2024 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Hawai'i QUEST

United Healthcare Community Plan

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Welcome

Welcome to the UnitedHealthcare Community Plan provider manual. This up-to-date reference 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 to access different care provider manuals:

- **Administrative Guide – UHCprovider.com/guides** Under UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans), click on View Guide. Some states may also have Medicare Advantage information in their Community Plan manual.

- **A different Community Plan care provider manual – UHCprovider.com/guides**
  - Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on **Find Your 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 **1-888-980-8728**

Using this care provider manual

If there is a conflict between your Agreement and this care provider manual, use this care provider manual, unless your Agreement states you should use the Agreement instead.

If there is a conflict between your Agreement, this care provider manual and applicable federal and state statutes and regulations and/or state contracts, the latter will control.

UnitedHealthcare Community Plan reserves the right to supplement this care provider manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This care provider manual will be amended as policies change.

Participation Agreement

Terms and definitions as used in this care provider 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 professional subject to this manual, including physicians, clinicians, facilities and ancillary providers; except when indicated and all items are applicable to all types of health care providers subject to this care provider manual
- "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.

Overview of the QUEST Program and UnitedHealthcare Community Plan

QUEST is the State of Hawai'i's managed care Medicaid program. It brings together into a single program previous Medicaid programs such as QUEST, QUEST Expanded Access (QExA), QUEST-ACE and QUEST-Net as well as Medicaid Expansion under the Affordable Care Act (ACA). The program includes persons eligible for Medicaid and Children's Health Insurance Program (CHIP).

The goals of the State of Hawai'i and UnitedHealthcare Community Plan are to:

- Improve the health status of the QUEST member population
- Minimize administrative burdens, streamline access to care for members with changing health status, and improve health care outcomes by integrating programs and benefits
- Align the program with the Affordable Care Act (ACA)
- Improve care coordination by establishing a "provider/medical home" for members through the use of assigned primary care providers (PCPs)
- Expand access to home and community based services (HCBS) and allow members to have a choice between institutional services and HCBS
- Maintain a managed care delivery system that assures access to high-quality, cost-effective care that is provided whenever possible, in the member's community, for all covered populations
- Establish contractual accountability among the State, UnitedHealthcare Community Plan and care providers
- Develop a program that is fiscally predictable, stable, and sustainable over time
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to a more appropriate utilization of the health care system
- Develop a program that places maximum emphasis on the efficacy of services and offers health plans both incentives for quality and sanctions for failure to meet measurable performance goals

Integrated care

Integrated care is based on a clinical model that directs care between medical and behavioral care providers. It began with the Collaboration of Care (CoC) clinical model, which introduced behavioral health in a primary care setting. With integrated care, care providers treat members with a shared care plan using telemedicine, clinical rounds, co-location, joint sessions or other methods.

We have clinical transformation consultants to support you in our journey to full integration. For more information on integrated care training, please visit **UHCprovider.com/IntegratedCare**.

Table of Contents

Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com** Live chat available at **UHCprovider.com/contactus**	**1-888-980-8728**
Training	**UHCprovider.com/training**	**1-888-980-8728**
UnitedHealthcare Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID or go to Provider Portal Self Service: **UHCprovider.com/portal** New user: **UHCprovider.com/access**	**1-888-980-8728**
CommunityCare Provider Portal Training	**UnitedHealthcare CommunityCare Provider Portal User Guide**	
One Healthcare ID support	Chat, with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**	**1-855-819-5909**
Resource Library	**UHCprovider.com** > Resources > Resource Library	

UnitedHealthcare Community Plan provides benefits and service to members, including:

- **TANF** – Temporary Assistance for Needy Families
- **CHIP** – Children's Health Insurance Program
- **AABD** – Assistance to the Aged, Blind, and Disabled
- **LTC** – Long-term Care
- **DSNP** – Dual Special Needs Plan

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com** or call **Provider Services** at **1-888-980-8728**.

How to join our network

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

The Hawaii Department of Human Services (DHS)/ Med-QUEST Division (MQD) requires all care providers who serve QUEST members to be enrolled with DHS as a Medicaid care provider. You must register with the new Med-QUEST Division care provider enrollment system, HOKU. HOKU is a web-based system that lets you register as a Medicaid care provider. Find more information and HOKU resources at medquest.hawaii.gov/en/plans-providers/Provider-Management-System-Upgrade.html.

Already in network and need to make a change?

To change an address or phone number, add or remove physicians from your TIN, or make other changes, go to My Practice Profile at **UHCprovider.com/attestation.**

Approach to healthcare

Care Model

The Care Model program seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community partners 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 primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist
- 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 member advocates refer member for health coordination with a registered nurse or social worker, behavioral health advocate 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 outcomes by inpatient (IP) admission and ER rates
- Improve access to PCP and other needed services, measured by number of PCP visit rates within identified time frames
- Identify and discuss behavioral health (BH) needs, measured by number of BH care provider visits within identified time frames
- Match our members' dynamic needs with the most appropriate treatment available to address their behavioral health care needs through seamless transitions in care adjusted based on their current clinical status.
- Help ensure behavioral health treatment is based on clear medical necessity criteria, is flexible enough to meet members' clinical needs and is coordinated across the service array without disrupting member care or outcomes
- Improve access to pharmacy
- Identify and remove social and environmental barriers to care
- Improve health outcomes, measured by improved Health Plan Employer 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
- Improve coordination of care through dedicated staff resources and to meet unique needs
- Engage community care and 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 **Provider Services** at **1-888-980-8728**.

Complementary and alternative healing practices

Many cultures engage in traditional health practices such as holistic medicine, acupuncture, medicinal herbs, meditation, spiritual counseling, therapeutic massage or martial arts.

When developing a treatment plan for members, consider:

- Asking the member if they take any treatments, medicines or herbs to help them stay healthy or as treatment for their condition
- Inquiring whether the member has sought advice or treatment from friends, alternative healers or other practitioners
- Acknowledging the member's choice for consultation of spiritual or traditional practitioners in addition to prescribing more western forms of treatment

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.

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. The goal of the program is to break down linguistic and cultural barriers to build trust and improve health outcomes. You must support UnitedHealthcare Community Plan's Cultural Competency Program. For more information, go to **UHCprovider.com** > Resources > Resource Library > Health Equity Resources > **Cultural Competency**.

Cultural competency training and education

Free continuing medical education (CME) and non-CME courses are available on our **Cultural Competency page** as well as other important resources.

Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process**.

Translation/interpretation/auxiliary aide services

You must provide language services and auxiliary aides, including, but not limited to, sign language interpreters to members as required, to provide members with an equal opportunity to access and participate in all health care services.

If the member requests translation/interpretation/auxiliary aide services, you must promptly arrange these services at no cost to the member.

Members have the right to a certified medical interpreter or sign language interpreter to accurately translate health information. Friends and family of members with limited English proficiency, or members who are deaf or hard of hearing, may arrange interpretation services only after you have explained our standard methods offered, and the member refuses. Document the refusal of professional interpretation services in the member's medical record.

Any materials you have a member sign, and any alternative check-in procedures (like a kiosk), must be accessible to an individual with a disability.

If you provide Virtual Visits, these services must be accessible to individuals with disabilities. Post your Virtual Visits procedures for members who are deaf or hard of hearing, so they receive them prior to the Virtual Visit.

Care for members who are deaf or hard of hearing

You must provide a sign language interpreter if a member requests one. You must also have written office procedures for taking phone calls or providing Virtual Visits to members who are deaf or hard of hearing.

UnitedHealthcare Community Plan provides the following:

- **Language interpretation line**
  - We provide oral interpreter services Monday–Friday from 8 a.m.–8 p.m. ET
  - To arrange for interpreter services, please call **1-877-842-3210** (TTY **711**)
  - Hawaii is the only state in the United States that has designated a native language, Hawai'ian, as one of its 2 official state languages. To support this, we provide anytime oral interpreter services to our members free of charge.
  - More than 250 non-English languages and hearing-impaired services are available. If a UnitedHealthcare Community Plan member needs interpreter services, they can call the phone number on their ID card. If you need a professional interpreter during regular business hours, call **Provider Services** at **1-888-980-8728**. After hours, call **1-877-261-6608**.

- **Sign language interpretation**: We also provide sign language interpreters for our members by calling **1-888-980-8728.**
- **I Speak language assistance card**
  This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare members.
- **Materials for limited English-speaking members**
  We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members. For more information, go to **uhc.com > Language Assistance** or to view Hawaii's full Cultural Competency plan, go to **UHCprovider.com/HIcommunityplan > Cultural Competency Plan**.

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual® for medical care determinations.

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 **UnitedHealthcare Provider Portal Digital Guide Overview course**.
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 transactions can interact with your software system. 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.com/api**.

Electronic data interchange

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' 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)
  - Electronic remittance advice (ERA/835)

Visit **UHCprovider.com/edi** for more information. Learn how to optimize your use of EDI at **UHCprovider.com/optimizeedi**.

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.

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.

The secure **UnitedHealthcare Provider Portal** allows you to access patient information such as eligibility and benefit information and digital ID cards. You can also perform administrative tasks, such as submitting prior authorization requests, checking claim status, submitting appeal requests, and finding copies of PRAs and letters in Document Library. All at no cost to you and without needing to pick up the phone.

See **UnitedHealthcare Provider Portal** for access and to create ID or sign in using a One Healthcare ID.

- If you already have a One Healthcare ID, simply go to the **UnitedHealthcare Provider Portal** to access
- If you need to set up an account on the portal, follow **these steps** to register

Here are the most frequently used tools on **UnitedHealthcare Provider Portal**:

- **Eligibility and benefits** – View patient eligibility and benefits information for most benefit plans see **UHCprovider.com/eligibility**
- **Claims** – Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies see **UHCprovider.com/claims**
- **Prior authorizations and notifications** – Submit notification and prior authorization requests see **UHCprovider.com/paan**.
- **Specialty pharmacy transactions** – Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to **UHCprovider.com/pharmacy** for more information.
- **My Practice Profile** – View and update your provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.
- **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**.

See **UnitedHealthcare Provider Portal** to learn more about the available self-paced user guides for various tools/tasks.

Direct Connect

Direct Connect is a free online tool on our portal that lets you securely communicate with payers to address 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.
- Run real-time reporting to track statuses of inventories in resolution process.
- Provide control over financial resolution methods.

All users will access Direct Connect using our **UnitedHealthcare Provider Portal**. On-site and online training is available. Email **directconnectsupport@optum.com** to get started with Direct Connect.

Privileges

To help 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.

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. They can answer your questions about 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.

How to contact us

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

Topic	Contact	Information
Administrative office	1132 Bishop St., Suite 400 Honolulu, HI 96813 **NOTE:** Please do not submit claims to this address. Use the claims address listed below under Claims. 1-888-980-8728 TTY: **711** (Hearing Impaired)	Open 7:45 a.m. to 4:30 p.m. Hawaii Standard Time (HT) Monday-Friday
Behavioral health, mental health and substance abuse and health claim disputes	Optum® **providerexpress.com** **1-888-980-8728** **1-866-622-8054 (MA D-SNP)** Mailing Address: **Optum** P.O. Box 30757 Salt Lake City, UT 84130-0757 Payer ID: 87726	Review eligibility, claims, benefits, authorization and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	**UHCprovider.com/benefits** **1-888-980-8728**	Confirm a member's benefits and/or prior authorization.
Cardiology prior authorization	**UHCprovider.com/cardiology** **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Care model (care management/disease management)	**1-888-980-8728**	Refer high-risk members (e.g., asthma, diabetes) and members who need private-duty nursing.
Claims	**UHCprovider.com/claims** **1-888-980-8728** Mailing address: **UnitedHealthcare Community Plan QUEST** P.O. Box 31365 Salt Lake City, UT 84131-0365 Payer ID#: 87726 (EDI Claims Submission) Payer ID# 04567 (ERA use)	Ask about a claim status or about proper completion or submission of claims.

Topic	Contact	Information
Claim overpayments	Sign in to **UHCprovider.com/claims** to access the UnitedHealthcare Provider Portal. **1-888-980-8728** Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.
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.
Eligibility	**UHCprovider.com/eligibility** **1-888-980-8728**	Confirm member eligibility.
Fraud, waste and abuse (payment integrity)	Payment Integrity Information: **UHCprovider.com/HIcommunityplan** > Integrity of Claims, Reports, and Representations to the Government Reporting: **uhc.com/fraud** **1-844-359-7736**	Learn about our payment integrity policies. Our policy requires you to adhere to federal and state anti-FWA regulations and statutes. Report suspected fraud or abuse by submitting an online report using the button on webpage or calling the hotline. The webpage also includes frequently asked questions.
Laboratory services	**UHCprovider.com/findprovider** > **Preferred Lab Network** Labcorp: **1-800-833-3984** Quest Diagnostics	Labcorp and Quest Diagnostics are network laboratories.
Medicaid [Department of Social Services]	Medicaid.gov Department of Human Services: (Oahu) 1-808-524-3370 TTY/TDD #: 1-808-692-7182 (Neighbor Islands) 1-800-316-8005 TTY/TDD #: 1-800-603-1201 Website: medquest.hawaii.gov	Contact Medicaid directly.

Topic	Contact	Information
Medical claim disputes	**UHCprovider.com/claims** **1-888-980-8728** Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at one of the following addresses: Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 31350 Salt Lake City, UT 84131-0365 Appeals mailing address: **Community Plan Grievances and Appeals** 1132 Bishop Street Suite 400 Honolulu, HI 96813	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	**myuhc.com** **1-888-980-8728**/TTY **711** for help accessing members account	Assist members with issues or concerns. Available 7:45 a.m. to 4:30 p.m. HT Monday-Friday.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	**1-888-980-8728** or TTY **711** for hearing impaired	Available 7:45 a.m. – 4:30 p.m. HT, Monday-Friday, except state-designated holidays.
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, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**	A team of provider relation advocates. Ask about contracting and care provider services.
NurseLine	**1-866-311-5791** or TTY **711** for hearing impaired	Available 24 hours a day, 7 days a week.
Obstetrics/pregnancy and baby care (Hāpai Mālama)	Sign in to the **UnitedHealthcare Provider Portal** Department email: **hapaimalama@uhc.com** **1-888-980-8728** (TTY users: **711**)	Refer pregnant members to the Hāpai Mālama program. To notify UnitedHealthcare of pregnant patients digitally and reduce paperwork, you can also use Care Conductor and Notification on our **UnitedHealthcare Provider Portal**

Topic	Contact	Information
One Healthcare ID support center	Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**. **1-855-819-5909**	Contact if you have issues with your ID. Available 3 a.m - 5 p.m HT, Monday-Friday: 2 a.m - 2 p.m HT, Saturday: 5 a.m. - 2 p.m. HT
Pharmacy services	**UHCprovider.com/hicommunityplan > Pharmacy Resources and Physician Administered Drugs** **professionals.optumrx.com** **1-877-305-8952** (Optum Rx® and Mail Order) **1-844-568-2147** (Pharmacy Help Desk - pharmacies only) **1-855-427-4682** (Optum Specialty Pharmacy)	Optum Rx oversees and manages our network pharmacies. Use the UnitedHealthcare 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.
Prior authorization/ notification for pharmacy	**UHCprovider.com/pharmacy** **1-800-310-6826** covermymeds.com	Request authorization for medications as required.
Prior authorization requests/advanced and admission notification	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 (online solutions available after hours) and select "Care Notifications." Or call **1-888-980-8728.**	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: **UHCprovider.com/ HIcommunityplan > Prior Authorization and Notification**
Provider Services	**1-888-980-8728** For Medicare Advantage-Dual Special Needs Program (MA D-SNP): **1-866-622-8054**	7:45 a.m. to 4:30 p.m. HT Monday-Friday
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.
Referrals	**UHCprovider.com/referrals** or use Referrals on the UnitedHealthcare Provider Portal. Click Sign In at the top right corner of **UHCprovider.com**. Provider Services **1-888-980-8728**	Submit new referral requests and check the status of referral submissions.

Topic	Contact	Information
Reimbursement policy	**UHCprovider.com/hicommunityplan** > **Policies and Protocols**	View reimbursement policies that apply to Hawaii UnitedHealthcare Community Plan members. Regularly visit this site to view reimbursement policy updates.
Technical support	**UHCprovider.com/contactus** Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**. **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 portal, you cannot submit a form, etc.
Tobacco Free Quit Line	1-888-980-8728 (TTY users 711)	Ask about services for quitting tobacco/smoking.
Transportation	ModivCare 1-866-475-5746 1-866-288-3133 (Hearing Impaired)	Schedule transportation or for transportation assistance. To arrange non-urgent transportation, please call 3 days in advance.
Utilization management	Provider Services **1-888-980-8728**	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. For UM policies and protocols, go to **UHCprovider.com/protocols**. Request a copy of our UM guidelines or information about the program.
Vaccines for Children (VFC) program	1-808-586-8300 Fax: 1-573-526-5220	You must participate in the VFC Program administered by the Department of Health (DHS) and use the free vaccine when administering vaccine to qualified eligible children. You must enroll as VFC care providers with DHS to bill for the administration of the vaccine.
Website for Hawai'i Community Plan	**UHCprovider.com/HIcommunityplan**	Access your state-specific Community Plan information.

Chapter 2: Care provider standards and policies

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com**	**1-888-980-8728**
General care provider assistance		**1-877-842-3210**
Eligibility	**UHCprovider.com/eligibility**	**1-888-980-8728**
Referrals	**UHCprovider.com/referrals**	**1-888-980-8728**
Provider Directory	**UHCprovider.com/findprovider**	**1-888-980-8728**

General care provider responsibilities

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. You may only direct the member to another care provider type if that illness or condition may be better treated by someone else.

Communication between care providers and members

The UnitedHealthcare Community Plan Agreement is not intended to interfere with your relationship with members as patients or 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. Share findings of history and physical exams.
3. 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.
4. Recognize members (and/or their representatives) have the right to choose the final course of action among treatment options.
5. Collaborate with the plan care manager in developing a specific care plan for members enrolled in high-risk care management.

Provide official notice

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

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

Visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

Sanctions

When we are notified of a care provider's exclusion from Medicare or Medicaid, we send them a letter with the date that they will be removed from our contract care provider's list. Except for post-stabilization, emergency, and urgently needed care, no payments will be made after that effective date. Members are notified of the care provider's status so they can choose a new care provider.

We immediately terminate any care providers or affiliated care providers whose owners, agents, or managing employees are found to be on the state or federal exclusion list(s), including denial of credentialing for fraud related concerns, as they occur. If DHS requires removal of a care provider from its network, we remove them from our network.

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

Upon reinstatement by DHS, the care provider is responsible for notifying us and applying for reinstatement.

Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This may include providing services 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

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

For the most current list of network professionals, review our Provider Directory at **UHCprovider.com/findprovider**.

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:

- 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.
- Inactivate any tax identification numbers (TINs) with no claims submitted for one year. This is not a termination of the Provider Agreement. Call UnitedHealthcare Community Plan to reactivate a TIN.

Changing an existing TIN or adding a care provider

Visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

Updating your practice information

You can update your practice information through the UnitedHealthcare Provider Portal on **UHCprovider.com**, then Sign In > My Practice Profile. Or submit your change by:

- Visiting **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data electronically
- Calling our general provider assistance line at **1-877-842-3210**

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 fit them in your schedule, refer them to an urgent care center.

Admitting privileges

You must have admitting privileges to at least 1 in-network general acute care hospital on the island of service. For the island of Hawai'i, it needs to be on the same side of the island- east or west.

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 10** for more details on the initiatives.

Provide access to your records

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request.

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 6 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 care provider manual. You may view protocols at **UHCprovider.com/protocols.**

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 9** for Medical Record Standards.

Inform members of advance directives

The federal Patient Self-Determination Act (PSDA) gives patients the legal right to make choices about their medical care before incapacitating illness or injury through an advance directive.

Care providers are responsible for the following:

- Complying with all applicable state and federal laws regarding advance directives
- Asking and promptly documenting in the medical record if adult members have advance directives and include existing ones in the member's medical record.

Existing advance directives are prominently displayed within the patient's medical record maintained in care provider's office.

- Documenting in the medical record and implementing any changes or revocation to an advance directive by the member or the authorized representative or surrogate. Care providers may contact us to assist the member or their surrogate in making changes to the advance directive form as needed.
- Neither requiring a member to have an advance directive to receive medical care or behavioral health care, nor preventing a member from having an advance directive
- Adhering to the member rights. We have no institution-wide conscientious objections or limitations regarding advance directives.
- If a care provider is unable or is unwilling to carry out a member's written request, and the member transfers care to a new care provider, transferring, upon request, a copy of the relevant medical records to the new care provider
- Not executing advance directives until the member is no longer able to give informed consent
- Maintaining written policies for their office staff regarding advance directives and prominently display documented advance directives within the patient's medical record maintained in the provider's office
- Helping ensure that members understand their rights and responsibilities regarding advance directives

Member rights

- Competent, adult members have the right to execute written or non-written advance directive, a do-not-resuscitate order, an out-of-hospital do-not-resuscitate order and/or assign a Medical Power of Attorney at any time
- Competent, adult members also have the right to complete an advance mental health care directive that expresses their preferences and instruction about behavioral health treatment and/or designate an agent to make behavioral health and treatment decisions on their behalf
- Members have the right to receive medical care even if the member does not have an advance directive
- Members have the right to change or cancel advance directives at any time
- Members who are incapacitated and cannot make decisions about their medical treatment can make changes to their advance care directive once their decision-making capacity is restored. Members are informed of this in the Member Handbook.
- Members have the right to obtain clear and concise information regarding the different types of advance directives available to them and when an advance directive will take effect
- The desire of a competent qualified member supersedes the effect of an advance directive

To comply with these requirements, we inform members of state laws on advance directives through our Member Handbook and other communications. We provide an Aging with Dignity Pamphlet, "Five Wishes," to help members determine their end of life care. Members can find Five Wishes and Hawaii Provider Orders for Sustaining Treatment (POLST) forms for their use through **myuhc.com/communityplan**. The Kokua Mau website has information on advance care planning at kokuamau.org. You can also obtain copies by calling **1-888-980-8728.**

Your Agreement

If you have a concern about your Agreement with us, send a letter with the details to the address in your contract. A representative will look into your complaint. 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 complaint 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 appeal process in the member's benefit contract or handbook. Locate the Member Handbook at **UHCCommunityPlan.com/Hi** > Medicaid Plans > UnitedHealthcare Community Plan QUEST Program > Member Resources.

Also reference **Chapter 12** of this manual for information on Care Provider Claim Disputes, Appeals and Grievances.

Appointment standards (HI DHS Access and Availability Standards)

Comply with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- After-hours care phone number: at any time
- Emergency care: immediately or referred to an emergency facility
- Urgent care appointment: within 24 hours
- Pediatric sick visits: within 24 hours
- Adult sick visits: within 72 hours
- Routine care appointment: within 21 calendar days
- Physical exam: within 180 calendar days
- EPSDT appointments: within 6 weeks
- New member appointment: within 30 calendar days
- In-office waiting for appointments: not to exceed 1 hour of the scheduled appointment time

Specialty care

Specialists should arrange appointments for:

- Routine appointment type: within 4 weeks of request/ referral

Behavioral health

Behavioral health care providers should arrange appointments for:

- Care for non-life-threatening emergencies: within 6 hours
- Urgent care: within 24 hours
- Routine visits: within 10 business days

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- First and second trimester: within 7 calendar days of request
- Third trimester: within 3 days of request
- High-risk: within 3 calendar days of identification of high-risk

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.

Provider Directory

You are required to tell us, within 5 business days, if there are any changes to your ability to accept new patients. If a member, or potential member, contacts you, and you are no longer accepting new patients, report any Provider Directory inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional assistance in finding a care provider.

Following CMS guidelines, we are required to contact all participating care providers annually and independent physicians every 6 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 Provider 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 information. We are required to confirm your information.

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

- **Delegated care providers** – submit changes to your designated submission pathway
- **Nondelegated care providers** – visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data

Find the medical, dental and mental health care provider directory at **UHCprovider.com/findprovider.**

Care provider attestation

Confirm your provider data every quarter through the **UnitedHealthcare Provider Portal** or by calling Provider Services. If you have received the upgraded My Practice Profile and have editing rights, access

the **UnitedHealthcare Provider Portal** for My Practice Profile to make many of the updates required in this section.

When you submit demographic updates, list only those addresses where a member may make an appointment and see the health care provider. On-call and substitute health care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address.

Prior authorization request

Prior authorization is the process of requesting approval from UnitedHealthcare Community Plan to cover costs. Prior authorization requests may include procedures, 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.

Take the following steps before providing medical services and/or medication to UnitedHealthcare Community Plan members:

- Verify eligibility using the **UnitedHealthcare Provider Portal** or by calling Provider Services. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice
- Get prior authorization:
  1. To access the Prior Authorization app, go to **UHCprovider.com**, then sign in.
  2. Select the **Prior Authorization and Notification app.**
  3. View notification requirements.

Identify and bill other insurance carriers when appropriate.

Requirements for reporting suspected child or adult abuse

Report all cases of suspected child abuse to Child Protective Services:

- 1-808-832-5300 (Oahu), available 24 hours
- 1-888-380-3088 (Neighbor Islands), available 24 hours
- Additional information is available at humanservices.hawaii.gov/ssd/home/child-welfare-services

Report all cases of suspected dependent adult abuse to Adult Protective Services:

- 1-808-832-5115, available 7:45 a.m. to 4:30 p.m. HT, Monday-Friday, except state holidays
- Additional information is available at humanservices.hawaii.gov/ssd/home/adult-services

Timeliness standards for notifying members of test results

After receiving results, notify members within:

- **Urgent** – 24 hours
- **Nonurgent** – 10 business days

Requirements for PCP and specialists serving in PCP role

Specialists include internal medicine, pediatrics, or obstetrician/gynecology

PCPs are an important partner in the delivery of care, and Hawaii Department of Human Services (DHS) members may seek services from any participating care provider. The Hawaii DHS 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 case manager in the UnitedHealthcare Community Plan system by improving health care delivery in 4 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, 7 days a week coverage and backup coverage when they are not available.

Medical doctors (M.D.s), doctors of osteopathy (DOs), Advanced Practice Registered Nurses (APRN) and physician assistants (PAs) from any of the following practice areas can be PCPs:

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

The health plan may allow specialists or other care providers to serve as PCPs for members with chronic conditions if:

- The member has selected a specialist with whom they have a historical relationship as their PCP
- The health plan has confirmed the specialist agrees to assume the responsibilities of the PCP. Confirmation may be in writing, electronically or verbally
- The health plan submits to DHS prior to implementation of a plan, for monitoring their performance as PCPs

Members may change their assigned PCP by contacting Member Services at any time during the month. Customer service is available 7:45 a.m. – 4:30 p.m. HT, Monday-Friday.

We ask members who don't select a PCP during enrollment to select one:

- Medicare and Medicaid eligible members may choose an in-network or out-of-network PCP. Out-of-network PCPs will be identified on the member's ID card as "Medicare PCP."
- Non-Medicare Medicaid eligible members must choose an in-network PCP. UnitedHealthcare Community Plan may auto-assign a PCP to complete the enrollment process.

Women have direct access (without a referral or authorization) to any OB/GYNs, midwives, physician assistants (PAs), or nurse practitioners (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 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 primary care case management system. The coverage will include anytime availability. During non-office hours, access by telephone to a live voice (i.e., an answering service, on-call care providers, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services. **Recorded messages are not acceptable.**

Consult with other appropriate care providers to develop 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.
- We recommend using these guidelines for preventive services:
  - Children: American Academy of Pediatrics
  - Adults: U.S. Preventive Services Task Force
- 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 the same as any other coverage type (i.e., commercial plan)
- Be available to members by telephone any time.
- Tell members about appropriate use of emergency services
- Discuss available treatment options with members

Responsibilities of PCPs and specialists serving in PCP role

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this manual
- Conduct a baseline exam during the UnitedHealthcare Community Plan member's first appointment
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to UnitedHealthcare Community Plan Provider Services, Clinical or Pharmacy departments as appropriate
- Admit UnitedHealthcare Community Plan members to the hospital when necessary, and 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 in accordance with 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. Provide copies of medical records to members upon request at no charge
- Facilitate the transfer of a member's medical records to a new PCP within 7 business days from receipt of the request
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS® or 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 Hawaii DHS access and availability standards for scheduling emergency, urgent care and routine visits. Appointment standards are covered in **Chapter 2** of this manual.

PCP checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services**
- Check the member's ID card at the time of service. Verify member with photo identification. Plan participating specialists when needed.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/paan**.
- Refer patients to UnitedHealthcare Community Plan care providers
- 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

Rural health clinic or federally qualified health center as PCP

Members may choose a rural health clinic (RHC) or a federally qualified health center (FQHC) as their PCP.

- **Rural health clinic:** The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be located in rural, underserved areas.
- **Federally qualified health center:** An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a care provider, PA, NP and/or social worker
  - Mental health services
  - Immunizations (shots)
  - Home nurse visits

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.
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care.
- 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 Hawaii DHS Access and Availability standards for scheduling routine visits. Appointment standards are covered in **Chapter 2** of this manual.
- Provide anytime coverage. Or PCPs and specialists 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.

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.

A specialist must be available at the hospital to which UnitedHealthcare's PCPs admit its QUEST members. A specialist with an ambulatory practice who does not have admission and treatment privileges must have written arrangements with another care provider with admitting and treatment privileges with an acute care hospital within UnitedHealthcare's network on the island of service. For the island of Hawai'i, this means that a care provider in East Hawaii who does not have admission and treatment privileges shall have a written arrangement with another care provider with admitting and treatment privileges in East Hawaii (same requirement applies to West Hawai'i).

Ancillary care provider responsibilities

Ancillary providers include:

- Freestanding radiology
- Freestanding clinical labs
- Home health
- Hospice
- Dialysis
- Durable medical equipment
- Infusion care
- Therapy
- Ambulatory surgery centers
- Freestanding sleep centers
- Other non-care providers

PCPs and specialists must use the UnitedHealthcare Community Plan ancillary network.

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

Ancillary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare 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**.
- Identify and bill other insurance carriers when appropriate

Chapter 3: Care provider office procedures

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com**	**1-888-980-8728**
Prior authorization	**UHCprovider.com/paan**	**1-888-980-8728**
Dual Complete (HMO SNP)	**UHCprovider.com/HI** > Medicare > **Hawaii Dual Complete Special Needs Plan**	**1-888-980-8728**

Assignment to PCP panel roster

Once a member is assigned a PCP, view the panel rosters electronically on the Provider Portal at **UHCprovider.com**. 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. UnitedHealthcare Community Plan monitors PCP panel status.

Go to **UHCprovider.com**

1. Select Sign In on the top right.
2. Log in.
3. 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**.

Cost sharing (share of cost)

Members may have to share in the cost of their health care services. This is based on Medicaid financial eligibility. Share of Cost (SOC) is also called "cost share" or "enrollment fee." The member's SOC amount is determined by their State of Hawai'i Medicaid eligibility worker. Members must pay that amount to one of their care providers (e.g., foster care home, nursing facility [NF] or a home and community-based provider such as a home health agency) or UnitedHealthcare Community Plan every month. Members are notified of their SOC amount or responsibility and any changes by mail from their State of HawaiiMedicaid eligibility worker.

Premium and cost-sharing collection for Indian members

Any Indian members eligible to receive or have received an item or service provided by an Indian Health Care Provider or through a referral under contract health services, are exempt from having any cost-sharing or premium amounts or fees. Cost-sharing amounts related to services provided by an Indian Health Care Provider or through a referral under contract health services refers to any copayment, coinsurance, deductible or similar charge.

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. UnitedHealthcare Community Plan will assign members to the closest and appropriate PCP.

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

Hawaii DHS 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. Hawaii DHS 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, each member receives a welcome packet that includes a copy of the UnitedHealthcare Community Plan Member Handbook. The handbook explains the member's health care rights and responsibilities through UnitedHealthcare Community Plan.

Download a copy of the Member Handbook online at **UHCCommunityPlan.com/Hi** > Medicaid Plans > **UnitedHealthcare Community Plan QUEST Program**. Go to Plan Details, then Member Resources, View Available Resources.

Immediate enrollment changes

Immediate enrollment into managed care means the responsible payer for members, including newborns, may change from Fee for Service (FFS) to Medicaid Managed Care during hospitalization. To avoid delays in claims processing and payment, have the payer assignment of newborns checked daily.

Get eligibility information by calling **Provider Services**.

Unborn enrollment changes

Encourage your members to notify the Hawaii DHS when they know they are expecting. DHS notifies managed care organizations (MCOs) daily of an unborn when Hawaii Medicaid learns a member associated with the MCO is expecting. The MCO or you may use the online change report through the Hawaii website to report the baby's birth. With that information, DHS verifies the birth through the member. The MCO and/or the care provider's information is taken as a lead. To help speed up the process, the member should notify DHS when the baby is born.

Members may call Hawaii Department of Human Services:
(Oahu)
1-808-524-3370
TTY/TDD: 1-808-692-7182

(Neighbor Islands)
1-800-316-8005
TTY/TDD: 1-800-603-1201

Newborns may get UnitedHealthcare Community Plan-covered health services beginning on their date of birth. Check eligibility daily until the member 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.

Member eligibility

UnitedHealthcare Community Plan serves members enrolled with Hawaii DHS, Hawai'i's Medicaid program. The Hawaii DHS determines program eligibility. An individual who becomes eligible for the Hawaii DHS program either chooses or is assigned to one of the Hawaii DHS-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, if this is your office practice.

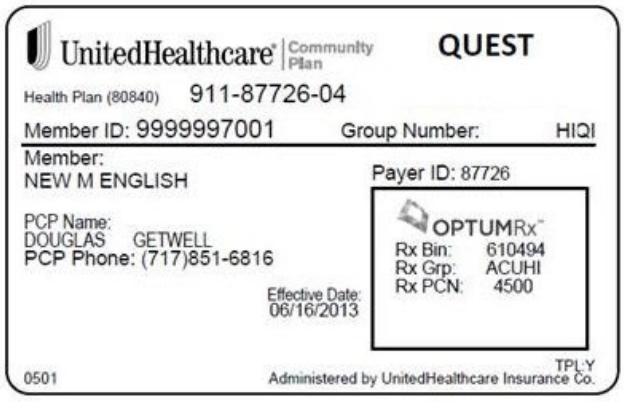
If a fraud, waste and abuse event arises from a care provider or a member, file a report at **uhc.com/fraud**. Or you may call the **Fraud, Waste, and Abuse Hotline**.

The member's ID card also shows the PCP assignment on the front of the card. If a member does not bring their card, call **Provider Services**. Also document the call in the member's chart.

Member identification numbers

The member ID printed on the UnitedHealthcare Community Plan member card is the same number that Hawaii DHS issues.

Sample health member ID card



PCP-initiated transfers

A PCP may transfer a UnitedHealthcare Community Plan member due to an inability to start or maintain a professional relationship or if the member is non-compliant. The PCP must provide care for the member until a transfer is complete.

- To transfer the member, call the Member Services number on the back of the member's card or contact UnitedHealthcare Community Plan by mail with the specific events documentation. Documentation includes the dates 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
  Attn: Member Services
  1132 Bishop Street, Suite 400
  Honolulu, HI 96813

- 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.
- 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.
- 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 5 business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

Verifying member enrollment

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

- Provider Portal: access the portal through **UHCprovider.com/eligibility**
- **Provider Services** is available from 7:45 a.m. – 4:30 p.m. Hawaii Time (HT), Monday-Friday.
- Hawaii Medicaid Eligibility System (MES)

UnitedHealthcare Dual Complete

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

For general information about D-SNP, go to **uhc.com/medicaid/dsnp**.

For information about UnitedHealthcare Dual Complete, please see the Medicare Products chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) at **UHCprovider.com/guides**. For state-specific information, go to UHCprovider.com/HI > Medicare > **Hawaii Dual Complete® Special Needs Plans**.

Chapter 4: Medical management

Key contacts

Topic	Link	Phone Number
Referrals	**UHCprovider.com/referrals**	**1-888-980-8728**
Prior authorization	**UHCprovider.com/paan**	**1-888-980-8728**
Pharmacy	**professionals.optumrx.com**	**1-888-980-8728**
Babyscripts™	**babyscripts.com**	**1-800-599-5985**
UHC Doctor Chat	**UHCDoctorChat.com**	**1-888-980-8728** TTY: **711**

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

Ambulance and transportation 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**.

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 major:

- Injury to their overall health,
- Impairment to bodily functions,

  Or

- Dysfunction of a bodily organ or part.

Emergency transports (in- and out-of-network) are covered. 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. Facility to facility nonemergent transportation fees will be the responsibility of the originating facility.

Non-emergent medical transportation

UnitedHealthcare Community Plan members may get non-emergent stretcher/ambulance transportation services through ModivCare for covered services.

If the member resides in an area not served by the public bus or cannot take the public bus because of their medical condition or disability, they may take public para-transit transportation. Every island has different public para-transit transportation arrangements. The member's health coordinator can see if the member is eligible.

For public para-transit-eligible members, we (through ModivCare) provide ride coupons. Members should call ModivCare 5 days in advance so the coupons may be mailed. Members with recurring trips are given coupons based on the number of medical or authorized non-medical trips as the health coordinator or PCP determines.

Facility to facility nonemergent transportation fees will be the responsibility of the originating facility.

We do not reimburse for travel expenses to another island or state for which we have not given prior authorization.

Medicaid members should never be charged for a covered service.

Covered services include:

- Ground/air transportation
- Meals and lodging for member and 1 approved escort (if medically necessary)
- If the adult member is hospitalized and does not require the escort, we will arrange for the escort to return home
- If it is medically necessary for an escort to bring the member home the day of discharge, we will arrange for the escort's travel
- Meal vouchers for the member/escort
- If the member pays out-of-pocket for meals for approved travel and wants to be paid back, they must send a reimbursement request to ModivCare with a copy of an itemized receipt(s.
- Meal reimbursement for medical services for 1 day (applies to travel to another island for same-day appointment). It includes up to $15 per day per member and per authorized escort.
- Meal reimbursement for medical services for more than 1 day (applies to travel to another island or out of state):
  - Up to $30 a day for members age 11 and older (and per authorized escort) and $15 a day for members age 10 and younger.
  - We reimburse 1 round-trip travel to a restaurant/eating establishment if none are available within a half-mile from the hotel/motel.
  - Reimbursement allowed if using EBT card or Supplemental Nutrition Assistance Program (SNAP) benefits to purchase food.

The following are not allowed for reimbursement:

- The days the member is in the hospital, beginning when they are admitted into the hospital until they are discharged
- Tips/gratuity
- Meal delivery fees
- Personal baggage or luggage fees for airline travel

Non-covered transportation includes:

- Transport to a pharmacy
- Transport for personal errands
- Transport to an SSI Determination Medical Appointment or Medicaid eligibility
- Transport to classes, support groups, community events, etc., unless they are part of the service plan
- Transport for any services not covered under QUEST
- Under their primary insurance coverage, members may seek health care services on a different island from the one they live on. However, Medicaid requires members receive care on the island where they live if those services are available. If the member travels to another island or to the mainland, and those health care services are available on their island, we will not pay for the transportation.

For non-urgent appointments, members must call ModivCare transportation 3 days before their appointment. They may make requests by phone at 1-866-475-5746 or fax at 1-866-475-5745.

For recurring appointments, such as dialysis or adult day care, the member's health coordinator, PCP or care provider must request rides by calling ModivCare's Facility Line at 1-866-475-5746 (or faxing 1-866-475-5745). The request must be made **once per quarter**.

Discharges from a facility are considered urgent. Facilities may call ModivCare's Facility Line at 1-866-475-5746 (or fax 1-866-475-5745) to arrange transport.

Members must call between 7:45 a.m. – 4:30 p.m. HT, Monday-Friday, to schedule transportation. If they have questions about their order, they may call ModivCare.

Type of Request	Contact	Time Frame	Fax	Phone
Urgent air transportation requests	**UnitedHealthcare Community Plan 1-888-980-8727**	At least 3 business days advance notice.	1-800-267-8328	**1-888-980-8728** TTY: **711** (for hearing impaired)
Non-emergency air transportation requests (including transportation needed as part of air transportation)		At least 14 calendar days advance notice.		
Special Instructions: If ground transportation is needed as part of an air transportation request, please check the box at the bottom of the Transportation Form. Add any special notes about the request (e.g., wheelchair, gurney, level of transport, wheelchair service at airport, meals or lodging may be needed). If the member also needs ground transportation from his/her home to and from the airport on the date of travel, please specify the member's physical address to ensure timely pickup and drop off.				
Routine ground transportation (not part of the air transportation)	ModivCare (Transportation Vendor)	Routine ground transportation requires a 48-hour advance request.	1-800-475-5745	1-866-475-5746
		Requests for a Monday trip should be made by Thursday at noon.		

Non-medical transportation

This service gives individuals access to community services, activities, and resources, specified by the service plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be used. Members living in a residential care setting or a CCFFH are not eligible for this service.

Babyscripts

Pregnant members can sign up for Babyscripts™ by visiting the Apple App Store® or Google Play™ store on their smartphone and downloading the Babyscripts™ myJourney app.

Babyscripts™ engages members in a variety of methods (app notifications, email and text messages) and provides daily education on important topics that are specific to pregnancy stages.

Members will also receive appointment reminders for recommended doctor visits and can earn up to 3 Walmart Healthy Living gift cards for completing important prenatal and postpartum visits.

Members self-enroll on a smartphone or computer. They can go to **babyscripts.com** or call **1-800-599-5985.**

How can you help

1. Identify UnitedHealthcare Community Plan members during prenatal visits.
2. Provide program information.
3. Encourage the member to enroll in Babyscripts™.

Cardiology

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** > Prior Authorization and Notification Tool
- Phone: **1-866-889-8054** from 7 a.m. - 7 p.m., Monday-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.

Clinical trials

Not all clinical research studies are open to QUEST members. An approved clinical trial is defined as Phase I, Phase II, Phase III, or Phase IV related to the prevention, diagnosis, treatment, palliative care or supportive care of cancer. It must be reviewed and approved by 1 or more of the following:

- The National Institutes of Health (NIH)
- National Cancer Institute (NCI)
- Centers for Disease Control and Prevention (CDC)
- Agency for Healthcare Research and Quality (AHRQ)
- CMS
- Department of Defense (DOD)
- Department of Veterans Affairs (VA)

This includes trials conducted under a new drug application (IND) reviewed by the Food and Drug Administration (FDA).

Covered services

Covered services include all items and services normally covered under the QUEST plan that would be covered if member were not involved in a clinical trial. Items or services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications. Items or services needed for medically necessary care arising from the provision of an investigational item or service, in particular, for the diagnosis or treatment of complications.

Non-covered services

The following items or services are not covered:

- Investigational item or service, unless otherwise covered outside the clinical trial
- Provided solely to satisfy data collection and analysis needs not used in the member's direct clinical management
- Provided by the research sponsors free-of-charge for participation in the trial
- Except for being provided in a clinical trial, otherwise specifically excluded from coverage under the QUEST plan
- Excluded from QUEST plan coverage
- For a clinical trial that does not have therapeutic intent

Exception: We will cover travel and transportation expenses if not covered by the approved agency sponsoring or conducting the clinical research study.

Durable medical equipment

Durable medical equipment (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

See our Coverage Determination Guidelines at **UHCprovider.com/policies** > For Community Plans > **Medical & Drug Policies and Coverage Determination Guidelines for Community Plan**.

Emergency/urgent care services

Emergency services are any covered inpatient and outpatient services that are furnished by a care provider qualified to furnish services and that are needed to evaluate or stabilize an emergency medical condition.

Inpatient and outpatient emergency health services are covered inside or outside of our service area. In the event of an emergency, the member should seek immediate care, or call 911 for help. Prior authorization is not required, and we will not deny payment if a contracted care provider instructs a member to seek emergency services.

UnitedHealthcare Community Plan provides coverage for the treatment of an emergency medical condition, which is defined by DHS as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the physical or mental health of the individual (or, with respect to a pregnant member, the health of the member or their unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious harm to self or others due to an alcohol or drug abuse emergency;
- Injury to self or bodily harm to others; or
- With respect to a pregnant member having contractions: 1) that there is not adequate time to effect a safe transfer to another hospital before delivery, or 2) that transfer may pose a threat to the health or safety of the member or their unborn child.

An emergency medical condition shall not be defined on the basis of lists of diagnoses or symptoms.

UnitedHealthcare Community Plan will base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and will cover emergency services when the presenting symptoms are of sufficient severity to constitute an emergency condition in the judgment of a prudent layperson. The ER physician or the treating care provider is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

We do not limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. We do not refuse to cover emergency services based on the ER care provider, hospital or fiscal agent not notifying the member's PCP or UnitedHealthcare Community Plan of the member's screening and treatment within 10 calendar days of presentation for emergency services.

We do not hold the member, who has an emergency medical condition, liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. We accept the emergency physician or care provider's determination of when the member is sufficiently stabilized for transfer or discharge.

UnitedHealthcare Community Plan includes coverage for post-stabilization services. Post-stabilization services are provided after a member is stabilized after a related emergency medical condition to maintain the stabilized condition or to improve or resolve the member's condition. The attending physician or care provider determines when the condition is no longer an emergency and the member is considered stabilized for discharge or transfer. Continuation of care after the condition is no longer an emergency will require coordination with UnitedHealthcare Community Plan.

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

UnitedHealthcare Community Plan includes coverage for urgently needed health services and symptomatic office visits. A symptomatic office visit is an encounter associated with a presentation of medical symptoms or signs, but not requiring immediate attention. Urgent care is the diagnosis and treatment of medical conditions which are serious or acute but pose no immediate threat to life and health but which require medical attention within 24 hours.

Urgent care is appropriately provided in a clinic, in a physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent care does not include PCP services or services provided to treat emergency conditions. Urgently needed services are also covered when obtained from any care provider within the UnitedHealthcare Community Plan service area in extraordinary cases in which UnitedHealthcare Community Plan contracted care providers are unavailable or inaccessible due to an unusual event.

Our contracted care providers must notify us if a member is admitted to the hospital. The PCP should work with the attending physician to coordinate transfer to a contracted facility as soon as medically appropriate.

Urgent care (non-emergent)

Urgent care services are covered.

For a list of urgent care centers, call **Provider Services**.

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

Nurses in the Health Services Department review emergency admissions within 1 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**.

Nurses in the Health Services Department review emergency admissions within 1 business day of notification.

UnitedHealthcare Community Plan makes utilization management (UM) determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally developed clinical criteria. UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize UM staff to support service underutilization.

The criteria are available in writing upon request or by calling **Provider Services**.

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

End-of-life care: Our Care, Our Choice Act

The state's Medicaid FFS program covers end-of-life care. Members with a terminal illness who have 6 months or less to live can voluntarily request for medical aid-in-dying medication to end their life peacefully. Services include physician, consult, counseling visits and self-administered medications. UnitedHealthcare QUEST will deny any claims billed with code combination of T1023/SE. Contact the State Medicaid FFS Program for more information.

Facility admission notification requirements

Facilities are responsible for admission notification for the following inpatient admissions (even if an advanced notification was provided before the 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

Family planning

Family planning services are preventive health, medical, counseling and educational services that help members manage their fertility and achieve the best reproductive and general health. UnitedHealthcare Community Plan members may access these services without a referral. They may also seek family planning services at the care provider of their choice. The following services are included:

- Annual gynecological examination
- Annual pap smear
- Contraceptive supplies, devices and medications for specific treatment
- Diagnosis and treatment of sexually transmitted diseases
- Contraceptive counseling
- Emergency contraception
- Laboratory services
- Pregnancy testing

Blood tests to determine paternity are covered **only** when the claim indicates tests were necessary for legal support in court.

Non-covered items include:

- Reversal of voluntary sterilization
- Hysterectomies for sterilization
- In-vitro fertilization, including:
  - GIFT (Gamete intrafallopian transfer)
  - ZIFT (zygote intrafallopian transfer)
  - Embryo transport
- Infertility services, if given to achieve pregnancy
  Note: Diagnosis of infertility is covered. Treatment is not.

Parenting/child birth education programs

- Child birth education is covered.
- Parenting education is not covered.

Voluntary sterilization

In-network treatment with consent is covered. The member needs to give consent 30 days before surgery, be mentally competent and be at least 21 years old at the time of consent for:

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the DHS Regulations for more information on sterilization.

Gender dysphoria services and treatment

Gender dysphoria is a condition in which different opinions exist between an individual's assigned gender and their experienced or expressed gender (i.e., an individual feeling a difference between their self-image and actual experience). Children, adolescents and adults experience gender dysphoria.

Treatment options

Treatment options include behavioral therapy, psychotherapy, hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. Treatment may include surgery.

Surgical treatment options

Surgical treatments may include the following:

- Clitoroplasty
- Hysterectomy
- Labiaplasty
- Mastectomy
- Orchiectomy
- Penectomy
- Phalloplasty or metoidioplasty (alternative to phalloplasty)
- Placement of testicular and/or penile prostheses
- Salpingo-oophorectomy
- Scrotoplasty
- Urethroplasty
- Vaginectomy
- Vaginoplasty
- Vulvectomy

Other terms used to describe surgery for gender dysphoria include sex transformation surgery, sex change, sex reversal, gender change, transsexual surgery, transgender surgery and sex reassignment.

Benefits limitations and exclusions

Certain treatments and services are not covered. Non-covered examples include:

- Treatment received outside of the United States
- Reproduction services, including sperm preservation in advance of hormone treatment or gender dysphoria surgery, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm and host uterus
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics
- Cosmetic procedures

Certain ancillary procedures are considered cosmetic and not medically necessary when performed as part of a surgical treatment for gender dysphoria. These include:

- Abdominoplasty
- Blepharoplasty
- Body contouring
- Breast enlargement, including augmentation mammaplasty and breast implants
- Brow lift
- Calf implants
- Cheek, chin and nose implants
- Face/forehead lift and/or neck tightening
- Facial bone remodeling for facial feminization
- Hair transplantation
- Injection of fillers or neurotoxins
- Laser or electrolysis hair removal not related to genital reconstruction
- Lip augmentation
- Lip reduction
- Liposuction (suction-assisted lipectomy)
- Mastopexy
- Pectoral implants for chest masculinization
- Rhinoplasty
- Skin resurfacing (i.e., dermabrasion, chemical peels, laser)
- Thyroid cartilage reduction/reduction thyroid chondroplasty/trachea shave (removal or reduction of the Adam's apple)
- Voice modification surgery (i.e., laryngoplasty, glottoplasty or shortening of the vocal cords)
- Voice lessons and voice therapy

Prior authorization

Prior authorization is required for all surgical procedures to determine medical necessity.

Health education

Our health education program is led by our qualified, full-time health education manager. You are encouraged to collaborate with us to ensure health education services are provided to members. This program is a proactive approach to help members manage specific conditions and support them as they take responsibility for their health.

The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle
- Improve the quality of care, quality of life and health outcomes of members
- Help individuals understand and actively participate in the management of their condition, adherence to treatment plans, including medications and self-monitoring
- Reduce unnecessary hospital admissions and ER visits
- Promote care coordination by collaborating with care providers to improve member outcomes
- Prevent disease progression and illnesses related to poorly managed disease processes
- Support member empowerment and informed decision making
- Effectively manage their condition and co-morbidities, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues

Our program makes available population-based, condition-specific health education materials, websites, interactive mobile apps and newsletters that include recommended routine appointment frequency, necessary testing, monitoring and self-care. We send health education materials, based upon evidence-based guidelines or standards of care, directly to members that address topics that help members manage their condition. Our program provides personalized support to members in case management. The case manager collaborates with the member to identify educational opportunities, provides the appropriate health education and monitors the member's progress toward management of the condition targeted by the health education program.

Programs are based upon the findings from our Health Education, Cultural and Linguistic Group Needs Assessment (GNA) and will identify the health education, cultural and linguistic needs.

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice. Prior authorization is required only for services provided in an inpatient hospital setting. Prior authorization is not needed for hospice services provided in a standalone SNFs.

Laboratory

Use UnitedHealthcare Community Plan network laboratories when referring members for lab services not covered in the office. Medically necessary laboratory services ordered by a PCP, other care provider or dentist in 1 of these laboratories do not require prior authorization except as noted on our prior authorization list.

For more information on our in-network labs, go to **UHCprovider.com/findprovider** > **Preferred Lab Network**.

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 providers rendering clinical laboratory and certain other diagnostic services.

See the Billing and Submission chapter for more information.

Maternity/pregnancy/ well-child care

Pregnancy/maternity

Bill the first pregnancy visit as a separate office visit. You may bill global days if the member has been a UnitedHealthcare Community Plan member for at least 3 consecutive months or had at least 7 prenatal visits.

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

4. The member was in their second or third trimester of pregnancy when they became a UnitedHealthcare Community Plan member, and
5. If they have an established relationship with a non-participating obstetrician.

UnitedHealthcare Community Plan must approve all out-of-plan maternity care. Call Provider Services to obtain prior approval for continuity of care.

To notify UnitedHealthcare Community Plan of pregnancies, call Hāpai Mālama at **1-888-980-8728** (TTY users: **711**). You can also use the Care Conductor and Notification of Pregnancy tool on our Provider Portal.

A UnitedHealthcare Community Plan member does not need a referral from her PCP for OB/GYN care. Perinatal home care services are available for UnitedHealthcare Community Plan 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**.

Provide the following information within 1 business day of the admission:

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

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

- Date of delivery
- Sex
- Birth weight
- Gestational age
- Baby name

Non-routine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires prior authorization. Infants remaining in the hospital after the parent's discharge require separate notification and will be subject to medical necessity review. The midwife (CNM) must be a licensed registered nurse recognized by the Board of Nurse Examiners as an advanced practice nurse (APN) in nurse-midwifery and certified by the American College of Nurse-Midwives.

A CNM must identify a licensed care provider or provider group with whom they have arranged for referral and consultation if complications arise.

Furnish obstetrical maternity services on an outpatient basis. This can be done under a physician's supervision through an NP, PA or licensed professional nurse. If handled through supervision, the services must be within the staff's scope of practice or licensure as defined by state law.

You do not have to be present when services are provided. However, you must assume professional responsibility for the medical services provided and help ensure approval of the care plan.

Post maternity care

UnitedHealthcare Community Plan covers post-discharge care to the member and their newborn. Post-discharge care consists of a minimum of 2 visits 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. Prior authorization is required for home health care visits for post-partum follow-up. Complete the postpartum visit 7-84 days after birth.

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.

The member must also notify DHS of the birth of their newborn. The DHS normally assigns the newborn to the same QUEST health plan as the member's. DHS will notify the member that they may select a different health plan for their newborn at the end of the 30-day period (if the member has not chosen a different health plan for their newborn). Choice of health plan will be effective the first day of the following month.

Bright Futures Guideline

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics and supported by the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

The Bright Futures Guideline recommendations are for all preventive care screenings and well-child visits. The state of Hawaii Med-QUEST division recommends using Bright Futures into your daily practice. Access the AAP/Bright Futures periodicity schedule and guideline at pediatriccare.solutions.aap.org/DocumentLibrary/periodicity_schedule.pdf.

The main goal of Bright Futures is to support primary care practices (medical homes) in providing well-child and adolescent care based on *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Settings for Bright Futures include private practices, hospital-based or hospital affiliated clinics, resident continuity clinics, school-based health centers, public health clinics, and community health centers.

The state of Hawaii Med-QUEST division supports the Bright Futures' medical home model and recommends the Hilopa'a Family to Family services for parents or caregivers of someone with special health care needs. Call them at 1-808-791-3467 or visit hilopaa.org.

Home care and all prior authorization services

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

Hysterectomies

Hysterectomies cannot be reimbursed if performed for sterilization. Members who get hysterectomies for medical reasons must be told, orally and in writing, they will no longer be able to have children.

All hysterectomy claims (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by a consent form. The member should sign and date the form stating they were told before the surgery that the procedure will result in permanent sterility.

Find the form medquest.hawaii.gov/en/resources/forms.html.

See Sterilization consent form section on next page for more information. Exception: Hawaii DHS does not require informed consent if:

6. As the care provider performing the hysterectomy, you certify in writing the member was sterile before the procedure. You must also state the cause of the sterility.
7. 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.

Mail the claim to claims administration identified on the back of the member's ID card. 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

Pregnancy termination services are not covered, except in cases to preserve the member's life. In this case, follow the Hawaii consent procedures for abortion.

Allowable pregnancy termination services do not require a referral from the member's PCP. Members must use our provider network.

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, the State Medical Assistance Program must have documented evidence that all the sterilization requirements have been met before making a payment. The member must sign the Medical Assistance 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 Hawaii Department of Social Services Medical Assistance Consent Form for sterilization is properly filled out. A member has only given informed consent if the federal form HHS 687 is completed. Other consent forms do not replace the Medical Assistance Consent Form. Be sure the member fully understands the sterilization procedure and has been told of other family planning options. 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** before submitting it with the billing form. The Hawaii Medical Assistance Program cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.
- 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.

You may also find the form on medquest.hawaii.gov.

Have 3 copies of the consent form:

- For the member.
- To submit with the Request for Payment form.
- For your records.

Neonatal Intensive Care Unit case management

The Neonatal Intensive Care Unit (NICU) management program manages inpatient and post-discharge 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/policies** > For Community Plans > **Clinical Guidelines**.

Pharmacy

Visit **UHCprovider.com/hicommunityplan** > **Pharmacy Resources and Physician Administered Drugs** for pharmacy prior authorization forms, Preferred Drug Lists (PDLs), and other important pharmacy information.

Home delivery and mail order services (Medicare-Medicaid eligible)

UnitedHealthcare Community Plan QUEST members can receive up to a 30-day supply of covered medications through our mail order program.

Members with UnitedHealthcare Medicare Dual Special Needs coverage can also receive their medication through mail order.

Retail pharmacies

UnitedHealthcare Community QUEST members can go to participating pharmacies and get up to a 90-day supply of most covered medicines.

Members with UnitedHealthcare Medicare Dual Special Needs Program can receive up to a 100-day supply of most covered medications at participating retail pharmacies.

To help members arrange mail order pharmacy services, have the member call **Optum Rx** at **1-877-889-6358**.

Pharmacy Preferred Drug List

UnitedHealthcare Community Plan determines and maintains its PDL of covered medications. This list applies to all UnitedHealthcare Community Plan of Hawaii members.

You must prescribe Medicaid members drugs listed on the PDL. We may not cover brand-name drugs not on the PDL if an equally effective generic drug is available and is less costly unless prior authorization is followed.

If a member requires a non-preferred medication, call the Pharmacy Prior Authorization department at **1-800-310-6826**. Or use CoverMyMeds at covermymeds.com to submit the request.

We provide you PDL updates before the changes go into effect. Change summaries are posted on **UHCprovider.com**. Find the PDL and Pharmacy Prior Notification Request form at **UHCprovider.com/priorauth**.

Pharmacy prior authorization

Medications can be dispensed 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 those affected by a clinical prior authorization edit.

To request pharmacy prior authorization, call Pharmacy Prior Authorization at **1-800-310-6826**. We provide notification for prior authorization requests within 24 hours of request receipt.

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 1 or more of the following characteristics:

- Is 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** > Clinical Pharmacy and Specialty Drugs.

Radiology

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** > Prior Authorization and Notification Tool.
- Phone: **1-866-889-8054** from 8 a.m. – 5 p.m. CT, Monday-Friday. Make sure the medical record is available.

For a list of Advanced Outpatient Imaging Procedures that require prior authorization, a prior authorization crosswalk, and/or the evidence-based clinical guidelines, go to **UHCprovider.com/radiology** > Specific Radiology Programs.

Screening, Brief Interventions, and Referral to Treatment services

Screening, Brief Interventions, and Referral to Treatment (SBIRT) services are covered when:

- Provided by, or under the supervision of, a certified care provider or other certified licensed care provider within the scope of their practice.
- Determining risk factors related to alcohol and other drug use disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed.
- SBIRT screening will occur during an Evaluation and Management (E/M) exam and is not billable with a separate code. You may provide a brief intervention on the same day as a full screen in addition to the E/M exam. You may also perform a brief intervention on subsequent days. Brief interventions

are limited to 4 sessions per patient, per care provider per calendar year.

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 drug (substance) use problems and determine how severe those problems already are. 3 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 and certified behavioral health agency for assessment and treatment of a substance use disorder. **This includes coordinating with the alcohol and drug program in the county where the member resides for treatment.**

SBIRT services will be covered when all of the following are met:

- The billing and servicing care providers are SBIRT certified.
- The billing care provider has an appropriate taxonomy to bill for SBIRT.
- The diagnosis code is V65.42.
- The treatment or brief intervention does not exceed the limit of 4 encounters per client, per care provider, per year.

The SBIRT assessment, intervention, or treatment takes places in 1 of the following places of service:

- Office
- Urgent care facility
- Outpatient hospital
- ER – hospital
- FQHC
- Community mental health center
- Indian health service – freestanding facility
- Tribal 638 freestanding facility
- Homeless shelter

For more information about E/M services and outreach, see the Department of Health and Human Services Evaluation and Services online guide at cms.gov.

Medication-assisted treatment

Medication-assisted treatment (MAT) combines behavioral therapy and medications to treat opioid use disorders (OUD). The FDA-approved medications for OUD include buprenorphine, methadone and naltrexone.

To prescribe buprenorphine, you must have a current registration with the United States Drug Enforcement Agency (DEA) and be authorized to prescribe buprenorphine in the state.

As a medical care provider, you may provide MAT services even if you don't offer counseling or behavioral health therapy in-house. However, you must refer your patients to a qualified care provider for those services.

As a medical care provider, you may provide MAT services even if you don't offer counseling or behavioral health therapy in-house. However, you must refer your patients to a qualified care provider for those services.

If you need help finding a behavioral care provider, call the number on the back of the member's health plan ID card or search for a behavioral health professional on **liveandworkwell.com**.

Talk to members about crisis management supports they may need. To find a medical MAT care provider in Hawai'i:

- Go to **UHCprovider.com.**
- Select "Our Network," then "Find a Provider" from the menu on the home page.
- Select the care provider information.
- Click on "Medical Directory."
- Click on "Medicaid Plans."
- Click on applicable state.
- Select applicable plan.
- Refine the search by selecting "Medication Assisted Treatment."

If you have questions about MAT, please call **Provider Services** at **1-877-842-3210**, enter your TIN then say "Representative," and "Representative" a second time. Say "Something Else" to speak to a representative.

Tuberculosis screening and treatment

Guidelines for tuberculosis (TB) screening and treatment should follow the recommendations of the American Thoracic Society (ATS) and the Centers for Disease Control and Prevention (CDC).

The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all members at increased risk unless they have documentation of prior positive test results or currently have active TB under treatment. You will coordinate and collaborate with local health departments (LHDs) for TB screening, diagnosis, treatment, compliance, and follow-up of members. PCPs must comply with all applicable state laws and regulations relating to the reporting of confirmed and suspected TB cases to the LHD. The PCP must report known or suspected cases of TB to the LHD TB Control Program within 1 day of identification.

Waiver programs

Human immunodeficiency virus (HIV)/ Acquired immune deficiency syndrome (AIDS) HCBS waiver program

The HIV/AIDS in-home waiver services program is available to members who would otherwise require long-term institutional services.

Identification – Members with symptomatic HIV or AIDS who require nursing home level of care services may be eligible for the waiver. The care coordinator or the PCP may identify members potentially eligible for the waiver program. They may also inform the member of the waiver program services.

Referral – If the member agrees to participation, provide the waiver agency with supportive documentation including history and physical, any relevant labs or other diagnostic study results and current treatment plan.

Continuity of Care – The HIV/AIDS waiver program will coordinate in-home home- and community-based services (HCBS) in collaboration with the PCP and care coordinator. If the member does not meet criteria for the waiver program, or declines participation, the health plan will continue care coordination as needed to support the member.

Other federal waiver programs

Other waiver services, including the Nursing Facility Acute Hospital Waiver, may be appropriate for members who may benefit from HCBS services. These members are referred to the Long Term Care Division/ HCBS Branch to determine eligibility and availability. If deemed eligible, the health plan will continue to cover all medically necessary covered services for the member unless/until member is disenrolled from UnitedHealthcare QUEST.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

- Patient name and ID number
- Ordering care provider and TIN/NPI
- Rendering care provider and TIN/NPI
- ICD clinical modification (CM)
- Anticipated dates of service
- Type of service (primary and secondary) procedure codes and volume of service, when applicable
- Service setting
- Facility name and TIN/NPI, when applicable

For behavioral health and substance use disorder authorizations, please contact **Optum Behavioral Health**.

If you have questions, go to your state's prior authorization page at **UHCprovider.com/HIcommunityplan** > **Prior Authorization and Notification**.

The following table lists medical management notification requests and the amount of time required for a decision, approval or denial.

Type of request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent pre-service	Within 5 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 3 days of request receipt	Within 3 days of the request	Within 3 days 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

Carved-out services

These services are not covered by UnitedHealthcare Community Plan but are offered through the state or other local agency. See **Chapter 6** for more information:

- Services for Adults with severe mental illness (SMI) or severe and persistent mental illness (SPMI)
- Developmental Disabled/Intellectually Disability (DD/ID) services
- Child and Adolescent Mental Health Division (CAMHD) services for children ages 3 through 20
- Behavioral Health Services for Children/Support for Emotional and Behavioral Development (SEBD) program
- Cleft and craniofacial services
- Abortions or intentional termination of pregnancies (ITOPs)
- End of Life Care Option (Our Care, Our Choice Act)
- Dental services
- School-based services
- Zero-to-Three services
- State of Hawaii Organ and Tissue Transplant (SHOTT) program
- Services provided by another state, county or federal program
- Any services otherwise provided to a member by a local, state or federal agency or facility
- Services for members determined eligible and transferred to the Department of Health's Adult Mental Health Division (AHMD) for services
- Members criminally committed for evaluation or treatment in an inpatient setting under the provisions of Chapter 706, HRS

Case management

We provide case management services to members with complex medical conditions or serious psychosocial issues. The Medical Case Management Department assesses members who may be at risk for multiple hospital admissions, increased medication use, or would benefit from a multidisciplinary approach to medical or psychosocial needs.

Refer members for case management by calling **Member Services** at **1-888-980-8728**. Additionally, UnitedHealthcare Community Plan provides the **Hāpai Mālama** program, which manages members with high-risk pregnancies.

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 and ambulatory facilities. We perform a record review or phone review for each day's stay using Interqual, CMS or other nationally recognized guidelines to help clinicians make informed decisions in many health care settings. 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 finds medical necessity clinical information for a continued inpatient stay, including review for extending a previously approved admission. It may be done by phone or record review.

Concurrent review involves notification within 24 hours or 1 business day of admission when all clinical information is included. For requests without all necessary clinical information, please try at least once to obtain the necessary clinical information. Document the attempt within the initial 24 hours of the request. For instances where all clinical information is not available, the time frame to make the determination and send notification is extended to 72 hours from the initial request.

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.

UnitedHealthcare Community Plan uses Interqual, CMS or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, SNFs, home health care and ambulatory facilities.

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
- 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
- Not experimental treatments

Support the opportunity for an enrollee receiving long-term services and supports (LTSS) to have access to benefits of community living, to achieve person-centered goods, and to live and work in the setting of their choice.

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. You may freely communicate with members about their treatment, regardless of benefit coverage limitations.

Hāpai Mālama

Hāpai Mālama is a specialized case management program designed to improve the health and well-being of all pregnant members. It gives particular attention to those with a high-risk pregnancy and special health care needs. It tracks the member's adherence to the recommended prenatal treatment plan. It also highlights activities and treatments that prevent prenatal and postpartum medical and behavioral complications. Use the Obstetrics Risk Assessment form at **UHCprovider.com/hicommunityplan** > Provider Forms and References > **Obstetrics Risk Assessment Form** to screen members.

Hāpai Mālama care model

The Hāpai Mālama care model strives to:

- Identify pregnant members and to provide education on the importance of initiating prenatal care within the first trimester of pregnancy (or within 42 days of member health plan enrollment)
- Raise the number of pregnant members who are enrolled in the program
- Base member stratification on medical, behavioral health, long-term care and special healthcare needs
- Work with obstetrical care providers on condition monitoring, managing co-morbidities and adherence to treatment plans
- Increase member awareness of pregnancy management, preventive health behaviors, importance of recognizing and reporting symptoms of early labor and/or pregnancy complications, and compliance with the service plan
- Raise adherence to prescribed medications
- Reduce environmental barriers to care related to transportation, translation services, and phone access to assure compliance with required appointments, laboratory and prenatal testing procedures
- Identify more members who use tobacco and refer them for smoking cessation
- Raise the percentage of pregnant members who get their post-partum exam 7-84 days post-partum
- Lower the rate of preterm deliveries annually
- Reduce the rate of low birth weight and very low birth weight infants
- Cut back the annual NICU admission rate and NICU length of stay
- Teach the importance of routine health exams and EPSDT check-ups
- Apply an integrated approach that uses health coordinators, Hāpai Mālama CHWs, behavioral health advocates, clinical program managers, inpatient care managers, UM managers, quality clinical practice managers, medical directors, and nonclinical support staff, in a collaborative effort to increase timeliness of prenatal and postpartum care

Call us when a member becomes pregnant: **1-888-980-8728**.

Medical and drug policies and coverage determination guidelines

Find medical policies and coverage determination guidelines at **UHCprovider.com/policies** > For Community Plans > **Medical and Drug Policies and Coverage Determination Guidelines for Community Plan**.

Referral guidelines

You must coordinate member referrals for medically necessary services beyond the scope of your practice. Monitor the referred member's progress and help ensure they are returned to your care as soon as appropriate.

We require prior authorization for 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, but not limited to, the following:

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

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

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 **UHCprovider.com**, contacting UnitedHealthcare Community Plan's Provider Services Department, or the Hawaii Medicaid Eligibility System
- 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:

- Services UnitedHealthcare Community Plan decides are not medically necessary
- Non-covered services
- Services provided to members not enrolled on the date(s) of service

Second opinion benefit

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the Hawaii DHS. These access standards are defined in **Chapter 2**. The care provider giving the second opinion must not be affiliated with the attending care provider.

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. The PCP forwards a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion then forwards their report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If a network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating care provider. The participating care provider should contact UnitedHealthcare Community Plan at Hawai'i: **1-888-980-8728**.
- 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

Health coordination

Members receiving LTSS and those with special health care needs (SHCN) are assigned a health coordinator.

Once the eligible member is identified, the health coordinator contacts member. If the member wishes to participate, they complete a comprehensive assessment of the member's health status. With member input and participation, the health coordinator develops the member's service plan. This includes:

- Making long-term and short-term goals
- Identifying any barriers to meeting member's goals
- Documenting in the automated care management system
- Implementing automated tasks and reminders to help ensure follow-up

The health coordinator uses evidence-based clinical practice guidelines for ongoing management and evaluation.

Health coordinators send copies of the LTSS/SHCN member service plans to the PCP. They make calls to the PCP if they have specific concerns.

For PCPs with a higher volume of our LTSS/SHCN members, we have a more targeted approach. This include case reviews with the medical director, the PCP and other members of the care team. We also fax service plans to PCP for their input and review.

Health coordination

Care coordination also includes referrals for services covered through other programs, such as:

- CAMHD
- Community Care Services (CCS)
- Department of Education - Women, Infants and Children Supplemental Nutrition Program (WIC)
- SHOTT

Not all members will have a health coordinator. Health coordination is for QUEST members with SHCN, Expanded Health Care Needs (EHCN), and members who may need LTSS or Community Integration Services (CIS).

Role of PCP in health coordination

The PCP serves as the point of initial contact and as the member's "medical home." They are responsible for:

- Providing medical oversight to the health coordination process
- Being fully aware of all services delivered
- Conducting face-to-face medical assessments
- Providing primary care medical services and coordinating care with in-network specialist physicians (out-of-network physicians by the prior authorization process), as needed
- Participating in the creation and maintenance of the service plan including establishing goals with the needs of the member
- Providing clinical education to the care team
- Working with the care team to provide the member and their family education in disease self-management
- Implementing care that is consistent with best practice guidelines and customizing for the member
- Collaborating with the health coordinator
- Supporting and facilitating connections with local community care and service care providers

Role of other care providers

Specialists, behavioral health care providers, therapists, home- and community-based care providers, assisted living services providers, and other care providers are included in the service planning process. HCBS care providers can't develop the member's service plan, however they may inform the development of the plan. Health coordinators work with care providers to arrange care based on the results of the member assessment and service plan.

When to contact health coordinators

Please contact a member's health coordinator when:

- You cannot contact the member
- You cannot provide or arrange for medically necessary services
- There is a significant change in the member's condition
- The member unexpectedly leaves their place of residence
- The member is admitted to the hospital
- The member suffers a fall
- There are skin integrity issues
- There are behavioral health issues
- The member elects hospice
- There is a bed hold and therapeutic leave request (nursing facilities only)
- The member needs outpatient therapies including PT/OT/ST/RT
- The member dies

If you feel the member could benefit from health coordination but does not have currently have this benefit, refer that member to the health coordination team for an assessment. You may call Member Services at **1-888-980-8728** or use the Health Coordination Coordination Referral Form found at **UHCprovider.com**.

Services requiring prior authorization

For a list of services that require prior authorization and related forms, go to **UHCprovider.com/hicommunityplan** > **Prior Authorization and Notification**.

Pharmacy

To receive prior authorization for prescriptions, you must call our Pharmacy Prior Notification department at **1-800-310-6826**. Or submit requests through the CoverMyMeds website at covermymeds.com.

The prior authorization forms are on **UHCprovider.com/HIcommunityplan** > Pharmacy Resources and Physician Administered Drugs.

Direct access services – Native Americans

Native Americans seeking tribal clinic or Indian Health hospital services do not require prior authorization.

Seek prior authorization within the following time frames

- **Emergency or urgent facility admission:** 1 business day
- **Inpatient admissions; after ambulatory surgery:** 1 business day

- **Non-emergency admissions and/or outpatient services (except maternity):** at least 14 business days beforehand. If the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time.

Utilization management guidelines

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.Call **Provider Services** at **1-888-980-8728** to discuss the guidelines and utilization management.

Medical director

You can discuss the requested services with the physician who will make the decision by calling our medical director at **1-888-980-8728**. Select option 1 and then option 1 again (for Medicaid). Or call **1-800-410-1925** and select option 1 (for Medicare).

Utilization management 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 **Chapter 12** for more details.

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

Key contacts

Topic	Link	Phone Number
EPSDT	medquest.hawaii.gov > Plans & Providers > EPSDT	1-808-524-3370
Vaccines for Children	health.hawaii.gov > Vaccines and Immunizations > Vaccines for Children	1-808-586-8300

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) prevention benefit provides comprehensive and preventive health care services for children younger than age 21 who are enrolled in Medicaid.

Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members to age 21, including pregnant members. EPSDT screening includes immunizations, hearing, vision, speech screening and nutritional assessments; dental screening; and growth and development tracking.

For complete details about diagnoses codes as well as full and partial screening, examination, and immunization requirements, view the EPSDT schedule at medquest.hawaii.gov > Plans & Providers > EPSDT.

Development disability services and coordination

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. The Developmental Disabilities Division is responsible for a system of diagnosis, counseling, case management, and community support of persons with intellectual disability, cerebral palsy, epilepsy, and autism for children older than 36 months to adulthood.

Referral – Refer Keiki members identified through the screening process with behavioral health challenges to CAMHD's Support for Emotional and Behavioral Development (SEBD) program.

Continuity of care – The CAMHD case manager, the member's PCP and the health plan's health coordinator arrange the member's care and services.

Early Intervention Program

The Early Intervention Program provides early intervention services to infants and toddlers with disabilities and their families.

Referral – Refer children who are identified as potentially requiring developmental intervention services to the appropriate agency for evaluation once you identified the need for services. Provide information as requested to complete the referral process. If the child has a visual impairment, hearing impairment, or severe orthopedic impairment, or any combination of these impairments, contact the Department of Health Early Intervention Program (DOHEIP) for evaluation and early intervention services. A health coordinator will be assigned to help the child's parents through the process to determine eligibility.

Continuity of care – Support the development of the Individualized Family Service Plan (IFSP) developed by the Early Start Program through the DOHEIP. UnitedHealthcare Community Plan provides member case management and care coordination to help ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the IFSP developed by the Early Intervention Program, with your participation.

Contact the DOHEIP referral line at **1-808-594-0066** for Oahu or **1-800-235-5477** for Neighbor Islands. To make a referral by fax, please download the EI referral form and instructions.

Full screening

Perform a full screen. Include:

- Interval history
- Unclothed physical examination
- Anticipatory guidance
- Lab/immunizations (Lab and administration of immunizations is reimbursed separately.)
- Lead assessment (Use the Lead Risk Assessment form.)
- Personal-social and language skills
- Fine motor/gross motor skills
- Hearing
- Vision
- Dental

Without all these age appropriate components, you cannot bill for a full screen. You may only bill for a partial screen.

Interperiodic screens

Interperiodic screens are medically necessary screens outside the standard schedule that do not require the full screen. Use this screen to start expanded services. 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.

Lead screening/treatment

Call Provider Services if you find a child has a lead blood level over 10ug/dL. Children with elevated blood lead levels are offered enrollment in a care coordination program.

SAFE/CARE examinations

The HPD covers Sexual Assault Findings Examinations (SAFE) and Child Abuse Resource Education (CARE) exams. Members can get an exam by calling the following hotlines or HPD:

Oahu
satchawaii.org/get-help
The Sex Abuse Treatment Center 1-808-524-7273 (24-hour hotline)

Kauai
YWCA of Kauai, Sexual Abuse Treatment Program 1-808-245-4144 (24-hour hotline)

Maui
Child and Family Service, Maui Sexual Assault Center 1-808-873-8624 (24-hour hotline)

Hawaii Island
YWCA of Hawaii Island, Sexual Assault Support Services 1-808-935-0677 (24-hour hotline)

Visit ag.hawaii.gov for more information.

Targeted case management

Targeted case management (TCM) consists of case 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.

Identification – The 5 target populations include:

1. Children younger than 21 years at risk for medical compromise
2. Medically fragile individuals
3. Individuals in frail health, older than 18 years and at risk of institutionalization
4. Members in jeopardy of negative health or psychosocial outcomes
5. 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

Referral – Refer eligible members to a regional center or local governmental health program, as appropriate, for TCM services. To refer, contact your local CMHC.

Continuity of care – UnitedHealthcare Community Plan is responsible for coordinating the member's health care with the TCM provider and for determining the Medical Necessity of diagnostic and treatment services recommended by the TCM provider that are covered services under the contract.

Vaccines for Children program

The Vaccines for Children Program (VFC) provides federally purchased vaccines for care provider use. The vaccines are registered with the VFC Program and are free of charge to you. This means you do not have to purchase vaccines through the VFC Program. All EPSDT care providers must register with the VFC Program.

Vaccine administration fees are reimbursable when submitted with an appropriate CPT and modifier code. We cannot reimburse for private stock vaccines when they are available through VFC.

Contact VFC if you have questions.
Phone: 1-808-586-8332 or
1-800-933-4832

Any child through 18 years of age who meets at least 1 of the following criteria is eligible for the VFC Program:

- 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. Children in this category may receive their vaccinations from an FQHC, RHC, or a private care provider using a VFC-supplied vaccine.)

Chapter 6: Value-added services

Key contacts

Topic	Link	Phone Number
Member benefits	**UHCCommunityPlan.com/HI** > Medicaid	**1-888-980-8728**
Member handbook	**UHCCommunityPlan.com/HI** > Plan Details > Member Information	
Provider Services	**UHCprovider.com**	**1-888-980-8728**
Dental	ccmchawaii.com/dental_program	1-808-792-1070 or 1-888-792-1070
Value-added services	**UHCCommunityPlan.com/HI**> Medicaid > Plan Details	

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 **1-888-980-8728** unless otherwise noted.

Covered benefit information

Benefit	Benefit description	Frequency, limitations and exclusions
Ambulance, emergent and urgent care services		
Ambulance	Emergency transport.	None
	Non-emergent medical transport.	NA
Emergency services	Covered 7days a week at any emergency room. Emergency and post-stabilization services (including observation services).	Limitation: Covered only in the USA
Urgent cares	Covered 7 days a week at any urgent care clinic or facility. Emergency and post-stabilization services (including observation services).	Limitation: Covered only in the USA

Benefit	Benefit description	Frequency, limitations and exclusions
Inpatient services – Inpatient hospital and inpatient behavioral health; observation care for behavioral health and residential substance abuse treatment; hospice, long term care and transplants.		
Inpatient hospital (medical)	Inpatient hospital care includes medical, surgical care to include post-stabilization services, maternity and newborn care, sterilization and hysterectomies as well as any emergency inpatient care.	None
Inpatient hospital (behavioral health)	Inpatient behavioral health care includes: psychiatric/ mental health or substance abuse treatment inpatient stays in a facility.	None
Cleft and craniofacial services	Care is provided in coordination with the Kapi'olani Cleft and Craniofacial Clinic and Department of Health/ Family Services Division/Children with Special Health Needs (CSHN) Branch. The clinic provides the services of pediatric dentists, orthodontists, oral surgeons, otorhinolaryngologic, pediatric psychiatrists, audiologists, speech and feeding specialists, neonatalogists, geneticists and genetic counselors.	Call the Kapi'olani Cleft and Craniofacial Clinic at 1-808-983-8500 (choose option 1).
Observation – behavioral health	Partial hospitalization for mental health or substance abuse.	None
Residential reatment facility	Alcohol and chemical dependency services – substance abuse services in a treatment setting accredited according to the standards established by the State of HawaiiDepartment of Health Alcohol and Drug Abuse Division (ADAD). Substance abuse counselors shall be certified by ADAD. Includes detoxification.	None
Hospice	End of life care – Care for the terminally ill and are expected to live less than 6 months. Hospice care maybe done in a hospital, other facility or in the member's home. Children younger than 21 years can receive treatment to manage or cure their disease while concurrently receiving hospice services.	None
Long term services and support and facility stays	Long term care includes skilled nursing care, intermediate care, sub-acute, and custodial care in a facility or alternative setting such as at home. Facility can be a nursing facility (NF), hospital or other facility licensed for long term care. These services are for members who need assistance with activities of daily living and require skilled monitoring and support.	Limitation: Services are based on member's eligibility by the state level of care assessment.

Benefit	Benefit description	Frequency, limitations and exclusions
Transplants by us	Cornea transplants and bone grafts. Bone grafts are covered as an orthopedic procedure.	Exclusions: Experimental and investigational transplants and those covered by SHOTT
Transplants by the State of HawaiiOrgan and Tissue Transplant (SHOTT) Program	For members with Medicare or other coverage primary to QUEST (Medicaid) - Medicare or other primary insurance payer will always pay first. QUEST or the SHOTT program will pay last: **Kidney transplants for adults (21 years old and older)** • We will coordinate coverage with the member's Medicare or other primary payer for members having only a kidney transplant. • If the member needs or has a kidney transplant plus another type of transplant (for example, a kidney transplant plus a pancreas transplant), the member's primary or other insurance payer will pay first for both transplants and then the SHOTT program will pay as secondary or last payer of resort. The SHOTT program will coordinate payment with the member's primary or other insurance payer. **Kidney transplants for children (younger than 21 years old)** We will refer the case to the SHOTT program for review and they will let us know if they will cover the kidney transplant. • If the SHOTT program accepts the member's case then the SHOTT program will coordinate payment with the member's primary or other insurance payer. • If the SHOTT program does not accept the member's case then we will coordinate payment with the member's primary or other insurance payer.	See benefit description section to the left
Inpatient professional/ medical services	Hospital, skilled nursing facility (SNF) or alternate facility – Covered during an authorized facility stay including emergent admissions.	None

Benefit	Benefit description	Frequency, limitations and exclusions
Outpatient services– Outpatient surgery, outpatient lab, imaging services and diagnostic tests; outpatient radiation therapy; blood and blood administration; outpatient therapy, cancer treatment and dialysis; outpatient behavioral health and specialized behavioral health programs.		
Outpatient surgery	Surgeries performed in an outpatient hospital or ambulatory surgical center.	None
Outpatient laboratory tests, imaging services and diagnostic tests	Laboratory tests, EKG, pulmonary function tests, sleep studies, treadmill stress tests, CT/PET/MRI/MRA, other imaging services and diagnostic tests.	None
Outpatient radiation treatment	Therapeutic radiology treatment. Radium and Isotope therapy including technician, materials and supplies.	None
Blood and blood administration	Blood, blood components and blood clotting factors are covered as part of the emergency/urgent care, inpatient, or outpatient surgery benefits or as medically necessary.	None
Outpatient therapy and rehabilitation services	Includes outpatient therapy and rehabilitation services such as physical, occupational, audiology, speech, and respiratory therapy.	None
Outpatient cancer services	Includes diagnosis and treatment of cancer – physician services, other practitioner services, outpatient hospital services, chemotherapy, radiation therapy, or other services related to the diagnosis and treatment of cancer.	None
Renal dialysis services	Dialysis services include equipment, supplies, diagnostic/ lab tests, drugs. Members with chronic dialysis needs are reviewed for possible change or determination for disability through the ADRC process.	Noned
Outpatient behavioral health	Includes professional services for evaluation, testing and treatment of mental illnesses and/or substance abuse including therapy and medication management; individual and group therapy sessions. See specific services listed below for additional information.	None
	Standard outpatient behavioral health services such as visits to a psychiatrist, psychologist, or behavioral health advance practice nurse practitioner (APRN).	None
	Mental health individual therapy sessions/ medication management.	None

Benefit	Benefit description	Frequency, limitations and exclusions
Outpatient detoxification	Outpatient medically managed detoxification treatment.	None
Methadone management services	Methadone/LAAM services for adult members are covered for acute opiate detoxification as well as maintenance.	None
Severe mental illness (SMI) or severe and persistent ental illness (SPMI) members	Services with a diagnosis of SMI and SPMI, additional outpatient services are available such as behavioral health intensive case management, psychosocial rehabilitation, therapeutic living program, mental health support and crisis management.	Limitation: SMI and SPMI members only; if member is in the Community Care Services (CCS) program, the additional services will be provided through CCS.
Behavioral health intensive case management services	Includes case assessment, planning, outreach, ongoing monitoring and health coordination, including disease and self management to promote illness management and recovery.	Limitation: SMI and SPMI members only; if member is in the CCS program, the additional services will be provided through CCS.
Psychosocial rehabilitation/ clubhouse services	Therapeutic day rehab social skill building services, such as group skill building activities that focus on development of problem solving skills, medication education, and symptom management, which results in opportunities to improve the quality of life through meaningful work, positive relationships, and gainful employment.	Limitation: SPMI members only; if member is in the CCS program, the additional services will be provided through CCS.
Therapeutic iving program	Services in settings such as group living arrangements or therapeutic foster homes. Therapeutic supports are only available when the identified individual resides in a licensed group living arrangement or licensed therapeutic foster home.	Limitation: SMI and SPMI members only; if member is in the CCS program, the additional services will be provided through CCS.
SMI, mental health support and crisis management	Includes 24-hour access line, mobile crisis response, crisis stabilization, and crisis management.	Limitation: SMI and SPMI members only; if member is in the CCS program, the additional services will be provided through CCS.

Benefit	Benefit description	Frequency, limitations and exclusions
Physician services – Primary and specialty care provider services; physical exams and preventive services; home health, hearing, chiropractic, podiatry, vision and dental services.		
Primary care provider services	Services by a primary care provider (PCP). In addition to medical and related services, the PCP can help refer members to a specialist for specialty care services. A PCP can be a family practice, general practice, internal medicine, pediatrician, OB/GYN, advance practice nurse practitioner with prescriptive authority (APRN-Rx), physician assistant (PA) or community clinic provider. Fluoride Varnish: Topical fluoride varnish application by qualified PCPs will be covered for children between the age of 1 and 6 who have not received a topical fluoride treatment by a dentist or qualified PCP within the previous 6 months. You must bill topical fluoride varnish application with HCPCS code D1206.	None
Physician services	Services provided by physicians other than a PCP (including specialty care). These are services that a PCP cannot provide.	None
Physical examinations	Exams to determine the member's health status (typically provided by the PCP).	None

Benefit	Benefit description	Frequency, limitations and exclusions
Preventive services	Includes, for example, well-visits, immunizations, and screening visits. Preventive services are usually done by the PCP and include the services listed below and the specified frequency to the right. The frequency can be exceeded based on PCP recommendation.	See below for frequency per specified benefit.
	• Total cholesterol measurement	Frequency: For females age 45-65 and males 35-65, 1 exam every 5 years.
	• Pap smears and screening pelvic examinations	Frequency: 1 every 1 to 2 year(s)
	• Annual mammogram (breast cancer)	Frequency: Every 1 to 2 years starting at age 40; ages 18-40 with high risk: upon physician recommendation for members with family history of breast cancer
	• Bone mass measurement (bone density full body)	None
	• Glaucoma screening	None
	• Colorectal cancer screening	Frequency: Age 45+, 1 exam per every 2 years
	• Prostate cancer screening	Frequency: Age 50+, 1 exam per year
	• HIV/AIDS testing	None
	• Immunizations and vaccines	None
	• Blood pressure measurement	Frequency: Every 2 years if normal
	• Weight/height measurement	Frequency: Every 2 years if normal
	• Nutrition Counseling: includes diabetes self-management training (DSMT) programs as part of an American Diabetes Association (ADA)/American Association of Diabetes Educators (AADE) recognized DSMT programs, nutrition counseling for obesity, and when medically necessary for other metabolic conditions. • Requires physician's order and must be part of a treatment program to mitigate the effects of an illness or condition.	NA

Benefit	Benefit description	Frequency, limitations and exclusions
Home health services	Services include medical equipment, medial supplies, therapy or rehabilitative services, skilled nursing care, audiology, speech-language pathology and home health aides.	None
Hearing services	Services include screening, evaluation, diagnostic, or corrective services, equipment, or supplies provided by, or under the direction of an otorhinolaryngology or an audiologist to whom a patient is referred by a physician.	Frequency/Limitation: Initial Eval/Selection: Every 12 months Electroacoustic Eval: 3 years or less is 4 times per year; greater than 4 years is 2 times per year Fitting/Orientation/Hearing Aid Check: <21 years is 2 times per year; >21 years is 1 time per year
	Hearing aid device coverage is for both analog and digital models and includes service, loss, damage warranty, a trial or rental period. Prior authorization is required for hearing aid devices and replacements during the warranty period or within 3 years of the purchase or replacement of another hearing aid. If the primary insurance coverage does not cover the hearing aid devices, the care provider must request a prior authorization to cover the hearing aid under the member's QUEST benefit.	Limitation: 1 hearing aid per ear every 2 years. Limit can be exceeded if medically necessary
Chiropractic services	Not a covered benefit.	Exclusion
Podiatry care	Includes foot and ankle care related to the treatment of infection or injury provided in the office/outpatient clinic setting, surgical procedures involving the ankle and below, diagnostic radiology procedures limited to the ankle and below, bunionectomies when bunion is present with overlying skin ulceration or neuroma secondary to the bunion. Also includes professional services not involving surgery provided in the office/clinic or related to diabetic foot care in the outpatient/inpatient hospital.	None

Benefit	Benefit description	Frequency, limitations and exclusions
Vision services	**Emergency/medically necessary eye exams** • Eye/vision exams for medical diagnosis	Limited to exams to diagnose and treat diseases and conditions of the eye (not to correct poor vision/ visual acuity).
	Routine eye exams (to correct poor vision/visual acuity, must be provided by a qualified optometrist) • Vision exams • Refraction	Adults: Limit to 1 routine eye exam every 24 months Children under the age of 21: Limit to 1 eye exam every 12 months
	Visual aids – must be prescribed by ophthalmologists or optometrists • Eye glasses • Contact lenses • Miscellaneous vision supplies including prosthetic eyes, lens, frames or other parts of the glasses as well as fittings and adjustments • Replacement glasses or contact lenses	Adults/children: Limit to 1 pair of glasses or contact lenses every 24 months. (Either a pair of glasses or contact lenses.) For eye glasses, limit 1 pair of lens and 1 frame every 24 months. Individuals under 40 years of age require medical justification for bi-focal. Prior authorization is required for the following: • Contact lenses • New eye glasses with significant changes in prescription within the 24-month period • Replacement for eye glasses or contact lenses that are lost, stolen or damaged within the 24-month period • Polycarbonate glasses for adults 21 years or older • Bifocal lenses for members younger than 40 years old
	Orthopedic training, prescription fee; progress exams, radial keratotomy, visual training, Lasik procedure, and visual aids for cosmetic reasons.	Exclusion
	Cataract removal: covered under the outpatient surgery benefit.	None

Benefit	Benefit description	Frequency, limitations and exclusions
Dental services	**Routine and emergency dental** • Exams • X-rays • Preventative care and treatment	Carved out to the state: • For children under 21 years old. • Call Community Case Management Corporation (CCMC) at 1-808-792-1070 or 1-888-792-1070. We can also make a referral to CCMC.
	Emergency and routine dental services Routine dental and emergency services that include services to help relieve dental pain, eliminate infections, and treat acute injuries to teeth and jaw	Carved out to the state: • Covered for adults age 21 years and older • Call Community Case Management Corporation (CCMC) at 1-808-792-1070 or 1-888-792-1070. Individuals with primary dental insurance coverage through a Medicare Advantage or commercial payer must inform their dentist provider to help ensure appropriate coordination of benefits.
	Dental services covered by us • Dental services that are medically necessary to treat a medical condition • Dental or medical services resulting from a dental condition provided in a facility (hospital or an ambulatory surgery center) and are the result of a dental or medical condition • Dental services performed by a dentist or physician due to a medical emergency (e.g., car accident) where services provided are primarily medical • Dental services in relation to oral or facial trauma, oral pathology (including but not limited to infections or oral origin, cyst and tumor management) and craniofacial reconstructive surgery (performed on an inpatient basis in an acute care hospital setting)	Exclusion: Services provided in private dental offices, government sponsored or subsidized dental clinics, and hospital outpatient dental clinics.

Benefit	Benefit description	Frequency, limitations and exclusions
DME Prosthetics and diabetic monitoring supplies – Includes DME/Medical equipment and supplies; diabetic equipment, services and supplies.		
Durable medical equipment and medical supplies	Include but are not limited to the following: • Oxygen tanks and concentrators • Ventilators • Wheelchairs • Crutches and canes • Orthotic devices • Prosthetic devices • Pacemakers • Breast pumps • Incontinence • Foot appliances (orthoses, prostheses) • Orthopedic shoes and casts • Orthodigital prostheses and cases • Medical supplies as surgical dressings, ostomy, etc.	Incontinence supplies (diapers, underpads, liners): Provided only through Medline Industries (1-877-816-5587). Prior authorization is required for all enteral services and incontinence requests (i.e. new requests, renewals and requests for quantities exceeding the combined maximum 300 threshold limit).
Diabetic equipment	Insulin pump and glucose monitoring devices.	None
Diabetic supplies	All diabetic supplies, including but not limited to alcohol swabs, syringes, test strips and lancets. Diabetic supplies can be from a participating pharmacy or can be delivered to the member's home (from our mail order pharmacy, Optum Rx).	Limitation: Glucometers can be obtained through retail pharmacies with a prescription from you.
	Mail order pharmacy is provided through our pharmacy benefit manager Optum Rx; they can be reached at **1-877-889-6510.**	Limitation: Quantity limits apply. Please see the QUEST formulary at **UHCprovider.com/HIcommunityplan** > **Pharmacy Resources and Physician Administered Drugs**

Benefit	Benefit description	Frequency, limitations and exclusions
Special services – Includes Prevention and Health Promotions and disease management programs; translation and interpreter services; 24x7 NurseLine and Nurse Chat services; smoking cessation services, care management services, pain management services; transportation (non-ambulance) and related services.		
Prevention and health promotions and disease management programs	We use screening and evaluation procedures for the early detection, prevention, and treatment of chronic illnesses under our Prevention and Health Promotions and disease management programs. This helps members to manage their chronic disease or condition. Our disease management programs include diabetes, prediabetes, asthma, Healthy Weight Management, and high-risk pregnancy	None
Translation and interpreter services	Services for non-English speaking members and for members with visual and hearing impairments. Contact Provider Services to access services or for assistance. During regular office hours, call **1-888-980-8728.** After hours, call **1-877-261-6608**.	None
NurseLine & nurse chat services	Available for Members, 24-hours, 7 days a week. NurseLine can help with minor injuries, common illnesses, self-care tips and treatment options, recent diagnoses and chronic conditions, and much more.	None
	NurseLine: **1-866-311-5791**	None
	Access Nurse Chat at **myuhc.com**	None
Smoking	Counseling • Practical counseling (problem-solving/skills) • Social support	Limitation: Limited to 2 quit attempts per benefit period. At least 4 in-person sessions per quit attempt
	• Medications • NRT gum • NRT lozenge • NRT patch • NRT inhaler • NRT nasal spray • Bupropion • Varenicline	Limitation: Included as part of the Quit Attempts
Pain management	Professional management, medication and other services as medically necessary to help manage chronic pain.	None

Benefit	Benefit description	Frequency, limitations and exclusions
Transportation and related services (for emergency transport, see ambulance benefit)	Ground and/or air transportation to and from covered medically necessary appointments. Facility to facility nonemergent transportation fees will be the responsibility of the originating facility. We provide an escort if the member requires assistance. All transportation and related services are provided by ModivCare. Members should call ModivCare to schedule all trips at least 48 hours in advance of their health care appointment. ModivCare contact information: • Reservations 1-866-475-5746 • Ride assistance 1-866-475-5748 • Hearing impaired 1-866-288-3133 (TTY)	Limitation: Covered only for members who have no means of transportation and who reside in areas not served by public transportation or cannot access public transportation. The following is not covered: • Transport services when a prior authorization is required but not obtained. • Transport related to services that are not medically necessary. • Transport to a pharmacy. • Transport for personal errands such as shopping or visiting. • Transport to a SSI Determination Medical Appointment or Medicaid eligibility. • Transport to classes, support groups, community events, etc., unless included as part of the service plan. • Transport for any services not covered under QUEST.

Benefit	Benefit description	Frequency, limitations and exclusions
Transportation and related services (continued) (For emergency transport, see ambulance benefit)		**Transportation for individuals that have Medicare or other insurance coverage that is primary to Medicaid.** Medicare or other primary insurance and Medicaid have different benefits and coverage policies. Under the member's primary insurance coverage, members may be able to seek health care services on a different island from the one that they live on. However, Medicaid requires that members receive care on the island where they live if those services are available.If the member travels to another island or to the mainland and those health care services are available on the island that member resides in, we will not pay for transportation. Medicaid members should never be charged for a covered service.

Benefit	Benefit description	Frequency, limitations and exclusions
Transportation and related services (continued) (for emergency transport, see ambulance benefit)	Lodging and meals/food are covered if needed due to inter-island or out-of-state. Meals/food limit will be based on the case scenarios specified under limitations to the right. Reimbursement: No member reimbursement will be allowed without a receipt for all food/meal purchases.	Inter-island (same day doctor visit/1 day visit): Limit to $15 per member and per authorized escort. Inter-island (multiple doctor visits/days per duration): Limit to $30 per day per member and per authorized escort. Out-of-state (all visits): Limit to $30 per day per member and per authorized escort.
Maternity care		
Maternity care	Covered throughout pregnancy right up to and after delivery and may be provided by physicians and other practitioners as licensed and in their scope of practice, including certified nurse midwives or licensed midwives. Services include: • Prenatal care (which should begin as soon as possible) • Radiology, lab and other diagnostic testing • Prenatal vitamins • Doctor/practitioner visits • Up to 3 ultrasounds without needing authorization • Other necessary services that impact pregnancy outcomes • All pregnancies, you can get additional support and help from our Hāpai Mālama Program Service • Delivery of the baby • Postpartum care (up to 60 days from the date of delivery) • Health education and screening	None

Benefit	Benefit description	Frequency, limitations and exclusions
Newborn care	Includes newborn hearing assessment, laboratory screening, delivery, inpatient hospital related services, outpatient services, EPSDT services, circumcision and other needed newborn care services.	Newborn is an individual 28 days old or less.
Genetic testing	Tests such as chromosomal analysis to determine potential for genetic conditions that may be passed from parent to child.	None
Infertility testing and treatments	Not covered	Can be reviewed upon request for medical necessity on a case-by-case basis.
Family planning		
Family planning services	Services available on a confidential and voluntary basis to all members by in-network and out-of-network care providers and includes, at a minimum the following: • Family planning drugs, supplies and devices to include but not limited to generic birth control pills, medroxyprogesterone acetate (Depo-Provera), intrauterine device (IUD), and diaphragms. • Education and counseling necessary to make informed choices and understand-contraceptive methods • Emergency contraception • Follow-up, brief and comprehensive visits • Pregnancy testing • Contraceptive supplies and follow-up care; and • Diagnosis and treatment of sexually transmitted diseases **Note:** Care providers who do not provide family planning services on the basis of religious beliefs must refer the member to a care provider who will provide such services.	

Benefit	Benefit description	Frequency, limitations and exclusions
Intentional termination of pregnancy (ITOP) (abortion)	**Services we do not cover** The State of Hawaii (DHS) covers all procedures, medications (including abortion pills), transportation, meals, and lodging associated with ITOPs (abortions). Care providers must bill the State of Hawaii DHS' fiscal agent directly for services related to ITOPs.	Carved out to the state: Contact DHS' Fiscal Agent at 1-808-952-5570 (Oahu) or 1-800-235-4378 (Neighbor Islands).
	Services we cover We cover treatment of medical complications resulting from ITOPs (abortions). We cover treatments for spontaneous, incomplete or threatened terminations for ectopic pregnancies.	Limitation: Only related services for treatment of medical complications resulting from an ITOP (abortion).

Benefit	Benefit description	Frequency, limitations and exclusions
Sterilizations and hysterectomies	Sterilization is any medical procedure or treatment for the purpose of rendering a man or woman incapable of reproducing. Sterilization is only covered when: **1.** Member has voluntarily given informed consent (HHS-687) **2.** Member is mentally competent **3.** Member is at least 21 years old at the time of consent **4.** Consent is at least 30 days but not more than 180 days before the procedure **5.** The care provider signs the informed consent form (HHS-687) **6.** In the case of emergency abdominal pain, at least 72 hours have passed since informed consent was given **7.** In the case of premature birth, informed consent was given at least 30 days in advance of the expected delivery date **8.** Interpreter services have been given to non-English speaking members or other assistance to communicate with members with hearing or vision impairments or other disability **9.** An incapacitated person has a court order	Exclusions: If member is institutionalized in a correctional facility, mental hospital or other rehabilitative facility.
	Hysterectomy is a medical procedure to remove a member's reproductive system (all or part of the uterus). A hysterectomy is only covered when: **10.** Member has voluntarily given informed consent (DHS Form 1145) **11.** The member has been informed verbally and in writing that a hysterectomy will render her permanently incapable of reproducing. This not needed if member is already sterilized or in the case of an emergency hysterectomy **12.** The member has signed and dated the consent form (DHS Form 1145) in advance of the hysterectomy **13.** Interpreter services have been given to non-English speaking members or other assistance to communicate with members with hearing or vision impairments or other disability **14.** A court order is required for incapacitated members **15.** An incapacitated person has a court order	Exclusions: If member is institutionalized in a correctional facility, mental hospital or other rehabilitative facility. A hysterectomy is NOT covered: • For the sole or primary purpose of rendering a member permanently incapable of reproducing. • There is more than one purpose for performing hysterectomy but the primary purpose is to render the member permanently incapable of reproducing. • If performed for the purpose of cancer prophylaxis (prevention).

Benefit	Benefit description	Frequency, limitations and exclusions
Prescription drugs		
Pharmacy benefit manager (Includes home delivery)	The pharmacy benefit manager is Optum Rx (a UnitedHealth Group company).	Contact Optum Rx
	Home Delivery (mail service-dual members only): **1-877-889-6358**	
	Pharmacies Only: **1-844-568-2147**	
Prescription drugs	Drugs prescribed by a physician. This includes education about how to take the drugs.	Limitation See our QUEST drug formulary at: **UHCprovider.com/HIcommunityplan** > **Pharmacy Resources and Physician Administered Drugs**

Ambulance and transportation services

Additional information on these services is in **Chapter 4**.

Behavioral health services

Members whose behavioral diagnostic, treatment or rehabilitative services that we determine not be medically necessary or are not covered.

For adults with severe mental illness (SMI) and severe and persistent mental illness (SPMI)

The Department of Health covers eligible mental health services which include care management, housing, shelter, crisis services and more. Services are available on all islands. The 24-hour Crisis/Help ACCESS Line is available at 1-808-832-3100.

Members who have been determined eligible for these services may be referred by the member's health coordinator to the CCS, which is part of the HawaiiDHS. CCS is currently managed by Ohana Health Plan.

Department of Health's Child and Adolescent Mental Health Division (CAMHD) for children ages 3-20

Members 18 years or older with a diagnosis of SMI or SPMI may be eligible for the CCS program. This is a specialized behavioral health services program.

Members between 18 and 20 years of age may receive their behavioral health services either through the CCS program or the CAMHD Support for Emotional and SEBD program.

Contact information follows:

Family guidance center	Location	Telephone
Central Oahu	Pearl City	1-808-453-5900
Family Court Liaison Branch	Kailua	1-808-266-9922
Honolulu	Honolulu	1-808-733-9393
Leeward Oahu	Kapolei	1-808-692-7000

Family guidance center	Location	Telephone
Windward Kaneohe	Kaneohe	1-808-233-3770
Hawai'i Hilo Waimea Kealakekua	Hilo Kamuela Kealakekua	1-808-933-0610 1-808-887-8100 1-808-322-1541
Kauai	Lihue	1-808-274-3883
Maui	Lahaina Wailuku	1-808-662-4045 1-808-243-1252
Moloka'i	Kaunakakai	1-808-553-7878
Lana'i	Lana'i city	1-808-662-4045

Additional information is available in **Chapter 7.**

Additional behavioral health services – for members with autism spectrum disorder younger than 21

Children younger than 21 years of age who have an autism spectrum disorder diagnosis may receive applied behavior analysis (ABA), or other covered services, if needed and suggested by their doctor. This includes screening, evaluation, making a treatment plan, and starting services.

Exclusions

We do not provide behavioral health services to those members who have:

- Requested services that were determined to be not medically necessary
- Transferred to the DHS CCS Program (currently managed by "Ohana CCS Program")
- Transferred to the DOH Child and Adolescent Mental Health Division
- Criminally committed in an inpatient setting under the provisions of Chapter 706, HRS

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 Prevention and Health Promotion and 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, and diabetes 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 – We use claims data (e.g. hospital admissions, ER visits, and pharmacy claims) to identify members with gaps in care and/or chronic conditions.

Cognitive rehabilitation services

These are services provided to cognitively impaired persons. They assess and treat communication skills, cognitive and behavioral ability and cognitive skills related to daily living. Reassessments are completed at regular intervals, determined by the care provider and based on the member's assessed needs, treatment goals and objectives.

Community integration services

Community integration services (CIS) are available to members 18 years of age and older if the individual meets at least 1 of the following criteria and qualifying health conditions listed in the next section:

- Homeless, defined as lacking a fixed, regular, and adequate nighttime residence

- Living in a place not meant for human habitation. This includes a car, park, train station, airport, camping ground, an abandoned building, an emergency shelter, or they are leaving an institution where they are temporarily residing. Temporary housing includes congregate shelters, transitional housing, hotels and motels paid for by charitable organizations or by federal state or local government programs for low income members.
- Living in public housing and at risk of eviction
- Has received a written notification that their residence will be lost within 21 days of the date of application for assistance, but they do not have sufficient resources or support available to them. Resources include family, friends, church or other social support that can help them with immediate shelter or housing.
- Has a history of frequent and/or lengthy stays in a nursing facility: Frequent is defined as more than 1 stay in the past 12 months. Lengthy is defined as 60 or more consecutive or continuous days within an institutional care facility.

Qualifying health conditions

- A mental health disorder which interferes with 1 or more major life activities
- Diagnosis of substance use disorder (SUD)
- Chronic physical or complex health needs which interferes with daily life living activities

Covered CIS benefits

For information, contact our **Member Services** at **1-888-980-8728** or TTY: **711**

- Pre-tenancy services
- Identifying eligible individuals about housing preference, location, the number of household members, etc.
- Screening/assessments: Identify needs, strengths, motivations, barriers and resources. Identify level of functioning and assess entire family support system, including assistance with budgeting for housing and living expenses.
- Develop an individualized plan: Address identified barriers, short and long-term measurable goals, and establish how goals will be achieved and how concerns will be addressed
- Housing search: Assist the member with connecting to social services to help with finding and applying for housing necessary to support the member in meeting their medical needs
- Participate in person-centered plan meetings at redetermination and/or conducting revision plan meetings as needed and provide supports and interventions as per the person-centered plan. Person-centered plan meetings include a team of family, friends, neighbors, employers, community members and care providers to help determine appropriate help for the member.
- Tenancy sustaining services
  - Service planning support and participation in person-centered plan meetings at redetermination and/or while during revision plan meetings, as needed
  - Coordinating and linking the member to services and service providers including primary care and health homes, medical and behavioral health services including substance abuse treatment providers, physical health providers, probation and parole, crisis services, end of life planning and other support groups and natural supports
  - Assist member in applying for assistance that they may be entitled to, including obtaining documentation, navigating and monitoring application process, and coordinating with the appropriate agency office
  - Assistance in accessing support services such as individual and family counseling, support groups and natural supports so that the member can live independently
  - Assisting the member develop independent living skills, such as skills coaching, financial counseling, and anger management
  - Supporting the member in communicating with the landlord and/or property manager related to member's disability (if authorized and appropriate), accommodations needed and addressing emergency procedures involving the landlord and/or property manager
  - Helping the member to review, update and modify housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers

- Connecting member to training and resources that will help the member be a good tenant and achieve lease compliance, including ongoing support with activities related to household management

Corneal transplants

We cover these transplants in accordance with HAR 17-1737-92.

Dental services

Some dental services may be covered by the state, especially for members younger than 21 years. Community Case Management Corporation (CCMC) can help find a dentist and assist with transportation and translators. Contact CCMC at **1-888-792-1070**.

For more details, go to **UHCprovider.com**. To find a dental care provider, go to **UHCprovider.com/findprovider** > Our Network > Dental Providers by state.

Developmental disabled/intellectually disability services

The developmental disabled/intellectually disability services (DD/ID) program, through contracted care providers, serves people with mental or developmental disabilities including housing, living skills, home chores, alarm system, behavioral help nursing and personal care not covered by UnitedHealthcare Community Plan QUEST. Non-medical transport is also available.

The DD/ID case manager is the primary case manager and works with the UnitedHealthcare Community Plan QUEST health coordinator.

Contact DD/ID at **1-808-733-9303** (Oahu), **1-808-241-3406** (Kauai), **1-808-243-4625** (Maui, Lanai, and Molokai), **1-808-974-4280** (East Hawai'i) or **1-808-877-8114** (North Hawai'i).

Habilitative services

These services and devices develop, improve or maintain skills and functioning for daily living that were never learned. Habilitative services and devices include:

- Audiology services
- Occupational therapy
- Physical therapy
- Speech-language therapy
- Vision services
- Devices associated with these services including augmentative communication devices, reading devices, and visual aids but exclude those devices used specifically for activities at school

We cover these services and devices only when medically necessary and if not otherwise covered in the benefits package. Habilitative services do not include routine vision services.

Home and community-based services

These are long-term services and supports provided to members who meet NF or at-risk level of care to allow them to remain in their home or community.

We provide these home and community-based (HCBS) services:

Adult day care

This is a regular supportive care provided to 4 or more disabled adult participants. Services include observation and supervision by center staff; coordination of behavioral, medical, and social plans and implementation of the instructions as listed in the participant's care plan. Therapeutic, social, educational, recreational, and other activities are also provided. Adult day care staff may not perform health care related services such as medication administration, tube feedings, and other activities which require health care related training. All health care related activities must be performed by qualified and/or trained individuals only, including family members and professionals, such as an RN or LPN, from an authorized agency.

Adult day health

This is an organized day program of therapeutic, social, and health services provided to adults with physical or mental impairments, or both, which require nursing oversight or care. The purpose is to restore or maintain, to the fullest extent possible, an individual's capacity for remaining in the community. Each program must have nursing staff sufficient in number and qualifications to meet the needs of participants. Nursing services are provided under the supervision of a registered

nurse. In addition to nursing services, adult day health may also include emergency care, dietetic services, occupational therapy, physical therapy, physician services, pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech language pathology, and transportation services.

Assisted living services

This is personal care and supportive care services (homemaker, chore, attendant services, and meal preparation) given to members who reside in an assisted living facility. An assisted living facility is licensed by the Department of Health. It allows residents to maintain an independent assisted living lifestyle. Payment for room and board is prohibited.

Attendant care

This is hands-on care for medically fragile children. These services may be self-directed. The family must take part in the care of the home-based medically fragile child.

Community care management agency

Community care management agency (CCMA) services are provided to members living in community care foster family homes (CCFFH) and other approved community settings such as an expanded adult care home (E-ARCH) or assisted living facility (ALF). CCMAs:

1. Communicate with a member's physician(s) regarding the member's needs including changes in medication and treatment orders.
2. Work with families regarding service needs of members and serve as an advocate for their members.
3. Be accessible to the member's caregiver 24 hours a day, 7 days a week.

Community care foster family home

Care providers give personal care and supportive services, homemaker, chore, attendant care, companion services, and medication oversight in a certified private home by a principal care provider who lives in the home. CCFFH services are furnished for up to 3 adults who receive these services while living in the home. All care providers must give individuals their own bedroom unless the member consents to sharing a room with another resident. Both occupants must consent to the arrangement. The total number of individuals living in the home, who are unrelated to the principal care provider, cannot exceed 4 members. Members receiving CCFFH services must be receiving ongoing CCMA services.

Counseling and training

This service is provided to members, families/caregivers, and professional and paraprofessional caregivers on behalf of the member. Counseling and training services are given individually or in groups. This service may be provided at the member's residence or an alternative site. Activities include:

- Care training for members, family, and caregivers regarding the nature of the disease and its process
- Methods of transmission and infection control measures
- Biological, psychological care, and special treatment needs/regimens
- Employer training for consumer-directed services
- Instruction about treatment
- Use of equipment specified in the service plan
- Employer skills updates as necessary to safely maintain the individual at home
- Crisis intervention
- Supportive counseling
- Family therapy
- Suicide risk assessments and intervention
- Death and dying counseling
- Anticipatory grief counseling
- Substance abuse counseling and/or nutritional assessment and counseling on coping skills to deal with stress caused by the member's deteriorating functional, medical or mental status

Environmental accessibility adaptations

These are physical adaptations to the home, required by the individual's service plan, which are necessary to help ensure a person's health, welfare and safety. They also help the individual function at home with more independence. Without them, the person would require institutionalization. Adaptions may include

the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems to accommodate the medical equipment and supplies needed for the person's welfare. Window air conditioners may be installed when necessary for the member's health and safety.

Excluded are home adaptations or improvements that are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, and central air conditioning. Adaptations that add to the home's total square footage are also excluded. All services are provided following state or local building codes.

Home-delivered meals

These are nutritionally sound meals delivered to a location where an individual resides (excluding residential or institutional settings). The meals will not replace or substitute a full day's nutritional regimen (i.e., no more than 2 meals per day). Home-delivered meals are provided to individuals who cannot prepare nutritional meals without assistance and are determined, through an assessment, to need the service to remain independent in the community and prevent institutionalization.

Home maintenance

These services help maintain a safe, clean and sanitary environment. Home maintenance services are not included in personal assistance. They include:

- Heavy duty cleaning, which brings a home up to acceptable standards of cleanliness at the inception of services to a member
- Minor repairs to essential appliances limited to stoves, refrigerators and water heaters
- Fumigation or extermination services

Home maintenance is provided to individuals who cannot perform cleaning and minor repairs without help. They are determined, through an assessment, to require the service to prevent institutionalization.

Moving assistance

This is provided when the health coordinator determines an individual needs to relocate to a new home. Under the following circumstances, moving assistance can be provided to a member:

- The home is unsafe due to deterioration
- The individual is wheelchair-bound and living in a building with no elevator
- The person lives in a multi-story building with no elevator above the first floor
- The home cannot support the member's additional needs for equipment
- The member is evicted from their living environment
- The member is no longer able to afford the home due to a rent increase

Moving expenses include the packing and moving of belongings. Whenever possible, members should use family, landlord, community, or third-party resources that can provide this service without charge.

Non-medical transportation

This enables individuals to gain access to community services, activities, and resources, specified by the service plan. Whenever possible, members should use family, neighbors, friends, or community agencies that can provide this service without charge. Members living in a residential care setting or a CCFFH are not eligible for this service.

Personal assistance services – Level I

This is for individuals who need help with independent activities of daily living. This prevents a decline in health status and maintain individuals safely in their homes and communities.

Personal assistance services Level I may be self-directed and consist of:

- Companion services. Companion services are preauthorized by the health coordinator in the member's service plan and include non-medical care, supervision, and socialization provided to a member who is assessed to need these services. Companions may assist or supervise the individual with such tasks as meal preparation, laundry, and shopping/errands, but do not perform these activities as discrete services. Providers may also perform light

housekeeping tasks that are incidental to the care and supervision of the individual.

- Homemaker services. Homemaker services are covered when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for the member. Homemaker services, pre-authorized by the health coordinator in the member's service plan, do not require specialized training or professional skills such as those possessed by a nurse or home health aide. The scope of homemaker services covers only those activities that need to be provided for the member and not for other members of the household:
  - Routine housecleaning
  - Care of clothing and linen
  - Shopping for household supplies and personal essentials (not including the cost of supplies)
  - Light yard work
  - Simple home repairs, such as replacing light bulbs
  - Preparing meals
  - Running errands, such as paying bills and picking up medication
  - Escort to clinics, physician office visits, or other trips for the purpose of obtaining treatment or meeting needs established in the service plan, when no other resource is available
  - Standby/minimal assistance or supervision of activities of daily living
  - Reporting and/or documenting observations and services provided, including observation of member self-administered medications and treatments
  - Reporting to assigned providers, supervisor, or designee, observations about changes in the member's behavior, functioning, condition, or self-care/home management abilities that necessitate more or less service

These services may be limited to 10 hours per week. There may also be a maximum threshold of members who are not at an NF level of care who may receive Personal Assistance Level I services.

Members who live in a residential care setting such as a standalone SNF or a CCFFH are not eligible for these services.

Personal assistance services–Level II

These are for individuals who require moderate/substantial to total assistance to perform activities of daily living and health maintenance activities. Services are provided by a home health aide (HHA), personal care aide (PCA), certified nursing aide (CNA) or nurse aide (NA) with applicable skills competency. They may be self-directed.

The following activities may be included as a part of personal assistance services Level II:

- Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing
- Assistance with bowel and bladder care
- Assistance with ambulation and mobility
- Assistance with transfers
- Assistance with medications, which are ordinarily self-administered when ordered by the member's physician
- Assistance with routine or maintenance health care services by a personal care provider with specific training, satisfactorily documented performance, health coordinator consent and when ordered by the member's physician
- Assistance with feeding, nutrition and other dietary activities
- Help with exercise, positioning, and range of motion
- Taking and recording of vital signs, including blood pressure
- Measuring and recording intake and output, when ordered
- Collecting and testing specimens, as directed
- Special tasks of nursing care when delegated by an RN, for members who have a medically stable condition and who require indirect nursing supervision
- Proper use and maintenance of member's medical and adaptive equipment and supplies
- Checking and reporting any equipment or supplies that need to be repaired or replenished
- Reporting changes in the member's behavior, functioning, condition, or self-care abilities which necessitate more or less service
- Maintaining documentation of observations and services provided

When personal assistance services Level II activities are the primary services, personal assistance services Level I activities identified in the service plan that are incidental to the care furnished or are essential to the health and welfare of the member, rather than the member's family, may also be provided.

Members who live in a residential care setting such as a standalone SNF or a CCFFH are not eligible for these services.

Personal emergency response systems

This 24-hour emergency assistance service gives eligible members immediate help during an emotional, physical or environmental emergency. Service is for members who live alone or are alone for long periods. Personal emergency response systems (PERS) is an electronic device that enables individuals at high risk of institutionalization to get help in an emergency. The individual may also wear a portable "help" button. The system is connected to the member's phone and programmed to signal a response center once the button is activated. The response center is staffed by trained professionals.

These are allowable types of PERS items:

- 24-hour answering/paging
- Beepers
- Med-alert bracelets
- Medication reminder services
- Intercoms
- Life-lines
- Fire/safety devices, such as fire extinguishers and rope ladders
- Monitoring services
- Light fixture adaptations (e.g., blinking lights)
- Telephone adaptive devices not available from the telephone company
- Other electronic devices/services designed for emergency assistance

PERS services will only be provided to a member residing in a non-licensed setting except for an Assisted Living Facility (ALF).

Residential care services

These are personal care services, homemaker, chore, attendant care companion services, and medication oversight given in a licensed private home by a principal care provider who lives in the home.

Residential care is furnished:

- in a Type I Expanded Adult Residential Care Home (E-Arch) to a maximum of 6 individuals, no more than 3 of whom may be an NF level of care; or
- in a Type II E-Arch, for 7 or more individuals; no more than 20% of the home's licensed capacity may be individuals meeting an NF level of care who receive these services in conjunction with residing in the home.

Respite care services

These are provided to individuals unable to care for themselves. They are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing the care. Respite may be provided at 3 different levels: hourly, daily, and overnight. Respite care may be provided in the following:

- Home or place of residence
- Foster home/expanded-care adult residential care home
- Medicaid-certified NF
- Licensed respite day care facility
- Other community care residential facility approved by the state

Respite care services are authorized by the member's PCP and approved through the health coordinator. Respite services may be self-directed.

Skilled (or private duty) nursing

This service is for members who need ongoing nursing care listed in the care plan. It is provided by licensed nurses within the scope of state law. Skilled nursing services may be self directed under Personal Assistance Level II.

Specialized medical equipment and supplies

These supplies let members maintain or increase their daily living activities. This involves the purchase, rental, lease, warranty cost, installation, repairs, and removal of devices, controls or appliances specified in the service plan, that enables individuals to increase and/or maintain their abilities to perform activities of daily living, and/or to control, participate in, or communicate with the environment in which they live.

In addition, this service includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items. It also includes DME and non-DME not available under Medicaid. All

items must meet applicable standards of manufacture, design and installation. They may include:

- Specialized infant car seats
- Modifications of a parent-owned motor vehicle to accommodate the child (e.g., wheelchair lift)
- Intercoms for monitoring the member's room
- Shower seat
- Portable humidifiers
- Electric bills specific to electrical life support devices (e.g., ventilator, oxygen concentrator)
- Medical supplies
- Heavy-duty items, including patient lifts or beds that exceed $1,000 per month
- Rental of equipment that exceeds $1,000 per month, such as ventilators
- Miscellaneous equipment such as customized wheelchairs, specialty orthotics, and bath equipment that exceeds $1,000 per month

The PCP must recommend specialized medical equipment and supplies.

HawaiiCARES

HawaiiCARES is a free, 24/7 coordination center for substance use, mental health and crisis intervention. Call from any island: 1-808-832-3100 or toll-free at 1-800-753-6879.

The HawaiiCARES program is a statewide initiative of the Hawaii State Department of Health to increase access to support for individuals needing substance abuse treatment. The HawaiiCARES staff provides supportive counseling, screening for urgent or emergent mental health or substance use needs, and recommendations for behavioral health assessments and services and crisis intervention.

Home health services

This is part-time or intermittent care for members who do not require hospital care. This service is provided under the direction of a physician to prevent rehospitalization or institutionalization. Care providers must meet Medicare standards. We do not cover home health services provided to members who are covered by Medicare.

Hospice services

These are services that provide care to terminally ill patients who are expected to live less than 6 months. Care providers must meet Medicare requirements. We do not cover hospice services provided to dual eligible members that are covered by Medicare. In these instances, only when the service need is not related to the hospice diagnosis, can the service be covered.

Hospice services provided to dual eligible members that are covered by Medicare (e.g., personal care services, homemaker services) are not covered (i.e., duplicated) by UnitedHealthcare Community Plan QUEST. In these instances, only when the service need is not related to the hospice diagnosis can the service be covered by UnitedHealthcare Community Plan QUEST.

Institutional services

Nursing facility services

These services are provided to members who need care, including activities of daily living and instrumental activities of daily living, 24 hours a day from medical personnel on a long-term basis. NF services are provided in a freestanding or a distinct part of a licensed facility. The care that is provided includes:

- Independent and group activities
- Meals and snacks
- Housekeeping and laundry services
- Nursing and social work services
- Nutritional monitoring and counseling
- Pharmaceutical services
- Rehabilitative services

Acute waitlisted ICF/SNF

This is either ICF or SNF level of care services provided in an acute care hospital in an acute care hospital bed. We work with the facilities to identify these individuals who are acute waitlisted for discharge to a more appropriate location for treatment.

Subacute facility services

These are provided in either a licensed NF or a licensed and certified hospital based on HawaiiAdministrative Rules. Subacute facility services provides the patient with services that meet a level of care needed by the patient not requiring acute care, but who needs more intensive skilled nursing care than is provided to most of the patients at a SNF level of care. The Subacute level of care is designated either as Level I or II.

- **Level I** – Patients who require continuous ventilation for at least 50% of each day and are medically stable.
- **Level II** – Patients who do not require continuous mechanical ventilation for at least 50% of each day, are medically stable, and require the following services:
  - Tracheostomy care with suctioning at least once per hour
  - Any combination of mechanical ventilation, tracheostomy care with suctioning, and inhalation treatment at least once every 8 hours
  - Total prenatal nutrition (TPN)
  - Continuous intravenous therapy or intermittent intravenous therapy at least once every 8 hours
  - Stable newborns/premature infants younger than 1 year who are inpatients in an acute care hospital for at least 1 week and require manual stimulation for bradycardia/apnea or nasogastric or gastrostomy feedings
  - Stable patients who are admitted to an acute hospital for an infection for training of intravenous antibiotic administration or for close monitoring of oral antibiotics OR 2 or more of the following services:
- Tracheostomy care with suctioning at least once every 8 hours
- Traction (excluding Buck's traction) and pin care
- Medically necessary isolation precautions
- Treatment of State III and above pressure ulcers or wound infections
- Ventilation or inhalation therapy services at least daily
- Complex skilled nursing care of patients with conditions such as HIV/AIDS, terminal disease, and chronic dialysis who are at high risk of medical complications if discharged
- Complex skilled nursing care of patients who are receiving radiation therapy, hydration, or parenteral pain control medications who are at high risk for significant medical complications
- Complex skilled nursing care of psychiatric patients at high risk for imminent life threating complications to themselves or others if discharged or with bulimia/anorexia nervosa who are at high risk of medical complications if discharged

Intellectual and Developmental Disabilities program

The Intellectual and Developmental Disabilities (I/DD) program serves people with mental or developmental disabilities. The services are given by contracted providers. These include HCBS such as housing, living skills, home chores and personal alarm system. They also include behavioral help, nursing and personal assistance and habilitation.

The I/DD case manager works with the provider and the UnitedHealthcare Health Coordination Team. The team identifies and makes appropriate referrals to the CAMHD, Adult Mental Health Division (AMHD) and the Development Disability Division (DDD) for members that meet certain conditions. Care providers coordinate medically necessary services UnitedHealthcare covers, including transitioning of care in and out of the I/DD program.

Call I/DD at 1-808-733-9172 (Oʻahu), 1-808-241-3406 (Kauaʻi), 1-808-243-4625 (Maui, Lānaʻi, and Molokaʻi), 1-808-974-4280 (East Hawaiʻi), 1-808-887-6064 (Waimea), or 1-808-327-6212 (Kona). Or call your health coordinator for assistance.

Abortions or Intentional termination of pregnancies

These services are not covered by UnitedHealthcare Community Plan. This a carved-out service. Intentional terminations of pregnancies (ITOPs) are covered by the DHS in compliance with federal regulations through Conduent.

You may contact Conduent for additional information at 1-808-952-5570 (Oahu) or at 1-800-235-4378 (Neighbor Islands).

For transportation related to ITOP services care providers may contact Community Case Management (CCMC) at 792-1070 (Oahu) or 1-888-792-1707 (Neighbor Islands) for assistance.

All claims for ITOP procedures, medications, transportation, meals, and lodging associated with

ITOPs must be submitted directly to Xerox at:

Xerox State Healthcare
Attention: Claims
P.O. Box 1220
Honolulu, HI 96807-1220

Outpatient hospital services

These include 24 hours a day, 7 days a week, emergency services, ambulatory center services, urgent care services, medical supplies, equipment and drugs, diagnostic services, and therapeutic services including chemotherapy and radiation therapy.

Peer support services

This service is for behavioral health members. Peer specialists or consumer providers, often referred to simply as peers, are individuals with histories of successfully living with a serious mental illness who provide direct service to others with a serious mental illness or co-occurring mental and substance related disorder. There are various forms of peer support and work in a variety of clinical and rehabilitative settings, including but not limited to inpatient settings, outpatient programs, Clubhouses, and independent consumer-run support organizations. The peer provides non-professional and non-clinical assistance to members at various stages of their recovery. Their services are an extension of the formal healthcare services offered through our health plan and clinical team members but never to replace the roles of professional, licensed health care providers. Peers provide support and encouragement and may facilitate a conversation on symptom management techniques or identify barriers to medication adherence. Peers provide opportunities to model behaviors of interactions with their clinical team which in turn helps the individual improve advocacy for themselves around treatment preferences. Peers provide assistance in daily self-management, social and emotional support, linkage to various clinical care and community resources.

Eligible members are identified through a variety of internal practices that include but not limited to health coordination, behavioral health advocate, predictive modeling and claims data or your referral. The program has no age limitation.

Prescription drugs

We cover prescription drugs when medically necessary to optimize the member's medical condition.

Behavioral health prescription drugs are covered for children receiving services from the Children and Adolescent Mental Health Division. Medication management and patient counseling are also included. More pharmacy resources and information is available at **UHCprovider.com/HIcommunityplan** > **Pharmacy Resources and Physician Administered Drugs**.

School-based services

The Department of Education provides some services to students. It promotes caring relationships among students, teachers, families, and agencies and seeks to ensure timely intervention to provide optimum classroom climate, family involvement, and specialized help. Contact them at 1-808-784-6200.

State of Hawaii Organ and Tissue Transplant program

This is a carved-out service. The DHS provides transplants which are not experimental or investigational and not covered by UnitedHealthcare Community Plan QUEST. The State of Hawaii Organ and Tissue Transplant (SHOTT) program covers adults and children for liver, heart, heart-lung, lung and bone marrow transplants. In addition, children are covered for transplants of the small bowel with or without liver. Children and adults must meet medical criteria as determined by the state and the SHOTT program contractor.

For information, contact our **Member Services** at **1-888-980-8728** or TTY: **711**.

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 1-808-586-4400 or go to health.hawaii.gov/wic.

Zero to Three services

The Zero to Three Program helps children with conditions that may result in developmental delay. Members with children who may qualify can call the

Hawaii Keiki Information Service System (H-KISS) at 1-800-235-5477 or 1-808-594-0066 (Oahu).

H-KISS is the central point for referrals. Referrals may be from any source. This includes hospitals, doctors, parents, day care, education or public agencies, or other care providers. The Department of Health coordinates services with local agencies.

Services not covered by UnitedHealthcare Community Plan

Certain services and service categories are excluded from coverage under the UnitedHealthcare Community Plan QUEST Program. Certain Medicaid covered services may also be carved out and are provided by the state and/or other local agencies. The Member Handbook for the UnitedHealthcare Community Plan QUEST Program also lists the excluded services for our members.

In addition to specific excluded or non-covered services, here is a list of some services excluded from the QUEST program:

Services typically excluded but, in extenuating circumstances and upon request, we will review for medical necessity:

- Services that are not medically necessary (as defined in Hawaii statute)
- Services that are experimental or investigative
- Non-emergent or non-urgent services provided out of state that have not been authorized in advance (Post-stabilization services following emergent admission are covered)
- Services from a non-participating care provider if an in-network care provider is available
- Surgery for the member's appearance, excluding authorized reconstructive surgery
- Routine, restorative and cosmetic dental services excluding certain authorized medical procedures related to dental work
- Reversal of sterilization
- Artificial insemination, in-vitro fertilization or any other treatment to create a pregnancy
- Treatment of impotence
- Elective Cesarean
- Hysterectomies that are performed solely or primarily for rendering a member permanently incapable of reproducing
- Hysterectomies that are performed for the purpose of cancer prophylaxis; when not medically indicated
- Physical exams or other services for work, school, sports or athletic events;Personal hygiene, luxury or convenience items
- Foot care for comfort or appearance, like flat feet, corns, calluses or toenails
- Drugs for:
  - Hair growth
  - Cosmetics
  - Controlling your appetite
  - Treatment of impotence
  - Treatment of infertility
  - Erectile dysfunction or similar "lifestyle" products
- Drugs the FDA says are:
  - DESI – this means that research says they are not effective
  - LTE – this means that research says they are less than effective
  - IRS – this means that the drugs are identical, related, or similar to LTE drugs
- Environmental modifications or home adaptations that solely add to the square footage of the home, are of general utility, or are in excess of standard modification costs;
- Laboratory and diagnostic tests that are experimental, investigational or generally unproven; IgG4 testing; and procedures related to storing, preparation and transfer of oocytes for in vitro fertilization
- Certain vision services such as orthoptic training, prescription fees, progress exams, radial keratotomy, visual training, and Lasik.
- Ultrasound for gender determination
- Services that have been denied by another payer typically covered by the other payer but denied due to lack of approval or failure to follow the other payer's authorization and appeal processes
- Chiropractic, acupuncture, or massage therapy

Exclusions

- Services covered by another payer, such as Medicare
- Any services outside the United States
- Autopsy or necropsy
- Any services if the member is in local, state, or federal jail or prison

- UnitedHealthcare Community Plan QUEST Medicaid hospice services provided to members receiving Medicare hospice services that is duplicative of Medicare hospice benefits (e.g., personal care and homemaker services). This is only covered when the service need is not related to the hospice diagnosis
- UnitedHealthcare Community Plan QUEST Medicaid home health services when they are already covered by Medicare home health benefits (this exclusion applies only to members who also have Medicare)
- Services covered by Workers' Compensation insurance
- Services not allowed by the State of Hawai'i Medicaid Program
- Services that are carved out or covered by the DHS or other state agencies, such as those discussed in **Chapter 4**

Value-added services

UnitedHealthcare Community Plan offers value-added services to help keep you and your family healthy. These are in addition to the standard benefits available under QUEST. Some services have limits and may be available only in certain areas or for a period of time. For more information about these extra benefits, call **Member Services** at **1-888-980-8728** (TTY **711**), 7:45 a.m. - 4:30 p.m. HT, Monday-Friday.

Community Transition Program for the Justice-Involved

This program helps members who have criminal records return to and stay in the community. Employing a trauma-informed and whole-person care approach, health coordinators and community health workers partner with the Program's Justice Liaison to support members in navigating the health care and criminal legal systems. Together, they work with justice-involved members to meet physical and behavioral health needs, address social determinants of health, and reach personal goals.

Community Transitions also connects members to resources for issues such as housing, identification, and employment. Along the way, we take a broad view of health and wellness and promote health equity and cultural humility in all member engagements.

Health4Me app

The Health4Me app is available at no charge to our members. Health4Me enables users to review health benefits, access claims information and locate network care providers.

Integrated peer support services

These services help support persons who are in or seeking recovery from drugs or alcohol by instilling hope, accessing treatment, finding preventive care, and exploring vocational and education goals. Services are delivered by a peer specialist who has similar life experiences and offers education, skill building and member empowerment. Peer Support Services complement the services delivered by the Health Coordination Team and care providers. Integrated Peer Support Services are available to Medicaid members who are interested in additional recovery supports and are referred by their Health Coordination Team.

Medical respite

We provide temporary support for medically frail members who do not have safe housing to go upon discharge from the hospital, requiring temporary support. This includes accessing a medical respite bed, care management and additional community supports and programs. Medical respite services are subject to bed availability.

NurseLine

NurseLine is available at no cost to our members 24 hours a day, 7 days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the emergency room or to schedule an appointment with their PCP. Call **1-866-311-5791** to reach a nurse.

The nurse can assist members with:

- Minor Injuries
- Common illnesses
- Self-care tips and treatment options
- Recent diagnoses and chronic conditions
- Choosing appropriate medical care
- Illness prevention
- Nutrition and fitness
- Questions to ask your doctor

- How to take medications safely
- Men's, women's and children's health

Traditional healing

These services help introduce, strengthen and support Native Hawaiian practices that can improve the health and well-being of members through physical activity, social support and cultural knowledge. Services include traditional methods of healing including lomilomi (traditional massage) and la'au lapa'au (medicinal plan treatment). The program goals include a positive impact on diabetes and pre-diabetes in a manner that resonates with the native Hawai'ian population. These services are available only on Oahu and in certain areas.

UHC Doctor Chat– virtual visits

Members will have access to UHC Doctor Chat at **UHCDoctorChat.com**. This is an innovative, chat-first platform supported by live video for members to connect with a doctor from their computer or mobile device for non-emergent care. Using **UHCDoctorChat.com** or the UHC Doctor Chat app, a board-certified emergency medicine physician will assess the severity of the enrollee's situation, provide treatment (including prescriptions) and recommend additional care. Virtual visits can improve access to care, reduce health disparities and reduce avoidable use of the ED.

UHC Doctor Chat doctors can assist members with minor illnesses and common conditions such as:

- Allergies, rashes
- Animal/insect bites
- Coughs, fevers, sore throat, earaches
- Diarrhea/constipation
- Headache, back and abdominal pain
- Nausea, vomiting, stomach pain
- Pink Eye
- Urinary problems/UTI
- Sports injuries, burns, heat-related illness and more

This program highlights our commitment to bring forward looking solutions to expand and deliver access to care.

UnitedHealthcare On My Way

UnitedHealthcare On My Way (UnitedHealthcare OMW) is a website that gives young members transitioning to adulthood an effective and engaging online learning tool. It helps prepare them to make a successful transition to independent living. The website teaches real-life skills in 6 areas:

- Money
- Housing
- Health
- Employment
- Transportation
- Education

The website, similar to a digital interactive game, guides youth through things they need to know to get ready to live on their own. Youth earn points for taking action as they go through the activities. Members can get this learning tool at **uhcOMW.com**. There is no cost to members to use this website.

Chapter 7: Mental health and substance use

Key contacts

Topic	Link	Phone Number
Behavioral health/Provider Express	**providerexpress.com**	**1-800-888-2998**
Provider Services	**UHCprovider.com**	**1-888-980-8728**

UnitedHealthcare Community Plan supports members with mental health and substance use disorder (SUD) by using a stepped care approach to behavioral health treatment. This approach involves using a framework that incorporates professional behavioral health services and an emphasis on coordination between specialist care, care management and primary care. This helps provide the level of professional support necessary for effective self-management.

Stepped care provides a framework for organizing and assigning resources available for treatment, self-management support and active follow-up for behavioral health conditions. Treatments are selected based on evidence-based guidelines in line with member goals, treatment preferences and clinical status, and seamless transitions between levels of care are facilitated to support the member's current needs.

United Behavioral Health, operating under Optum, provides UnitedHealthcare Community Plan members with these benefits. The national Optum network manual generally applies to all types of business. Some sections may apply differently based on state law. The National Optum Behavioral Health manual is located on **providerexpress.com.**

This chapter does not replace the national Optum network manual. Rather, it supplements the national manual by focusing on Medicaid's specific services and procedures.

You must have an NPI number to see Medicaid members and receive payment from UnitedHealthcare Community Plan. To request an ID number, go to the Department of Social Services website at medquest.hawaii.gov/en/plans-providers/become-a-medicaid-provider.html.

How to join our network: 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. 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:

- Crisis stabilization services (includes treatment crisis intervention).
- Inpatient psychiatric hospital (acute and sub-acute).
- Psychiatric residential treatment facility.
- Outpatient assessment and treatment:
  - Partial hospitalization
  - Social detoxification
  - Day treatment
  - Intensive outpatient
  - Medication management
  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)
  - Child-parent psychotherapy
  - Multi-systemic therapy
  - Functional family therapy
  - Electroconvulsive therapy
  - Telemental health
- Rehabilitation services
- Day treatment/intensive outpatient
- Dual-disorder residential
- Intermediate residential (SUD)
- Short-term residential
- Community support
- Psychiatric residential rehabilitation
- Secure residential rehabilitation

Eligibility

Verify the UnitedHealthcare Community Plan member's Medicaid eligibility on day of service before treating them. View eligibility online on the Eligibility and Benefits application on the Provider Portal at **UHCprovider.com/eligibility**.

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; day treatment; or partial hospitalization, inpatient or residential care. Help ensure prior authorizations are in place before rendering non-emergent services. Get prior authorization by going to **UHCprovider.com/priorauth** or calling **Provider Services.**

Portal access

You can use the **UnitedHealthcare Provider Portal** for all of your online services, including claims, eligibility, prior authorization, referrals and much more. The portal allows you to take action and quickly access claims-related information using our digital features and tools. It's a one-stop shop for working with us more efficiently.

Appeals and grievances

Call **1-888-380-0809,** and a customer service representative will assist you. You may file an appeal with written consent from the member within 60 calendar days of the notice of adverse benefit determination.

Send written requests to:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances
1132 Bishop Street, Suite 400
Honolulu, HI 96813

Claims

Submit claims using the CMS 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 11**.

Monitoring audits

We conduct routine care provider on-site audits. These audits focus on the physical environment, policies and procedures, and quality record documentation.

Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction.

Brief summary of framework

- Prevention:
  - Prevent OUD before they occur through pharmacy management, care provider practice, and education.
- Treatment:
  - Access and reduce barriers to evidence-based and integrated treatment.
- Recovery:
  - Support case management and referral to person-centered recovery resources.
- Harm Reduction:
  - Access to Naloxone and facilitating safe use, storage, and disposal of opioids.
- Strategic community partnerships 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

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep OUD-related trainings and resources available on the 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 SUD/OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and 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.

Access these resources at **UHCprovider.com**. Then click "Drug Lists and Pharmacy." Click Resource Library to find a list of tools and education.

Prescribing opioids

Go to our **UHCprovider.com/pharmacy** to learn more about which opioids require prior authorization and if there are prescription limits.

Pharmacy high prescription utilization program

Pharmacy high prescription utilization programs minimize drug abuse. Pharmacy high prescription utilization programs identify and manage members who meet criteria indicative of potential prescription medication misuse or abuse, and specific therapeutic categories with the potential for high abuse, (e.g., narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances). When lock-in is determined appropriate, a member is placed into a lock-in where they can only receive prescriptions from a single pharmacy for at least 1 year.

Quarterly, our data analyst's team identifies members with potentially inappropriate patterns of medication utilization. This program is specific to pharmacy lock-in only and allows member to access ER/urgent care services. It does include emergency overrides if the pharmacy is closed or there is an issue with the medication being in stock.

Members that meet the criteria and that have been approved for lock-in are sent a notification letter prior to starting. If the member does not choose an approved pharmacy within 30 days following the notice, we select a pharmacy for them. Pharmacy selection is based on the location to the member's home and based on previous usage. We also evaluate for potential case management.

The member continues to be restricted to the designated pharmacy until the member shows a pattern of safe utilization. A member can be placed back on restriction if there is evidence of recurrent over-utilization or abuse of medical services during that period.

New to therapy short-acting opioid supply and daily dose limits

We have a short-acting opioid supply limit of 7 days and less than 50 Morphine Equivalent Dose (MED) per day for patients new to opioid therapy. Requests for opioids beyond these limits require prior authorization.

How this affects you and your patients

Long-term opioid use can begin with the treatment of an acute condition. For this reason, we recommend you consider prescribing the following:

- The lowest effective dose of an immediate-release opioid
- The minimum quantity of an opioid needed for severe, acute pain that requires an opioid

By adhering to these guidelines, you'll be working to help minimize unnecessary, prolonged opioid use.

Why we're making the change

Studies have shown chronic opioid use often starts with a patient prescribed opioids for acute pain. The length and amount of early opioid exposure is associated with a greater risk of becoming a chronic user. For this reason, the Centers for Disease Control and Prevention recommends when a patient is prescribed opioids for acute pain, they receive the lowest effective dose for no more than the expected time frame.

For more information on this change to UnitedHealthcare Community Plan, please call **1-888-362-3368**.

Expanding medication assisted treatment (MAT) access & capacity

Evidence-based MAT treatment is central to OUD treatment. MAT takes a chronic condition approach and incorporates medication use in addition to other services, such as counseling, cognitive behavioral therapies, and recovery support, to provide a comprehensive approach to OUD. We expand MAT access and help ensure we have an adequate member MAT network.

To find a behavioral MAT care provider in Hawai'i:

1. Go to **UHCprovider.com**.
2. Select "Our Network," then "Find a Provider" from the menu on the home page.
3. Select the care provider information.
4. Click on "Search for a Behavioral Health Provider."
5. Enter "(city)" and "(state)" for options.
6. Refine the search by selecting "Medication Assisted Treatment."

We contract with OUD Centers of Excellence (where available), which are designated as premier facilities to help ensure people with OUD stay in treatment and receive appropriate follow-up care and supports within their communities.

To find medical MAT care provider, see the MAT section in the **Chapter 4**.

Chapter 8: Member rights and responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	**UHCCommunityPlan.com/HI**	**1-888-980-8728**
Member handbook	**UHCCommunityPlan.com/Hi** > Medicaid Plans > **UnitedHealthcare Community Plan QUEST Program** > Member Resources	**1-888-980-8728**

Our **member handbook** has a section on member rights and responsibilities. In it, we ask that members treat you with respect and courtesy.

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.

Accounting of disclosures

Our members have the right to request an accounting of certain disclosures of their PHI, made by you or us, during 6 years prior to the request. This accounting must include disclosures by business associates. It will not include disclosures made:

- For treatment, payment and health care operations purposes
- To members or pursuant to member's authorization
- To correctional institutions or law enforcement officials
- For which federal law does not require us to give an accounting

Right to request restrictions

Members have the right to ask you or us to restrict the use and disclosures of their PHI for treatment, payment and health care operations. This request may be denied. If it is granted, the covered entity is bound by any restriction to which is agreed. Document these restrictions. We must agree to restrict disclosure. Members may request to restrict disclosures to family members or to others who are involved in their care or its payment.

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 at the following member website: UHCCommunityPlan.com/Hi > Medicaid Plans > **UnitedHealthcare Community Plan QUEST Program** > Member Resources.

Member rights

Members have the right to:

- Request information on advance directives.
  - Change their advance directive at any time
  - Change their advance directive if they are temporarily unable to make decisions related to their health
  - Ask for a description of applicable state laws
- Be treated with respect, dignity and privacy
- Receive courtesy and prompt treatment
- Receive cultural assistance, including having an interpreter during appointments and procedures
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered
- 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
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do
- Receive medically necessary services covered by their benefit plan
- Receive information about in-network care providers and practitioners, and choose 1 from our network
- Change care providers at any time for any reason
- 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 the 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, and talk with you when making decisions about their 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 provider's incentive plan, if they apply

Health plan policies and training protocols

Health plan policies and training protocols must help ensure that members:

- Understand their member rights
- Have access to services in non-disability specific settings among their service options for both residential and non-residential services
- Are provided with options and choice of activities
- Are consulted in active selecting, planning and scheduling organized activities
- Know how to request a change of service provider or support staff
- Are treated with dignity and respect
- Are afforded privacy for personal activities
- Are engaged in community living and social activities of their preference outside of the setting at will
- Have choice in visitors and opportunity to schedule visits and
- Are involved in choice of community activities based on their choices and interests, even beyond center-based programs

Member responsibilities

Members should:

- Understand their benefits so they can 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 emergency room 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

Our member rights and responsibilities help uphold the quality of care and services they receive from you. The 3 primary member responsibilities as required by the National Committee for Quality Assurance (NCQA) are to:

1. Supply information (to the extent possible) to UnitedHealthcare Community Plan and to you that is needed for you to provide care
2. Follow care to which they have agreed
3. Understand their condition and take part in developing mutually agreed-upon treatment goals, to the degree possible

Medical record charting standards

You must keep complete and orderly medical records, in paper or electronic format, which fosters efficient and quality member care.

You are subject to our periodic quality medical record review. 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. • Process for notifying UnitedHealthcare Community Plan upon becoming aware of a patient safety issue or concern. • Coordination of care between medical and behavioral health care provider.
Record organization and documentation	• Have a policy that provides medical records upon request. Urgent situations require you to provide records 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.
Procedural elements	**Medical records are readable*** • Sign and date all entries. • Member name/identification number is on each page of the record. • 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 list of significant illnesses and active medical conditions. • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions.*

Topic	Contact
History	An initial history (for members seen 3 or more times) and physical is performed. It should include: • **Medical and surgical history*** • A family history that includes relevant medical 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 • 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
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 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**

Member medical record copies

Members or their representative are entitled to 1 free copy of their medical record. Additional copies may be available at member cost. Medical records are generally kept for a minimum of 5 years unless federal requirement mandate a longer time frame (i.e., immunization and TB records required for lifetime).

Medical record review

On an ad hoc basis, we conduct a review of our members' medical records. 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 2 visits, with ongoing physical assessments occurring on 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 3 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 visit(s) 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)

Chapter 10: Quality management program and compliance information

Key contacts

Topic	Link	Phone Number
Credentialing	Medical: Network management support team Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**. Chiropractic: **myoptumhealthphysicalhealth.com**	**1-877-842-3210**
Fraud, waste and abuse (payment integrity)	**uhc.com/fraud**	**1-844-359-7736**

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 practice guidelines and service standards
- Monitoring and assessing the quality and appropriateness of services and care given to our members based on the guidelines
- Promoting wellness and preventive health, as well as population health management
- Maintaining a network of care providers that meets adequacy standards
- Striving for improvement of member health care and services
- Monitoring and enhancing 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 provider services representative/ provider advocate.

Cooperation with quality-improvement activities

We require your cooperation and compliance to:

- Provide requested timely medical records
- Cooperate with quality-of-care investigations - for example: responding to questions and/or completing quality-improvement action plans
- Participate in quality audits, such as site visits and medical record standards reviews, and taking part in the annual HEDIS® record review
- Provide requested medical records for quality activities at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email or secure email
- Respond timely to practitioner appointment access and availability surveys
- Allow the plan to use your performance data
- Offer Medicaid members the same number of office hours as commercial members (or don't restrict office hours you offer Medicaid members)

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.

As a participating care provider, you may offer input through representation on our Quality Improvement Committees and your provider services representative/provider advocate. We require your cooperation and compliance to:

- Allow the plan to use your performance data
- Offer Medicaid members the same number of office hours as commercial members (or don't restrict office hours you offer Medicaid members)

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 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.

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 **UHCprovider.com/cpg** to view the guidelines, as they are an important resource to guide clinical decision-making.

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable Hawaii statutes and the NCQA. The following items are required to begin the credentialing process:

- A completed credentialing application, including Attestation Statement
- Current medical license
- Current 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.

Credentialing and recredentialing activities are delegated to MDX Hawaii for all care providers except for behavioral and HCBS care providers (e.g., community care adult foster home, adult day care, adult health, respite, chore services).

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 Dental Medicine)
- DPMs (Doctors of Podiatric Surgery)
- DCs (Doctors of Chiropractic)
- CNMs (Certified Nurse Midwives)
- CRNPs (Certified Nurse Practitioners)
- Behavioral Health Clinicians (Psychologists, Clinical Social Workers, Masters Prepared Therapists)

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.

Health facilities

Facility providers such as hospitals, home health agencies, SNFs 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 accrediting body
- 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.

Peer review

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.

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every 3 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 with MDX Hawaii Inc.

Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have 3 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 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 connect with a live advocate via chat. It is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**.

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.

Failure to meet recredentialing requirements

If you don't meet our recredentialing requirements, we will end your participation with our network. We will give you a written termination notice. The termination notice will include the reasoning, the effective date and an explanation of your appeal rights, if applicable.

Resolving disputes

Contract concerns

If you have a concern about your Agreement with us, send a letter to:

UnitedHealthcare Community Plan Central Escalation Unit
P.O. Box 5032
Kingston, NY, 12402-5032

A representative will work to resolve the issue with you. If you disagree with the outcome of this discussion, please follow the dispute resolution provisions of your Agreement.

If your concern is about a UnitedHealthcare Community Plan procedure, such as the credentialing or Care Coordination process, we will resolve it by following the procedures in that plan. If you are still dissatisfied, please follow the dispute resolution provisions in your Agreement.

If we have a concern about our Agreement with you, we will send you a letter. If the issue can't be resolved this way, please follow the dispute resolution provisions in your Agreement.

If a member has authorized you to appeal a clinical or coverage determination on their behalf, that appeal follows the member appeals process as outlined in the Member Handbook and this manual.

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 care providers 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, care providers, 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.

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 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 7 elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

1. Oversight of the Ethics and Integrity program
2. Development and implementation of ethical standards and business conduct policies
3. Creating awareness of the standards and policies by educating employees
4. Assessing compliance by monitoring and auditing
5. Responding to allegations of violations
6. Enforcing policies and disciplining confirmed misconduct or serious neglect of duty
7. 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.

UnitedHealthcare Community Plan's Special Investigations Unit (SIU) is an important part of the Compliance program. The SIU focuses on prevention, detection and investigation of potentially fraudulent and abusive acts committed by care providers and members. This department oversees coordination of anti-fraud activities.

To facilitate the reporting process of questionable incidents involving members and care providers, call our **Fraud and Abuse line**.

Please refer to the Fraud, Waste and Abuse section of this manual for additional details about the UnitedHealthcare Community Plan Fraud, Waste and Abuse program.

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 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 Hawaii 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 the Hawaii Department of Health and Human Services.

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 10 years from the close of the Hawaii program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. 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 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 1 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 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 Hawaii program standards.

You must cooperate with the state or any of its authorized representatives, the Hawaii Department of Health and Human Services, CMS, the Office of Inspector General, or any other agency prior-approved by the state, at any time during your 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 Provider Agreement.

Delegating and subcontracting

If you delegate or subcontract any function, the delegate or subcontractor must include all requirements of your applicable 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 room(s) for providing member care
- Privacy in exam room(s)
- Clearly marked exits
- Accessible fire extinguishers
- Post file inspection record in the last year

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	Office facilities are dirty; smelly or otherwise in need of cleaning Office exams rooms do not provide adequate privacy	2 complaints in 6 months
Other	All other complaints concerning the office facilities	3 complaints in 6 months

Chapter 11: Billing and submission

Key contacts

Topic	Link	Phone Number
Claims	**UHCprovider.com/claims**	**1-888-980-8728**
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	1-800-465-3203
EDI	**UHCprovider.com/edi**	**1-888-980-8728**

Our claims process

For claims, billing and payment questions, go to **UHCprovider.com/claims.**

We follow the same claims process as UnitedHealthcare. See the Claims Process chapter of the Administrative Guide for Commercial, Medicare Advantage and D-SNP on **UHCprovider.com/guides**.

Claims process 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

If you think we processed your claim incorrectly, please see the Claims reconsiderations, appeals and grievances chapter in this care provider manual for next steps.

National Provider Identifier

HIPAA requires you have a unique NPI. The NPI identifies you in all standard transactions.

If you have not applied for an NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan, call **Provider Services**. 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 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.

Fee schedule

Reimbursements also depend on the fee schedule and the procedure performed. Refer to your bulletins for correct coding.

Modifier codes

Use the appropriate modifier codes on your claim form. Find our modifier reference policies in our **Community Plan Reimbursement Policies** by searching for "modifier." The modifier must be used based on the date of service.

Member ID card for billing

The member ID card has both the UnitedHealthcare Community Plan member ID and the state Document Control Number (DCN). UnitedHealthcare Community Plan prefers you bill with the member ID.

Acceptable claim forms

UnitedHealthcare Community Plan only processes claims submitted on CMS 1500 and UB-04 claim forms.

Use the CMS 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services.

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.

Clean claims and submission requirements

Complete a CMS 1500 or UB-04 form whether you submit an electronic or a paper claim. Clean claims have:

- A health service provided by an eligible care provider to a covered UnitedHealthcare Community Plan member
- All the required documentation, including correct diagnosis and procedure codes
- The correct amount claimed

Submit the claim within 1 year from the date of service or date of discharge. The member and the state are not responsible for late claims. We may require additional information for some services, situations or state requirements.

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'.

Care provider coding

UnitedHealthcare Community Plan complies with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) prevention state standards based on claims data and chart review. Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to find an ICD-9 or ICD-10 code.

For more information about ICD-10 coding and social determinants of health protocol and how they apply to the members you treat, see the Specific Protocols chapter in the Administrative Guide for Commercial, Medicare Advantage and D-SNP at **UHCprovider.com/guides**. You can also visit **UHCprovider.com/policies**. Under Additional Resources, choose **Protocols** > Social Determinants of Health ICD-10 Coding Protocol.

Electronic claims submission and billing

You may submit claims by electronic data interchange (EDI). EDI offers less paperwork, reduced postage, less time spent handling claims and faster turnaround.

- All claims are set up as "commercial" through the clearinghouse
- Our payer ID is 87726
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for CMS 1500 and UB-04 forms

EDI companion documents

Our 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. We use 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. See **UHCprovider.com/edi** > **EDI Companion Guides**

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. **UHCprovider.com/edi** > **EDI Clearinghouse Options**.

e-Business support

Call **Provider Services** for help with online billing, claims, 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.**

For further information about EDI online, go to **UHCprovider.com** > Resources > Resource Library to find Electronic Data Interchange menu.

Electronic payment solution: Optum Pay

UnitedHealthcare has launched the replacement of paper checks with electronic payments Optum Pay™ and will no longer be sending paper checks for provider 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, **UHCprovider.com/payment**
- If your practice/healthcare organization is already enrolled and receiving your claim payments through AHC/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**

All regulated entities have a Management Agreement with United HealthCare Services, Inc. (UHS), under which UHS provides a whole host of administrative services (many of which are provided to UHS by an Optum entity and then passed through to the regulated entities), including those of a financial nature. Those agreements are filed with the DOI in the regulated entity's state of domicile for approval.

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on **UHCprovider.com** > Resources > Resource Library to find the EDI section.

Visit the National Uniform Claim Committee website to learn how to complete the CMS 1500 form.

Completing the UB-04 form

Bill all hospital inpatient, outpatient and emergency room services using revenue codes and the UB-04 claim form:

- Include ICD CM diagnosis codes
- Identify other services by the CPT/HCPCS and modifiers

Form reminders

- Note the attending care provider name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims
- Send the referring care provider NPI and name on outpatient claims when this care provider is not the attending care provider.
- Include the attending care provider's NPI in the attending care provider name and identifiers fields (UB-04 FL76 or electronic equivalent) of your claims.
- Behavioral health care providers can bill using multiple site-specific NPIs

Subrogation and coordination of benefit

Our benefits contracts are subject to subrogation and coordination of benefits (COB) rules:

- **Subrogation:** The state may recover benefits paid for a member's treatment when a third party causes the injury or illness
- **COB:** 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 Explanation of Benefits or remittance advice with the claim. Use this chart to help determine when you bill to us:

Primary	Secondary	Process	Required action
Medicare Fee-for-Service	QUEST	An automatic crossover should occur from Medicare to UnitedHealthcare. UnitedHealthcare will use the crossover information received from Medicare to coordinate the member's benefits.	Do not submit a secondary claim to UnitedHealthcare unless otherwise requested.
UnitedHealthcare Dual Complete® (PPO D-SNP) - H2228-043 UnitedHealthcare Dual Complete® RP (Regional PPO D-SNP) - R3175-003	QUEST	An automatic crossover should occur within the UnitedHealthcare systems to coordinate both the Medicare/ QUEST benefits.	
AARP/Medicare Complete Choice and Complete Essential (Insured by UnitedHealthcare – Group# 77000-77007 and 77003/77008); External Medicare Advantage Plans; Commercial; No-Fault; and Other Third Party Liability (TPL) plans	QUEST	No crossover will occur.	Submit a secondary claim with a copy of the primary EOB to UnitedHealthcare to ensure proper coordination of benefits.

Hospital and clinic method of billing professional services

Hospital and clinics must bill for professional services bill on a CMS 1500. The servicing care provider's name is placed in box 31, and the servicing care provider's group NPI number is placed in box 33a.

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/policies** > 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(s) appears to be related. These edits can be further broken down to explain the bundling rationale. Some of the most common causes for denials in this category 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 your 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. For more information about the CLIA number, contact the CMS CLIA Central Office at 1-410-786-3531 or go to cms.gov.

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

Billing guidelines for obstetrical services

Follow this reporting procedure when submitting obstetrical delivery claims. Otherwise, we will deny the claim:

- If billing for both delivery and prenatal care, use the date of delivery
- Use 1 unit with the appropriate charge in the charge column

Billing guidelines for transplants

The Department of Health and Human Services covers medically necessary, non-experimental transplants. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation. Gather all required referrals and evaluations to complete the pre-transplant evaluation process once the member is a possible candidate.

Ambulance claims (emergency)

Ambulance claims must include the point of origin, destination address, city, state, and ZIP.

Hospital-acquired conditions

We follow State of Hawaii and Medicare guidelines for reimbursement protocols for hospitals and care providers for hospital-acquired conditions (HAC). Services related to HAC are typically non-reimbursable under Medicare and Medicaid programs.

National Drug Code

Claims must include:

- National Drug Code (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.

Medical necessity

UnitedHealthcare Community Plan only pays for medically necessary services. See **Chapter 4** for more information about medical necessity.

Place of Service codes

Go to CMS.gov for Place of Service codes.

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 45 days to solve your concern. Limit phone calls to 5 issues per call.

UnitedHealthcare Community Plan Provider Portal

You can view your online transactions by signing in to our Provider Portal on **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.

Our Provider Portal also 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 training on **UHCprovider.com/training**.

Resolving claim issues

To resolve claim issues, contact **Provider Services**, use our **UnitedHealthcare Provider Portal** or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

Medical Services:
UnitedHealthcare Community Plan
P.O. Box 31365
Salt Lake City, Utah 84131-0365

Behavioral Health Services:
P.O. Box 30757
Salt Lake City, Utah 84130-0757

Allow up to 30 days for UnitedHealthcare Community Plan to receive payment for initial claims and adjustment requests.

For paper claims

Submit a screen shot from your accounting 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

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 explanation of benefits.
- A letter from another insurance carrier or employer group saying that the member either has no coverage or had their coverage terminated before the date of service.

All the above 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. They must be accompanied by an acceptance report.

The date on the other carrier's payment correspondence starts the timely filing period for submission to UnitedHealthcare Community Plan.

To be timely, you must receive the claim within the timely filing period from the date on the other carrier's correspondence. If we receive the claim after the timely filing period, it will not meet the criteria.

If a claim is rejected, and corrections are not received within 365 days from date of service or close of business from the primary carrier, the clam is considered late billed. It will be denied timely filing.

All primary claims must be filed to us within 1 year from the date of service. All claims involving coordination

of benefits must be submitted within 1 year of the primary/secondary payer's EOB. Corrected claims must be submitted within 1 year of the original denial date.

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.
- UnitedHealthcare Community Plan is reviewing a claim

Refer to the following chart for additional scenarios. Medicaid members should never be charged for a covered service. You are able to 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.

If you don't know who your provider advocate is, chat with a live advocate is available from 7 a.m.–7 p.m. CT at **UHCprovider.com/chat**.

Scenario	Can you bill the member? (yes/no)
Non-payment due to your failure to follow our policies and procedures (e.g., obtain prior authorization)	**No**, you may not bill the member.
Non-payment due to the member's failure to follow our policies and procedures (e.g., self-referral without obtaining prior authorization)	**Yes**, however, you must first inform the member of our prior authorization requirement. You also need written agreement from the member regarding the cost of the procedure and the payment terms prior to rendering services.
Non-payment due to non-covered services	**Yes**, however, you must first inform the member of the non-covered services. You must get a written agreement from the member regarding the cost of the procedure and the payment terms prior to rendering services.

Chapter 12: Claim reconsiderations, appeals and grievances

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 Agreement. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

The following grid lists the types of disputes and processes that apply:

The prior definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements. UnitedHealthcare Community Plan and its contracted care providers may agree to more stringent requirements within care provider agreements than described in the standard process.

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form For mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	Unitedhealthcare Community Plan response time frame
Member appeal	A request to change an adverse benefit determination that we made.	• Member • Care provider on behalf of a member with member consent	**UnitedHealthcare Community Plan** Attention: Grievance and Appeals Department 1132 Bishop St., Ste 400 Honolulu, HI 96813	**providerforms.uhc.com/ProviderAppealsandGrievance.html** *AOR Consent Form on this site for member appeals	**1-888-380-0809** **HI_AG@uhc.com**	N/A	60 calendar days	Urgent appeals: We will respond within 72 hours Standard appeals: 30 days
Member grievance	A member's written or oral expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	• Member • Care provider on behalf of a member with member consent	**UnitedHealthcare Community Plan** Attention: Appeals Department 1132 Bishop St., Ste 400 Honolulu, HI 96813	N/A	**1-888-380-0809**	N/A	N/A	30 calendar days
Care provider claim resubmission	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission.	Care provider	**UnitedHealthcare Community Plan** QUEST P.O. Box 31350 Salt Lake City, UT 84131-0350	**UHCprovider.com/claims**	**1-888-980-8728**	Use the Claims Management application on the Provider Portal. To access the portal, go to **UHCprovider.com**, then Sign In or go to **UHCprovider.com/claimss**.	**must receive within** 365 calendar days	30 calendar days

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form For mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	Unitedhealthcare Community Plan response time frame
Care provider claim reconsideration (step 1 of claim dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care provider	Most care providers in your state must submit claim reconsideration requests electronically. For further information on claim reconsiderations, see the **Reconsiderations and Appeals interactive guide**. For those care providers exempted from this requirement, you may 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. **UnitedHealthcare Community Plan** QUEST P.O. Box 31350 Salt Lake City, UT 84131-0350	N/A	**1-888-980-8728**	Use the Claims Management application on the Provider Portal. To access the portal, go to **UHCprovider.com**,, then Sign In or go to **UHCprovider.com/claims**	**must receive within** 365 calendar days	45 calendar days
Care provider claim formal appeal (step 2 of claim dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care provider	Most care providers in your state must submit claim reconsideration requests electronically. For further information on claim reconsiderations, see the **Reconsiderations and Appeals interactive guide**. For those care providers exempted from this requirement, you may submit the claim by mail with a claim appeals request form. Allow up to 30 days to receive payment for initial claims and a response. **UnitedHealthcare Community Plan**, Attention: Appeals Department 1132 Bishop St., Ste. 400 Honolulu, HI 96813	N/A	**1-888-380-0809** **HI_AG@uhc.com**	Use the Claims Management application on the Provider Portal. To access the portal, go to **UHCprovider.com**,, then Sign In or go to **UHCprovider.com/claims**.	60 calendar days	60 calendar days
Care provider grievance	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member.	Care provider	**UnitedHealthcare Community Plan** Attention: Grievance & Appeals Department 1132 Bishop St., Ste. 400 Honolulu, HI 96813	N/A	**1-888-380-0809** **HI_AG@uhc.com**	Use the Claims Management application on the Provider Portal. To access the portal, go to **UHCprovider.com**,, then Sign In or go to **UHCprovider.com/claims**.	N/A	60 calendar days

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 an appeal.

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?

A corrected claim replaces a previously denied submitted claim due to an error. A denied claim has been through claim processing and determined it can't be paid.

When to use:

Submit a corrected claim to fix or void one that has already processed.

How to use:

Use the claims reconsideration application the Provider Portal. To access the portal, sign in to **UHCprovider.com** using your One Healthcare 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.

Mailing address:

UnitedHealthcare Community Plan
P.O. Box 31365
Salt Lake City, UT 84131-0365

Additional Information:

When correcting or submitting late charges on 837 institutional claims, use bill type xx7: Replacement of Prior Claim. Do not submit corrected or additional information charges using bill type xx5: Late Charge Claim. To void a claim, use bill type xx8.

Resubmitting a claim

What is it?

When you resubmit a claim, you create a new claim in place of a rejected one. A rejected claim has not been processed due to problems detected before processing.

When to use it:

Resubmit the claim if it was rejected. Since rejected claims have not been processed yet, there is no appeal – the claim needs to be corrected through resubmission.

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

How to use:

To resubmit the claim, follow the same submission instructions as a new claim. To mail your resubmission, provide all claim information to:

UnitedHealthcare Community Plan
P.O. Box 31365
Salt Lake City, UT 84131-0365

Claim reconsideration (step 1 of dispute)

What is it?

Claim issues include overpayment, underpayment, denial, or an original or corrected claim determination you do not agree with. A claim reconsideration request is the quickest way to address your concern about whether the claim was paid correctly. When you send a reconsideration, please send additional support information.

When to use:

Reconsiderations can be done repeatedly, but should include new information each time. Submit a claim reconsideration when you think a claim has not been properly processed.

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:

If you disagree with a claim determination, submit a claim reconsideration request electronically, by phone or mail:

- **Electronically:** Use the Claim Reconsideration application on Provider Portal. Include electronic attachments. You may also check your status using the **UnitedHealthcare Provider Portal**.
- **Phone:** Call Provider Services at **1-888-980-8728** 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.

Most care providers in your state must submit claim reconsideration requests electronically.

For further information on claim reconsiderations, see the **Reconsiderations and Appeals interactive guide**.

For those care providers exempted from this requirement, you may 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.

- **Mail**: Submit the Claim Reconsideration Request Form to:

  UnitedHealthcare Community Plan
  P.O. Box 31350
  Salt Lake City, Utah 84131-0350

  This form is available at **UHCprovider.com/claims**.

Questions about your appeal or need a status update?

Call Provider Services for questions about your appeal or if you need a status update. If you filed your appeal online, you should receive a confirmation email or feedback through the secure Provider Portal link.

Tips for successful claims resolution

To help process claim reconsiderations:

- 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
- 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.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract 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.

Valid proof of timely filing documentation (reconsideration)

What is it?

Proof of timely filing occurs when the member gives incorrect insurance information at the time of service.

It includes:

- A denial or rejection letter from another insurance carrier.
- Another insurance carrier's explanation of benefits.
- Letter from another insurance carrier or employer group indicating:
  - Coverage termination prior to the date of service of the claim
  - No coverage for the member on the date of service of the claim

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 electronically, by phone or mail with the following information:

- **Electronic claims:** Include the EDI acceptance report stating we received your claim

Most care providers in your state must submit claim reconsideration requests electronically.

For further information on claim reconsiderations, see the **Reconsiderations and Appeals interactive guide**.

For those care providers exempted from this requirement, you may 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.

- **Mail reconsiderations:** Submit a screen shot from your accounting software that shows the date you submitted the claim. The screen shot must show:
  - Correct member name
  - Correct date of service
  - Claim submission date

Additional information:

Timely filing limits can vary based on state requirements and contracts. If you do not know your timely filing limit, refer to your Agreement.

Appeals (step 2 of dispute)

What is it?

An appeal is a review of a reconsideration claim. It is a one-time formal review of a processed claim that was partially paid or denied.

When to use:

If you do not agree with the outcome of the claim reconsideration decision in step one, use the claim appeal process.

How to use/file:

Submit related documents with your appeal within 60 days of the date of the health plan's notice of adverse benefit determination or decision. These may include a cover letter, medical records and additional information. Send your information electronically or by mail. In your appeal, please include any supporting information not included with your reconsideration request.

- **Electronic claims:** Use the Claims Management application on the Provider Portal. Go to **UHCprovider.com** and sign in. You may upload attachments.

Most care providers in your state must submit claim reconsideration requests electronically.

For further information on claim reconsiderations, see the **Reconsiderations and Appeals interactive guide**.

For those care providers exempted from this requirement, you may 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.

- **Mail:** Send the appeal to:

  UnitedHealthcare Community Plan
  Grievances and Appeals
  1132 Bishop Street, Ste. 400
  Honolulu, Hi 96813

We have a 1-year timely filing limitation to complete all steps in the reconsideration and appeal process. It starts on the date of the first EOB.

Overpayment

What is it?

An overpayment happens when we overpay a claim you don't dispute.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within 60 calendar days of discovery. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer we recoup the funds from your next payment, 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
- Date of service
- Original claim number (if known)
- Date of payment
- 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 740804
Atlanta, GA 30374-0800

Instructions and forms are on **UHCprovider.com/claims**.

If you do not agree with the overpayment findings, submit a dispute within the required timeframe as listed in your contract.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See Dispute section in this chapter.

We make claim adjustments without requesting additional information from you. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional information is needed, we will ask you to provide it.

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	01/01/24	14A000000001	01/31/24	$115.03	$115.03	Double payment of claim
2222222	02/02/24	14A000000002	03/15/24	$279.34	$27.19	Contract states $50, claim paid $77.29
3333333	03/03/24	14A000000003	04/01/24	$131.41	$99.81	You paid 4 units, we billed only 1
44444444	04/04/24	14A000000004	05/02/24	$412.26	$412.26	Member has other insurance
55555555	05/05/24	14A000000005	06/15/24	$332.63	$332.63	Member terminated

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 **1-888-980-9728**, 7:45 a.m. to 4:30 p.m. HT, Monday-Friday
- **Mail:** Send care provider name, contact information and your grievance to:

  UnitedHealthcare Community Plan
  Grievances and Appeals
  1132 Bishop St., Ste. 400
  Honolulu, HI 96813

Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses the CMS definitions for appeals and grievances.

Notice of adverse benefit determination

If we decide to reduce, put on hold, or stop a service the member is receiving, they receive a written notice of adverse benefit determination (NABD) at least 10 days before the action takes place. If the member does not agree, they may file an appeal or they may have their care provider file an appeal on their behalf with the member's written consent.

We give the member and the referring care provider a written notice of any action. This notice includes:

- The action we have or plan to take
- The reasons for the action such as changes in regulation, federal or state law
- The member's or care provider's right to request an appeal
- Procedures for filing an appeal
- The member may represent himself or herself, use legal counsel or an authorized representative
- The circumstances under which an expedited resolution is available and how to request it
- The member's right to have benefits continue pending resolution of an appeal, how to request that the benefits be continued, and the circumstances under which a member may be required to pay the costs of these services

We mail the notice within these time frames:

- For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days prior to the date the adverse action is to start except for the following reasons:
  - We have factual information confirming the death of a member
  - We receive a clear written statement signed by the member that they no longer want services or gives information that requires termination or reduction of services and understands that this must be the result of supplying that information
  - The member has been admitted to an institution that makes them ineligible for further services
  - The member's address is unknown and the post office returns our mail directed to the member indicating no forwarding address
  - The member has been accepted for Medicaid services by another local jurisdiction
  - The member's care provider prescribes a change in the level of medical care
  - There has been an adverse determination made with regard to the preadmission screening requirements for NF admissions
  - In the case of adverse actions for NF transfers, the safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or the member has not resided in the NF for 30 days
  - The period of advanced notice is shortened to 5 days if there is alleged fraud by the member and the facts have been verified, if possible, through secondary sources

- For denial of payment: at the time of any action affecting a claim
- For standard service authorization decisions that deny or limit services: as expeditiously as the member's health condition requires, but not more than 14 days following receipt of request for service, with a possible extension of up to 14 additional days (total time frame allowed with extension is 28 days from the date of the request for services) if: 1) the member or care provider requests an extension or, 2) we justify a need for additional information and how the extension is in the member's interest. If we extend the time frame, we must: 1) give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if they disagree with the decision to extend the time frame and 2) issue and carry out its determination as expeditiously as the member's health condition requires but no later than the date the extension expires
- For expedited authorization decisions: as expeditiously as the member's health condition requires but no more than 72 hours after receipt of the request for service
- Service authorization decisions not reached within the time frames specified constitute a denial

Appeals

What is it?

An appeal is a formal way to share dissatisfaction with a claim determination.

You or a member may appeal when the plan:

- Makes a harmful determination or limits a requested service(s). This includes the type or level of service.
- 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 the state requires.

When to use:

You may act on the member's behalf with their written consent. You may provide medical records and certification of the appeal as appropriate.

Where to send:

Mail, call or email the information within 60 calendar days of the NABD:

UnitedHealthcare Community Plan
Attention: Grievance and Appeals Department
1132 Bishop St., Ste 400
Honolulu, HI 96813

Phone: **1-888-980-8728** (TTY 711). An oral appeal may be submitted but must be followed by a written request.

Email: **HI_AG@uhc.com**

We provide reasonable assistance to you and members in completing forms and taking other grievance system steps. This includes help providing oral and written interpreter services, toll-free numbers with TTY/TTD and personalized member outreach to make sure the health plan fully understands the concerns.

How to use:

Whenever we deny a service, we must provide the member with UnitedHealthcare Community Plan 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 if waiting for this health service could harm the member's health
- 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
- We must resolve a standard appeal 30 calendar days from the day we receive it
- We must resolve an expedited appeal 72 hours from when we receive it. With approval from DHS, we may extend the response 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 grievance

What is it?

A grievance is an expression of dissatisfaction about UnitedHealthcare Community Plan and/or a care provider about any matter other than an adverse benefit determination. This includes quality of care or service concerns and aspects of interpersonal relationships, such as a care provider or employee's rudeness.

When to use:

You may file a grievance as the member's representative.

Where to send:

You or the member may file a grievance by calling Member Services or writing UnitedHealthcare Community Plan:

Mailing address:

UnitedHealthcare Community Plan
Attention: Appeals Department
1132 Bishop St., Ste 400
Honolulu, HI 96813

We will send an answer no longer than 30 working days from when you filed the complaint/grievance.

We provide reasonable assistance to you and members in completing forms and taking other grievance system steps. This includes help providing oral and written interpreter services, toll-free numbers with TTY/TTD and personalized member outreach to make sure the health plan fully understands the concerns.

The member may also file a grievance to the state of Hawaii within 30 calendar days of receipt of the first determination letter.

Med-QUEST Division (MQD)
Health Care Services Branch
P.O. Box 700190
Kapolei, HI 96709-0190

Or call 1-808-692-8094.

The MQD will review the grievance and contact the member within 90 days from the date the request for a grievance review is received. The determination made by MQD is final.

State administrative hearing

What is it?

A state administrative hearing lets members share why they think Hawaii Medicaid services should not have been denied, reduced or terminated.

When to use:

Members have 120 calendar days from the letter date to ask for a hearing. At that point, they will be mailed a hearing form. Once they complete the form and send it back, we set a hearing date.

How to use:

The UnitedHealthcare Community Plan member may ask for a state fair hearing by writing a letter to:

State of Hawai'i Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809-0339

- The member may ask Member Services for help writing the letter
- The member may have someone attend with them. This may be a family member, friend, care provider or lawyer.
- Hearings are held on the phone. Members may go to the local Family Support Division office for the hearing or can take part from home.
- Expedited hearings are heard and determined within 3 business days after the date the member files the request for an expedited hearing

Processes related to reversal of our initial decision

If the State Administration Hearing reverses a decision to deny, limit, or delay services not provided while the appeal was pending, we authorize or provide the disputed services as quickly as the member's health condition requires, but no later than 72 hours from the date we receive notice reversing the determination. If the decision reverses denied authorization of services and the disputed services were received pending appeal, we pay for those services as specified in policy and/or regulation.

Continuation of benefits during an appeal or state administrative hearing

A member or their authorized representative may request a continuation of benefits. The health plan will continue the member's benefits if the following conditions have been met:

- The member timely files for continuation of benefits, meaning on or before the later of the following;
  - Within 10 days of the health plan mailing the notice of adverse benefit determination or the intended effective date of the health plan's proposed adverse benefit determination
  - The appeal or request for state administrative hearing is filed in a timely manner
  - The appeal or request for state administrative hearing involves the termination, suspension, or reduction of a previously authorized services
  - The services were ordered by an authorized care provider
  - The original authorization period has not expired

If we continue or reinstate the member's benefits while the appeal or the State Administrative Hearing is pending, we continue all benefits until:

- The member withdraws the appeal
- The member does not request a DHS Administrative Hearing within 10 days from when we mail a notice of adverse action or
- A State Administrative Hearing decision adverse to the member is made

If the final resolution of the State Administrative Hearing upholds our denial, we may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section.

If we or the DHS reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, we authorize or provide these disputed services promptly, and as quickly as the member's health condition requires.

If we or the state reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, we will pay for those services.

Fraud, waste, and abuse

Call the **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 works to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. To achieve this, UnitedHealthcare Community Plan works to prevent the payment of fraudulent and abusive health care claims. We detect, investigate, report and recover fraudulent and abusive claims as part of our Anti-Fraud, Waste and Abuse Program.

This program includes applicable federal and state regulatory requirements given that state and federal health plans are vulnerable to fraud, waste and abuse (FWA). As such, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of FWA. We will appropriately refer suspected FWA to law enforcement and regulatory and administrative agencies pursuant to state and federal law. State and federal laws require you to do the same.

An important aspect of this compliance program is reviewing our operation's high-risk areas. We implement reviews and audits to help ensure compliance with law, regulations and contracts. This means you will be subject to program integrity audits and activity. 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/HIcommunityplan** > Integrity of Claims, Reports, and Representations to the Government. You can also learn about UnitedHealthcare Community Plan's FWA program at our town hall meetings. To learn more about the next meeting, please call your provider advocate.

Fraud, waste, and abuse definitions

- **Abuse by a care provider:** Care provider practices that are inconsistent with sound fiscal, business or medical practices that result in an unnecessary cost to the program or in reimbursement for services not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the program.
- **Fraud by a member or care provider:** Intentional deception or misrepresentation made by a person or persons with the knowledge that the deception could result in some unauthorized benefit to them or some other person. It includes any act that constitutes fraud under applicable federal or state law.
- **Waste by a care provider:** Incurring unnecessary costs as a result of deficient management, practices or controls. Overuse of services that result in unnecessary costs to the Medicaid program.

Fraud, waste, and abuse examples

- **Falsifying claims/encounters**: altering a claim, incorrect coding, double billing and submitting false data
- **Falsifying services:** billing for services/supplies not provided, misrepresentation of services/supplies or substitution of services
- **Billing for services not medically necessary.**
- **Unlawful sales of prescriptions and/or prescription medications**
- **Administrative/financial:** Kickbacks, falsifying credentials, fraudulent enrollment practices, fraudulent third party liability (TPL) reporting and fraudulent recoupment practices
- **Member fraud/abuse:** Falsifying information, unlawful sale of prescriptions or misrepresentation to establish eligibility (e.g., non-disclosure of income/assets)

Care provider fraud, waste, and abuse requirements and responsibilities

Care providers who furnish services to Medicaid members agree to comply with all federal and state laws and regulations related to the provision of medical services. This includes, but is not limited to, Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, HIPAA and the state Medicaid Fraud Act. You also agree to conform to Department of Human Services policies and instructions as specified in this manual and its appendices, including any updates.

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.

You must also establish written policies and procedures for all employees, agents or contractors that provide detailed information about the Federal False Claims Act established under 31 U.S.C §§ 3729-3733, administrative remedies for false claims established under 31 U.S.C. 3801 et seq. This includes preventing and detecting FWA in federal health care programs (as defined in Social Security Act §1128B(f)). You are required, upon request, to make available to UnitedHealthcare and/or a recovery audit contractor (RAC) any and all administrative, financial and medical records relating to the delivery of items or services for which state monies are expended unless otherwise provided by law. In addition, you are required to provide the RAC with access during normal business hours to its respective place of business and records. According to your provider agreements with UnitedHealthcare Community Plan and contract(s) with the Department of Human Services, you must abide by all laws, rules and regulations related to providing Medicaid this information. Your contracts also require you to assume full responsibility for the claims you submit for services provided under Medicaid. This includes any and all claims submitted under your NPI, on your behalf, by an employee or third party billing contractor.

This means you have legal and contractual obligations to ensure the claims you submit are accurately coded based on the most recent updates and changes to the coding rules and guidelines. In some cases, failing to do so may result in administrative actions, including recoupment of payments made for inappropriately coded claims. In other cases, you may be in breach of contract and civil or criminal prosecutions for fraud.

You are required to abide by applicable state and federal law, rules and regulations and to maintain and furnish required records and documents as required by law, rules and regulations and contract.

Reporting fraud, waste, and abuse

You are required to report any known or suspected cases of fraud and abuse to either the state or UnitedHealthcare Community Plan.

To report to Hawaii's Department of Human Services, call:

- Member allegations: 1-808-587-8444
- Care provider allegations: 1-808-692-8072

To report FWA to UnitedHealthcare Community Plan, either:

- Go to **uhc.com/fraud**
- Fax your report to 1-866-223-5285

Detection and prevention tips

Visit HHS Office of Inspector General's website at oig.hhs.gov/fraud for information on detection and prevention of fraud.

You can also visit:

- **UHCCommunityPlan.com/hi/medicaid/quest-integration-program**
- medicaid.gov/medicaid/program-integrity/index.html
- medicare.gov/basics/reporting-medicare-fraud-and-abuse
- cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program?redirect=/deficitreductionact
- cms.hhs.gov/FraudAbuseforProfs/

UnitedHealthcare Community Plan may deny or revoke enrollment if the care provider, their agent or a managing employee is convicted under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct.

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 - SAM.gov

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.

Chapter 13: Care provider communications and outreach

Key contacts

Topic	Link	Phone Number
Provider education	**UHCprovider.com** > Resources > **Resource Library**	**1-888-980-8728**
News and bulletins	**UHCprovider.com/news**	**1-888-980-8728**
Care provider manuals	**UHCprovider.com/guides**	**1-888-980-8728**

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:

- **Chat support 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.
- **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.
- **UHCprovider.com/HIcommunityplan**: The UnitedHealthcare Community Plan of Hawaiipage has state-specific resources, guidance and rules.
- **Policies and protocols**: **UHCprovider.com/policies** > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols.
- **Social media**
  Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics.
  - Facebook
  - Instagram
  - LinkedIn
  - YouTube
  - X (formerly Twitter)
- **Hawaii health plans**: **UHCprovider.com/HIcommunityplan** is the fastest way to review all of the health plans UnitedHealthcare offers in Hawai'i. To review plan information for another state, use the drop-down menu at **UHCprovider.com/plans**. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **UnitedHealthcare Community & State newsletter**
  Stay current on the latest insights, trends and resources related to Medicaid. **Sign up** to receive this twice-a-month newsletter.
- **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 care provider manual or by visiting **UHCprovider.com/portal.**
  - You can also access **self-paced user guides** for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News**
  Bookmark **UHCprovider.com/networknews**. 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 **UHCprovider.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.

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 1 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 preferences**.
3. Already have a One Healthcare ID? To review or update your email, simply sign in to the **UnitedHealthcare Provider Portal**. Go to "Profile & Settings," then "Account Information" to manage your email.

Care provider office visits

Provider advocates regularly visit PCPs and specialist offices. We do this to create program awareness, promote compliance and problem resolution. To schedule a visit, please call **Provider Services** at **1-888-980-8728** or if you are not sure who your provider advocate is, you can view a map to determine which provider advocate to contact based on your location at **UHCprovider.com/HIcommunityplan** > Contact Us.

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** at **1-888-980-8728.**.

State website and forms

Find Hawaii DHS forms on the state's website at medquest.hawaii.gov/en/resources/forms.html:

- Sterilization Consent Form
- Informed Consent for Hysterectomies Form
- Provider Service Agreement (MC 19 Form)

Glossary

AABD

Aid to the Aged, Blind and Disabled

Abuse (by care provider)

Any practices inconsistent with sound fiscal, business or medical practice and result in unnecessary cost to the Medicaid program, or in reimbursement for services not medically necessary or that fail to meet professionally recognized standards or contractual obligations for health care in the managed care setting. (This includes the terms of the RFP, contracts and requirements of state and federal regulations.) Incidents or practices of care providers inconsistent with professionally recognized standards for health care.

Abuse (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. Also, beneficiary practices that result in unnecessary cost to the Medicaid program.

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

Advance directive

Legal papers that list a member's wishes about their end-of-life health care.

Adverse benefit determination

The denial or limited authorization of a requested service, including the type, level or care provider of service; reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

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 services

Extra health services, like laboratory work and physical therapy, which a member gets in the hospital.

Appeal

A member request that their health insurer or plan review 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."

Authorized representative

An individual or organization designated by the member, in writing, with the designee's signature or by legal documentation of authority to act on behalf of a member, in compliance with federal and state law regulations. Designation of an authorized representative may be requested at time of application or at other times as required.

Beneficiary

Any person determined eligible by the DHS and currently receiving Medicaid.

Benefit year

A continuous 12-month period following an open enrollment period. If the contract is not in effect for the full benefit year, any benefit limits shall be pro-rated.

Billed charges

Charges you bill for rendering services to a UnitedHealthcare Community Plan member.

Capitation

A prepaid, periodic payment to care providers based upon the number of assigned members for providing covered services for a specific period.

Carved-out service

Services not provided or covered under the UnitedHealthcare Community Plan QUEST program but are available through the State or other local agencies.

Case manager

The individual responsible for coordinating the overall service plan for a member in conjunction with the member, the member's representative and the member's primary care provider (PCP).

Centers for Medicare & Medicaid services

CMS - A federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and SCHIP programs.

Children's Health Insurance Program

CHIP – a federal program that provides medical coverage to those 18 years old or younger

Claim

A document submitted by care providers to the health plan for payments of health-related services rendered to a member.

Clean claim

A claim with no defect (including lack of any required substantiating documentation) or circumstance requiring special treatment that prevents timely payment.

Contracted care providers

PCPs, specialists, medical facilities, allied health professionals and ancillary service 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 2 or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

Covered services

The portion of a medical, dental or vision expense that a health insurance or plan has agreed to pay for or reimburse.

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 codes

CPT - 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, care provider offices and home health care.

Disallow amount

Amt -Medical charges for which the network care 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.

Dispute

A disagreement involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

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 prevention

EPSDT - A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA Section 1905 (R). 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 2 or more organizations.

Electronic funds transfer

EFT - The electronic exchange of funds between 2 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 medical condition

The sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms, substance abuse) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant member, the health of the member or their unborn child) in serious jeopardy;
2. Serious impairment to body functions;
3. Serious dysfunction of any bodily functions;
4. Serious harm to self or others due to an alcohol or drug abuse emergency;
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant member who is having contractions:
   - That there is inadequate time to effect a safe transfer to another hospital before delivery; or
   - That transfer may pose a threat to the health or safety of the member or their unborn child.

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 HawaiiMedicaid. The state audits encounter submission accuracy and timeliness on a regular basis.

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 appeal

An oral or written request by a member or member's representative received by UnitedHealthcare Community Plan requesting a faster reconsideration of an action. This speed is necessary when taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Expedited grievance

A grievance where delay in resolution could harm the member's health or life.

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.

Family Health Center

FHC - A healthcare facility that cares for the whole family.

Fraud

A crime that involves misrepresenting or concealing information to receive benefits or to make a financial profit.

Grievance

An oral or written complaint a member or their representative has and communicates to UnitedHealthcare Community Plan.

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

Health Insurance Portability and Accountability Act

HIPAA - 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.

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 members, 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 1 of the following to result:

- Their health would be put in danger;
- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body.

Medically necessity

Procedures and services, as determined by the Department, which are considered to be necessary and for which payment will be made. Medically necessary health interventions (services, procedures, drugs, supplies, and equipment) must be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The evidence shall demonstrate that the intervention can be expected to produce its intended effects on health outcomes. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided when evidence is sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the

intervention to health outcomes, and is reproducible both within and outside of research settings.

Member

An individual who is eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement.

National Provider Identifier

NPI – 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 M.D. (Medical Doctor) or D.O. (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.

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.

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

Rural health clinic

A clinic, located in a rural area, designated by the Department of Health 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 provided to enrolled members.

Service area

The geographic area served by UnitedHealthcare Community Plan, designated and approved by HI DHS.

Specialist

A care provider licensed in the state of HI 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 or care provider does not agree with a Notice of Decision or Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

Temporary Assistance to Needy Families

TANF - A state program that gives cash assistance to low-income families with children.

Telehealth/telemedicine

Telemedicine allows you to evaluate, diagnose and treat patients at a distance using telecommunications technology. This includes real-time video and web conferencing, or secure and non-interactive web-based communication, which allows you to share patients' medical information, including lab results, diagnosis or other information.

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.

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. Determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.

Comments

UnitedHealthcare Community Plan welcomes providers' comments and suggestions about this guide. If a provider needs information about the material covered in this guide or expansion on topics not addressed or finds incorrect or inaccurate information, please complete this form and mail to:

UnitedHealthcare Community Plan
Attn: Director of Network Programs
1132 Bishop Street, Suite 400
Honolulu, HI 96813

Comments and Recommendations (attach a separate sheet(s) if necessary):

_____
_____
_____
_____
_____

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

Name: _____

Provider Name (if different from above):_____

Address:

_____

Phone: _____