

Workforce Connectivity
The workplace's link to sources of potential workers, information required by workers to perform their jobs,

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and technologies for connecting to workers and/or connecting workers to information.

Workforce Development Alliance
Organized by the Workforce Development (WFD) department at AHCCCS, the alliance has members from Relias Learning, Arizona Association of Health Plans (AzAHP), Arizona Complete Health, Banner University Family Care, Care 1st, Magellan Complete Care, Mercy Care, Steward Health Choice Arizona and UnitedHealthcare Community Plan.

Workforce Development (WFD)
An approach to improving member health care outcomes that forecasts health care trends and needs as well as workforce capacity needs to enhance the training, skills and competency of our workforce. The collaborative effort sets goals and initiatives to improve the workforce to provide better member services and care.

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