2026 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Arizona UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001

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United Healthcare® Community Plan

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Chapter 1: Introduction

Welcome

Welcome to the UHC AZ Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 plan manual. This comprehensive and up-to-date reference PDF manual allows you and your staff to find important information such as processing a claim and prior authorization. This care provider manual explains the policies and procedures of the UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 programs network. This manual also includes important phone numbers and websites. We hope it provides you and your office staff with helpful information and guide you in making the best decisions for your patients.

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 **Your State**

If you have questions about the information or material in this manual or about any of our policies, please call **Provider Services** (ACC/DD): **1-800-445-1638.** We greatly appreciate your participation in our program and the care you offer our members.

Important information about the use of this care provider manual

In the event of a conflict between your agreement and this care provider manual, the manual controls unless the agreement dictates otherwise.

In the event of a conflict between your agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This care provider manual will be amended as policies change.

Background

UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 are Medicare Advantage Special Needs Plans, serving members who are dually eligible for Medicare and Arizona Health Care Cost Containment System (AHCCCS) (Medicaid) within the UHC Dual Complete AZ-S001 programs service area.

Members of UHC Dual Complete AZ-S001 programs have already demonstrated eligibility for and been enrolled in Medicare Part A, Medicare Part B, and AHCCCS Medicaid Title XIX benefits. UHC Dual Complete AZ-S001 programs members may be enrolled in UnitedHealthcare Community Plan.

For Division of Developmental Disabilities members who are dual eligible, UHC Dual Complete AZ-S001 is available statewide. For Arizona Long Term Care Elderly Physically Disabled (EPD) members who are dual eligible, UHC Dual Complete AZ-Y001 is available in: Maricopa, Pinal, Gila, Apache, Coconino, Navajo, Mohave, and Yavapai counties. UnitedHealthcare Community Plan provides AHCCCS programs for AHCCCS Complete Care (ACC), Arizona Long Term Care Elderly Physically Disabled (ALTCS EPD) and Developmental Disabilities (DD).

Contacting UHC Community Plan Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001

UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 programs manage a comprehensive care provider network of independent practitioners and facilities across Arizona. The network includes health care professionals such as primary care providers (PCPs), specialist care providers, medical facilities, allied health professionals, and ancillary service providers. UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 programs offer several options to support care providers who require assistance.

Electronic data interchange online resources

UHCprovider.com is your home for care provider information with access to Electronic Data Interchange (EDI), Provider Portal online services, medical policies, news bulletins. It also includes great resources to support administrative tasks such as eligibility, claims, claims status and prior authorizations and notifications. Go to **Self Service** for Self Service Tool online training and information. See **EDI Transaction Support Form**.

Electronic data interchange

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

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

- Send and receive information faster
- Identify submission errors immediately and avoid processing delays
- Exchange information with multiple payers
- Reduce paper, postal costs and mail time
- Cut administrative expenses
- EDI transactions available to care providers are:
  - 270/271: Eligibility and benefit inquiry and response
  - 275: Claim attachments
  - 276/277: Claim status inquiry and response
  - 278: Authorization and referral request
  - 278I: Prior authorization and notification inquiry
  - 278N: Hospital admission notification
  - 835: Electronic remittance advice (ERA)
  - 837D: Dental claim
  - 837I: Institutional claim
  - 837P: Professional claim or vision claim

Visit **UHCprovider.com/edi** > **EDI transaction and code sets** for more information.

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

Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal**. You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information – all at no cost without calling.

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

- Access remittance advice and review recoveries
- Review your preventive health measure report
- Access the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) toolset
- Search for CPT codes. Type the CPT code in the header search box titled "What can I help you find?" on **UHCprovider.com**, and the search results will display all documents and/or web pages containing that code
- Find certain web pages more quickly using direct URLs. You'll see changes in the way we direct you to specific web pages on our **UnitedHealthcare Provider Portal**. You can now use certain direct URLs, which helps you find and remember specific web pages easily and quickly. You can access our most used and popular web pages on **UHCprovider.com** by typing in that page's direct URL identified by a forward slash in the web address, e.g. **UHCprovider.com/claims**. When you see that forward slash in our web links, you can copy the direct URL into your web page address bar to quickly access that page.

You will conduct business with us electronically. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use both EDI and **UnitedHealthcare Provider Portal** for maximum efficiency in conducting business electronically.

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

- **Eligibility and Benefits** – View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility.**
- **Claims** – Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims.**
- **Prior Authorization and Notification** – Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/priorauth**.
- **Specialty Pharmacy Transactions** – Submit notification and prior authorization requests for certain medical injectable specialty drugs. see **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 claim letters for viewing, printing, or download. The Document Library Roster provides member contact information in a PDF and can only be pulled at the individual practitioner level. For more information, 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 portal that lets you securely communicate with payers to address errant claims. This portal can replace previous methods of letters, faxes, phone calls and spreadsheets. It also helps:

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

All users will access Direct Connect using the **UnitedHealthcare Provider Portal.** You will also find the optum-direct-connect-fact-sheet.pdf on this portal.

Email **directconnectsupport@optum.com** to get started with Direct Connect.

UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 Roster

PCPs are given access to a roster of all assigned members. PCPs should use this to determine if they are responsible for providing primary care to a particular member. Rosters can be viewed electronically on **UHCprovider.com**.

Additional resources

Provider Services

Provider Services is the primary contact for care providers who need help. 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.

- UnitedHealthcare Community Plan **Provider Services** (ACC/DD): **1-800-445-1638**
- Long-Term Care (ALTCS EPD): **1-800-293-3740**

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

Office of Individual and Family Affairs

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

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

UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 network

UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 programs maintain and monitor a network of participating care providers including physicians, hospitals, skilled nursing facilities (SNFs), ancillary providers and other health care providers through which members obtain covered services.

Members using this UHC Dual Complete AZ-Y001 must choose a PCP to coordinate their care. PCPs are the basis of the managed care philosophy.

UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 programs work with contracted PCPs who manage the health care needs of members and arrange for medically necessary covered medical services. You may, at any time, advocate on behalf of the member without restriction to help ensure the best care possible for the member. In particular, you are not prohibited or otherwise restricted from advising or advocating, on behalf of a member who is your patient, for:

a. The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.

b. Any information the member needs to decide among all relevant treatment options.

c. The risks, benefits, and consequences of treatment or non-treatment; and,

d. The member's right to participate in decisions regarding their behavioral health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

To help ensure continuity of care, members must coordinate with their PCP before seeking care from a specialist, except in the case of specified services (such as women's routine preventive health services, routine dental, routine vision, and behavioral health). Contracted health care professionals are required to coordinate member care within the care provider network. If possible, all members should be directed to UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 programs contracted care providers.

UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 programs require prior authorization. The services must be a covered benefit, and the member must be eligible on the date of service.

All out-of-network services will be denied unless prior authorization has been obtained, or services are emergent in nature.

The referral and prior authorization procedures explained in this manual are particularly important to the UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 programs. Understanding and adhering to these procedures are essential for successful participation. A prior authorization list is available online at **UHCprovider.com/azcommunityplan** in the Prior Authorization and Notification section.

Occasionally the Dual Complete AZ-S001 and Dual Complete One AZ-Y001 programs distribute communication documents on administrative issues and general information to you and your office staff. It is very important that you and/or your office staff read the newsletters and other special mailings and retain them with this care provider manual, so you can incorporate the changes into your practice.

Participating care providers

Primary care providers

UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 programs contract with certain care providers whom members may choose to coordinate their health care needs. These care providers are known as PCPs. PCPs are generally physicians of internal medicine, pediatrics, family practice or general practice. However, they may also be other provider types who accept and assume PCP roles and responsibilities. All members must select a PCP when they enroll in UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 programs and may change their designated PCP once a month.

Specialists

A specialist is any licensed participating care provider (as defined by Medicare) who provides specialty medical services to members.

A PCP may refer a member to a specialist as medically necessary.

Care provider privileges

To help our members get access to appropriate care, you must have privileges at applicable participating facilities or arrangements with a participating practitioner to admit and provide facility services. This includes but is not limited to full admitting hospital privileges, ambulatory surgery center privileges, and/or dialysis center privileges.

Autodialer, artificial or pre-recorded voice technology

You consent to UnitedHealthcare and its affiliates calling the phone number(s) you provided using an auto-dialer and/or artificial or prerecorded voice technology. To opt out of these outreaches, submit the **Telephone Consumer Act (TCPA) Opt Out form**. The Provider TCPA Opt Out will be processed within 10 business days and registered until such time that the phone number is opted back in for such communications. Should you decide to opt back into receiving such outreaches after opting out, submit the **TCPA Provider Opt In form** and it will be processed within 10 business days and your phone number will be removed from the do not call registry.

For additional TCPA Opt Out assistance, please contact Provider Services. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

Community Resource Guide

UnitedHealthcare Community Plan is committed to helping people live healthier lives. To support this commitment, the Community Resource Guide is available.

This guide lists community organizations across Arizona and highlights local resources that may help address health-related social needs.

You can access the Community Resource Guide here: **AZ Community Resource Guide AHCCCS**.

How to contact us

Topic	Contact	Information
Behavioral health, mental health, and substance abuse	Optum® **providerexpress.com** **1-877-614-0484**	Review eligibility, claims, benefits, authorization and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	**UHCprovider.com/benefits**	Confirm a member's benefits and/or prior authorization.
Claims	**UHCprovider.com/claims** **1**-800-445-1638 **UnitedHealthcare Community Plan** P.O. Box 5290 Kingston, NY 12402-5290 For Fed-Ex (large packages/more than 500 pages) **UnitedHealthcare Community Plan** 709 Grant Avenue, North Lobby Lake Katrine, NY 12449	Verify a claim status or get information about proper completion or submission of claims.
Community Resource Guide	**AZ Community Resource Guide**	The AZ Community Resource Guide lists community organizations and resources in your area to support health-related social needs.
Dental	**1-800-822-5353**	Dental care providers.
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**	Confirm member eligibility.
Enterprise Voice Portal	Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**	The Enterprise Voice Portal provides self-service functionality.
Fraud, waste and abuse (payment integrity)	**UHCprovider.com/azcommunityplan** > Integrity of Claims, Reports, and Representations to the Government Reporting: **uhc.com/fraud** **1-877-401-9430**	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.

Topic	Contact	Information
Medical claim, reconsideration and appeal	**UHCprovider.com/claims** **1-800-445-1638** Most care providers in your state must submit reconsideration/appeal requests electronically. For further information on reconsiderations and appeals, see the **Reconsiderations and Appeals interactive guide**.	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Medical /prior notification	EDI: Transactions 278 and 278N **UHCprovider.com/azcommunityplan** > Prior Authorization and Notification **UHCprovider.com/priorauth** **1-800-445-1638**	Submit prior authorization requests and advanced notifications. Find information about advance notification and the prior authorization lists.
Member Services	**1-800-348-4058**	Dual Complete AZ-S001 and Dual Complete One AZ-Y001.
Nationwide Vision	1-480-961-1865 nationwidevision.com	Vision care providers.
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 Monday–Friday, 7 a.m.–9 p.m. CT, Saturday, 6 a.m.–6 p.m. CT, Sunday. 9 a.m.–6 p.m. CT.
Pharmacy services	**professionals.optumrx.com** **1-800-711-4555**	Optum Rx® oversees and manages our network pharmacies.
Prior authorization/ notification for pharmacy	**UHCprovider.com/pharmacy** **1-800-310-6826**	Request authorization for medications as required. 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.

Topic	Contact	Information
Prior authorization requests/advanced and admission notification	Notify of member admission to a facility at **UHCprovider.com/admit**: EDI: Transactions 278 and 278N **UHCprovider.com/priorauth** Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications" or call **1-800-445-1638**:	**UHCprovider.com/azcommunityplan** > Prior Authorization and Notification 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:
Provider Services	**UHCprovider.com/azcommunityplan** • UnitedHealthcare Community Plan Provider Services (ACC/DD): **1-800-445-1638** • Long-Term Care (ALTCS EPD): **1-800-293-3740**	Available 8 a.m.- 5 p.m. PT, 7 days a week.
Referrals	**UHCprovider.com/referrals** or use Referrals on the UnitedHealthcare Provider Portal. Click Sign In at the top right corner of **UHCprovider.com**, then click Referrals.	Submit new referral requests and check the status of referral submissions.
Reimbursement policy	**UHCprovider.com/azcommunityplan** > **Policies and Protocols**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical support	For chat options and contact information, visit **UHCprovider.com/contactus**.	Contact us if you have issues logging in to the UnitedHealthcare Provider Portal, you cannot submit a form, etc.
Transportation (medical) Non-emergent transportation	MTM 1-888-889-0358 Visit MTM's website at MTM link.	Schedule transportation or for transportation assistance. To arrange non-urgent transportation, please call 3 days in advance. Members covered under UHC Dual Complete AZ-S001 do not have transportation benefits under their Medicare benefits.

Topic	Contact	Information
Utilization management	**Provider Services** **1-800-445-1638**	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. For UM policies and protocols, go to **UHCprovider.com/protocols.** Request a copy of our UM guidelines or information about the program.
Website for AZ Community Plan	**UHCprovider.com/azcommunityplan** **1-800-445-1638**	Access your state-specific Community Plan information on this website.

Chapter 2: Covered services

Summary

Medicare Cost-sharing for Members Enrolled in UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 (Costs will vary significantly based on the member's category of Medicaid assistance). Dual programs include QMB Plus, FBDE and SLMB Plus.

For Ancillary benefit planning	Medicaid eligibility status		Does Medicaid cover Part A premium?	Does Medicaid cover Part B premium?	Does Medicaid cover Part D premium?	Does Medicaid cover Medicare deductibles, copays, co-insurance?	Does the member have full Medicaid benefits?
Full Dual	QMB Plus (02)	Qualified Medicare Beneficiary w/full Medicaid.	Yes (when applicable.)	Yes	No*	Yes	Yes
Full Dual	FBDE (08)	Full benefit Dual eligible.	Yes (when applicable.)	Varies by state.	No	Yes	Yes
Partial Dual	SLMB Plus (04)	Specified low income Medicare beneficiary w/full Medicaid.	Yes (when applicable.)	Yes	No*	Yes	Yes
Partial Dual	QMB Only (01)	Qualified Medicare beneficiary.	Yes (when applicable.)	Yes	No*	Yes	No
Partial Dual	SLMB Only (03)	Specified low income Medicare beneficiary.	No	Yes	No*	No	No
Partial Dual I	QDWI (05)	Qualified disabled working individual.	Yes (when applicable.)	No	No	No	No
Partial Dual	QI (06)	Qualified individual.	No	Yes	No*	No	No

*QMBs, SLMBs and QIs are automatically enrolled in the low income subsidy program to cover Part D premium costs and will not have Part D premiums.

Medicaid (Medicaid contractor) pays the Medicare cost-sharing (coinsurance, deductible, or copayments except Part D), up to the lesser of the Medicare or Medicaid rate, for Medicare-covered benefits except prescription drug copayments (unless institutionalized and then no prescription drug copayments).

Supplemental benefits (dental, vision, product catalog, etc.) are covered by the Medicare Plan. There is no Medicare cost-sharing. Once a supplemental benefit is exhausted, if it's not covered by Medicare, the member is responsible for payment unless otherwise covered by Medicaid.

NON-QUALIFIED MEDICARE BENEFICIARY DUALS (ACOM 201)

A Non-QMB dual who receives covered services under A.A.C. R9-22 Article 2 or A.A.C. R9-28.

Article 2 from an in-network care provider is not liable for:

1. Any applicable Medicare Cost Sharing (deductible, coinsurance, or copayment) amounts associated with those services, or
2. For any balance of billed charges, unless services have reached the limitations specified within A.A.C. R9-22 Article 2.
3. a.) When a Non-QMB Dual elects to receive services that are covered by both Medicare and Medicaid, from an out-of-network care provider, the individual is responsible for any Medicare deductible, coinsurance, or copayment amounts unless the service is emergent, or, for non-emergency services, the care provider has obtained a signed document from the member to pay for the services as required in A.A.C. R9-22-702.
4. Contractor Payment Responsibilities (In Network)
5. a.) In accordance with A.A.C. R9-29-303, when a Non-QMB Dual receives covered services from an in-network care provider, and the covered service is provided up to the limitations as specified in A.A.C. R9-22 Article 2, the individual is not liable or any balance of billed charges.

Non-qualified Medicare beneficiary Duals (In-Network) Medicare cost sharing requirements	
When the service is covered by: **The contractor shall not pay:**	**When the service is covered by:** **The contractor shall pay:**
Medicare only: Any Medicare deductible, coinsurance, or copayment amounts	(Subject to the limits specified in this policy) Medicaid only: The care provider in accordance with the contractor's subcontract by both Medicare and Medicaid. The lesser of the following (unless the contractor's subcontract with the care provider sets forth different terms): a.) The Medicare deductible, coinsurance and/or co-payment amounts, or b.) Any remaining Medicare cost sharing amount after the Medicare payment amount is deducted from the care provider's subcontracted rate (The contractor's contracted rate).

Non-qualified Medicare beneficiary Duals (Out-of-Network) Medicare cost sharing requirements	
When the service is covered by:	**The contractor shall pay:** **(Subject to the limits specified in this policy)** a.) In accordance with A.A.C. R9-29-303, when a Non-QMB Dual receives covered services from an out of network care provider, the following applies.
Medicare only.	Has no responsibility for payment.
Medicaid only AND the contractor has not referred the member to the care provider OR has not authorized the care provider to render services and the services are not emergent.	Has no responsibility for payment
Medicaid only AND the contractor has referred the member to the care provider, or has authorized the care provider to render services, or the services are emergent	Shall pay in accordance with the requirements of A.A.C. R9-22-705.
By both Medicare and Medicaid AND the contractor has not referred the member to the care provider, OR has not authorized the care provider to render services and the services are not emergent	Has no responsibility for payment

2. Member

If a member has been advised of the contractor's (Medicaid HMO) network, and the member's responsibility is delineated in the member handbook, and the member elects to go out-of-network, the member is responsible for paying the Medicare cost-sharing amount. (Emergent care, pharmacy, and other prescribed services are the exceptions.) This member responsibility must be explained in the contractor's (Medicaid HMO) Member handbook.

Medicaid benefits

Information for members with Medicare and Medicaid

UHC Dual Complete AZ-Y001 is a Full Dual-Eligible Special Needs Plan (D-SNP). It is designed for persons entitled to both Medicare and Medicaid. If members have both Medicare and Medicaid, services are paid first by Medicare and then by Medicaid. Medicaid coverage depends on income, resources and other factors.

Following are the categories of people who may enroll in UHC Dual Complete AZ-Y001:

Qualified Medicare Beneficiary Plus

QMB+ You get Medicaid coverage of Medicare cost-share and are eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance and copayment amounts.

Specified Low-Income Medicare Beneficiary Plus

SLMB+Medicaid pays your Part B premium and provides full Medicaid benefits.

Full Benefits Dual Eligible

FBDE Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits.

If Specified Low-Income Medicare Beneficiary Plus or Full Benefits Dual Eligible:

SLMB+ or FBDE Members may be eligible for full Medicaid benefits. At times, they may also be eligible for limited assistance from the Arizona Health Care Cost Containment System (AHCCCS) in paying Medicare cost share amounts. Generally, cost-share is 0% when the service is covered by both Medicare and Medicaid.

There may be cases where members pay cost-sharing when a service or benefit is not covered by Medicaid.

If category of Medicaid eligibility changes, cost-share may also increase or decrease. Members must rectify Medicaid enrollment to continue to receive Medicare coverage.

UHC Dual Complete AZ-Y001

Eligible categories

Qualified Medicare Beneficiary Plus

QMB+ Medicaid pays the Medicare cost-share. This includes deductibles, coinsurance and copayment amounts. Medicaid also pays for QMB+ Part A and Part B premiums. QMB+ members have full Medicaid benefits. QMB+ beneficiaries have $0 cost-share except for Part D prescription drug copays.

Full Benefit Dual Eligible members

FBDE members have full Medicaid benefits. Medicaid pays the cost-share for covered services rendered by a participating Medicare care provider. At times, members may be eligible for limited assistance from the AHCCCS in paying Medicare cost-share amounts. Generally, members' cost-share is 0% when both Medicare and Medicaid cover the service.

There may be cases where members have to pay a cost-share when Medicaid and Medicare does not cover a service or benefit.

Specified Low-Income Medicare Beneficiary

SLMB+ Medicaid pays members' Part B premium and provides full Medicaid benefits.

What that means to our members:

If they are a QMB+ beneficiary:

They have 0% cost-share, except for Part D prescription drug copays.

If members are a Specified Low-Income Medicare Beneficiary Plus or Full Benefits Dual Eligible Beneficiary:

SLMB+ or FBDE They are eligible for full Medicaid benefits. At times, they may also be eligible for limited assistance from the AHCCCS in paying Medicare cost-share amounts. Generally, the cost share is 0% when both Medicare and Medicaid cover the service. There may be cases where members have to pay a cost-share when Medicaid does not cover a service or benefit.

How to read the Medicaid benefit chart

The following benefits are covered by Medicaid. For each of the following benefits listed, you can see what Arizona Health Care Cost Containment System (AHCCCS) covers and what our plan covers. If a benefit is used or not covered by Medicare, then Medicaid may provide coverage. This depends on the member's type of Medicaid coverage. Additional information regarding benefits can be found online at **UHCprovider.com** > Resources > Choose a Location > Arizona > Medicare > **Arizona Dual Complete® Special Needs Plans.**

Arizona Health Care Cost Containment System Medicare Advantage Special Needs Plans for Dual eligible members 2026 benefits

In order for you to better understand your health care options, the following chart notes your charges for certain services under the Arizona Health Care Cost Containment System (Medicaid) as an individual who has both Medicare and Medicaid. Your Medicare cost sharing responsibility is based on your level of Medicaid eligibility.

- Qualified Medicare Beneficiary (QMB) – $0. Your Medicare cost sharing amounts will be paid by your Medicaid Health Plan unless otherwise noted below
- Non-QMB with Medicare Parts A and B – Your Medicare cost sharing amounts will be paid by your Medicaid Health Plan only when the benefit is also covered by Medicaid

Accute and Long- term care Medicaid programs (1)	As an AHCCCS – QMB Dual Eligible – you pay:	As an AHCCCS – Non-QMB Dual Eligible – you pay:
Inpatient hospital stay	$0	$0
Inpatient behavioral health care stay	$0	$0
Nursing facility services	$0	$0
Home health care visit	$0	$0
Primary care physician (PCP) visits	$0	$0 for well visits, and $0 to $4 for other visits depending on eligibility (2) for ages 21 and over (2). $0 for ages 20 and under.
Specialist physician visit	$0	$0 for well visits, and $0 to $4 for other visits depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.
Medicare-covered services, including chronic/complex case management, etc.	$0	$0 for ages 20 and under. Not covered for ages 21 and over.
Chiropractic visits	$0	$0 for ages 20 and under; $0 to $2.30, for ages 21 over depending on eligibility (2), for up to 20 medically necessary visits beginning October 1st of each year, (additional visits may be authorized if medically necessary).

Accute and Long-term care Medicaid programs (1)	As an AHCCCS – QMB Dual Eligible - you pay:	As an AHCCCS – Non-QMB Dual Eligible - you pay:
Podiatry services visit	$0	$0
Outpatient behavioral health care visit	$0	$0
Outpatient substance abuse care visit	$0	$0
Ambulatory surgical center or outpatient hospital facility visit	$0	$0 to $3 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.
Ambulance services	$0	$0
Emergency services	$0	$0
Urgently needed care visit	$0	$0 to $4 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.
Outpatient occupational/physical/ speech therapy visit	$0	$0 to $3 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.
Durable medical equipment	$0	$0
Prosthetic devices	$0	$0. Lower limb microprocessor controlled limb or joint not covered for ages 21 and over.
Diabetes self-monitoring training & supplies (when provided as part of a PCP visit)	$0	$0
Community health worker (CHW) visit	$0	$0
Diagnostic tests, x-rays, and laboratory s(including COVID-19 diagnostic & testing services)	$0	$0
Colorectal screening	$0	$0

Accute and Long-term care Medicaid programs (1)	As an AHCCCS – QMB Dual Eligible - you pay:	As an AHCCCS – Non-QMB Dual Eligible - you pay:
Flu and pneumonia vaccines	$0	$0
Screening mammogram	$0	$0
Pap smear and pelvic exam	$0	$0
Prostate cancer screening	$0	$0
Renal dialysis or nutritional therapy for end-stage renal disease	$0	$0
Prescription medications (3)	$0	$0 to $2.30 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.
Hearing exams, routine hearing tests, and fitting evaluations for a hearing aid	$0 for ages 20 and under. Not covered for ages 21 and over.	$0 for ages 20 and under. Not covered for ages 21 and over.
Hearing aids	$0 for ages 20 and under. Not covered for ages 21 and over.	$0 for ages 20 and under. Not covered for ages 21 and over.
Cochlear implants	$0	$0
Routine eye exam, eyeglasses, contact lenses, lenses and frames	$0 for ages 20 and under. Not covered for ages 21and over unless following cataract surgery.	$0 for ages 20 and under. Not covered for ages 21 and over.
Adult emergency dental services	$0 for ages 21 and over. Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.	$0 for ages 21 and over. Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.
Non-emergency medically necessary transportation	$0	$0

Long term care Medicaid programs only (1)	As an AHCCCS – QMB Dual Eligible - you pay:	As an AHCCCS – Non-QMB Dual Eligible - you pay:
Nursing facility services	Cost sharing determined by AHCCCS.	Cost sharing determined by AHCCCS.
Respite services	$0. Subject to a 600 hour limit per each 12 month period beginning October 1st of each year.	$0. Subject to a 600 hour limit per each 12 month period beginning October 1st of each year.
Home and Community-Based Services	Member contribution determined by AHCCCS.	Member contribution determined by AHCCCS.
Adult preventive dental services (4)	$0 for ages 21 and over. Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.	$0 for ages 21 and over. Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.

1. Acute Medicaid Programs include AHCCCS Complete Care (ACC), ACC with a Regional Behavioral Health Agreement (ACC-RBHA), and the Mercy Care Department of Child Safety Comprehensive Health Plan (Mercy Care DCS CHP). Long Term Care Medicaid Programs include Elderly and/or Physically Disabled (E-PD) and the Division of Developmental Disabilities (DDD).
2. See the AHCCCS website for additional beneficiary cost sharing, co-payment and benefits related information.
3. Medicare Part D co-payment amounts are the sole responsibility of the beneficiary. AHCCCS health plans cannot assist with the payment of these amounts, except for behavioral health medications for those beneficiaries determined to be Seriously Mentally Ill (SMI) utilizing allowable Non-Title XIX/XXI funding.
4. In addition to Adult emergency dental services described above.

Arizona Health Care Cost Containment System
Additional services available through UHC Dual Complete AZ-S001 and Dual Complete AZ-Y001

Benefit	QMB or QMB + members pay	SLM B+ or FBDE members pay:	UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001
Additional dental services	No coverage.	No coverage.	Covered.
Additional foot care	No coverage.	No coverage.	Covered.
Additional hearing services	No coverage.	No coverage.	Covered.
Healthy food	No coverage.	No coverage.	Covered.
Over-the-counter items	No coverage.	No coverage.	Covered.
Utilities and in home supports	No coverage.	No coverage.	Covered.
Transportation (routine)	No coverage.	No coverage.	UHC Dual Complete AZ-S001: No coverage. UHC Dual Complete AZ-Y001: Covered.
Additional vision services	No coverage.	No coverage.	Covered.

Members who are enrolled in UHC Dual Complete programs may also be covered by UnitedHealthcare Community Plan AHCCCS (Medicaid) benefits. Members should refer to their Medicaid Member Handbook for further details on Medicaid benefits. Members who are enrolled in another AHCCCS (Medicaid) plan must coordinate their benefits with that plan.

Prior authorization

Services requiring prior authorization are available on **UHCprovider.com** in the Prior Authorization and Notification section (periodically updated). The presence or absence of a procedure or service on the list does not define whether coverage or benefits exist for that procedure or service. A facility or practitioner must contact UHC Dual Complete programs for prior authorization. Submit requests for prior authorizations using the Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal or by calling to the Prior Authorization Department at **1-800-445-1638.**

Referral guidelines

PCPs are generally responsible for initiating and coordinating coverage for medically necessary services beyond the scope of their practice for Dual Complete programs members if a **contracted care provider** is not available. A referral to a non-contracted care provider may be requested, but UnitedHealthcare Community Plan must authorize the referral. PCPs monitor the progress of referred members' care and see that members are returned to the PCP's care as soon as possible.

All referrals to non-contracted care providers require the completion of a referral form.

If a contracted care provider is not available to provide services a referral can be completed. Referrals are to be written on the same UHC Dual Complete programs referral form you use for UnitedHealthcare Community Plan Medicaid members. Prior authorization is required when services are performed by a non-contracted care provider.

The PCP is to complete, date, and sign (a signature stamp is acceptable) the referral form.

Forward a copy of the referral form to the non-contracted specialist. Referrals are limited to an initial consultation and up to 2 follow-up visits. Follow-up visits must be completed within 180 calendar days from the date the referral is signed and dated.

Referrals for hematology/oncology, radiation oncology, gynecology oncology, allergy, orthopedic services, and nephrology are valid for unlimited visits within the 180 day timeframe

Emergency and urgent care

Definitions

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a care provider qualified to furnish emergency services
- Needed to evaluate or stabilize an emergency medical condition

Members with an emergency medical condition should be instructed to go to the nearest emergency care provider.

Members who need urgent (but not emergency) care are advised to call their PCP, if possible, prior to obtaining urgently needed services. However, prior authorization is not required.

Urgently needed services are covered services that are not emergency services provided when:

- The member is temporarily absent from the UHC Dual Complete program's service area
- When such services are medically necessary and immediately required 1) as a result of an unforeseen illness, injury, or condition; and 2) it is not reasonable given the circumstances to obtain the services through a network care provider

Under unusual and extraordinary circumstances, services may be considered urgently needed when the member is in the service area but a network care provider is temporarily unavailable or inaccessible.

Out-of-area renal dialysis services

A member may obtain medically necessary dialysis services from any qualified care provider the member selects when they are temporarily absent from UHC Dual Complete programs service area and cannot reasonably access network dialysis care providers. No prior authorization or notification is required. However, a member may voluntarily advise UHC Dual Complete programs if they will temporarily be out of the service area. UHC Dual Complete programs may provide medical advice and recommend the member use a qualified dialysis care provider.

Direct access services

Members may access Behavioral Health services without a referral from their PCP as long as they obtain these services from a participating care provider. Those services are discussed in this section. Members requiring Behavioral Health services may call United Behavioral Health at **1-800-547-2797.** Telephonic access is available anytime. Mental Health Inpatient services as well as detoxification programs are available after coordination for emergency admissions or mental health care provider's evaluation has taken place.

Preventive services

Members may access the following services from a participating care provider without a referral from a PCP:

- Influenza and pneumonia vaccinations
- Routine and preventive women's health services (such as pap smears, pelvic exams and annual mammograms)
- Routine dental
- Routine vision
- Routine hearing

Members may not be charged a copayment for influenza or pneumonia vaccinations or pap smears.

Annual well-woman visit

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

a. A physical exam (well exam) that assesses overall health.

b. Clinical breast exam.

c. Pelvic exam (as necessary, according to current recommendations and best standard of practice).

d. Review and administration of immunizations, screenings and testing as appropriate for age and risk factors. NOTE: Genetic screening if considered Medically Necessary, non-experimental, cost effective genetic testing. Rapid Whole Genome Sequencing, and newborn screening within the requirements specified in AMPM 310.

e. Screening and counseling is included as part of the well-woman preventive care visit and should address.

1. Proper nutrition.
2. Physical activity.
3. Elevated BMI indicative of obesity.
4. Tobacco/substance use, abuse, and/or dependency.

5. Depression screening.
6. Interpersonal and domestic violence screening that includes counseling involving elicitation of information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems.
7. Sexually transmitted infections.
8. Human Immunodeficiency Virus (HIV).
9. Family planning counseling.
10. Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
    a. Reproductive history and sexual practices.
    b. Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake.
    c. Physical activity or exercise.
    d. Oral health care.
    e. Chronic disease management.
    f. Emotional wellness.
    g. Tobacco and substance use (caffeine, alcohol, marijuana and other drugs), including prescription drug use.
    h. Recommended intervals between pregnancies.

NOTE: Preconception counseling does not include genetic testing.

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

Primary care providers and primary care obstetricians responsibilities

Network primary care providers (PCPs) and primary care obstetricians (PCO) are responsible for the following:

- Physicians and practitioners must follow the American College of Obstetricians and Gynecology (ACOG) standards of care, including the use of a standardized medical risk assessment tool and ongoing risk assessment.
- Female members shall have direct access to contracted GYN care providers, including physicians, physician assistants, nurse practitioners and midwives within the scope of their practice, without a referral.
- If a member's pregnancy is confirmed by a PCO, the PCO is required to notify UnitedHealthcare Community Plan Healthy First Steps at 1-800-599-5985 to initiate a PCO reassignment. The ACOG form needs to be faxed to Healthy First Steps at 1-877-353-6913 immediately after the initial OB visit.
- The member's PCO effective date is the date the completed ACOG form is received. A PCO's failure to notify UHC Dual Complete programs of this reassignment may result in delay or denial of reimbursement. The date of the PCO assignment is the effective date of the transfer of care from the PCP to the PCO. PCOs are responsible for coordinating a member's care until the first day of the first month following the 60th day after delivery or termination of pregnancy
- EPSDT services for pregnant members younger than 21 years are to be performed by the assigned PCO or perinatologist

Additional primary care obstetricians responsibilities

- Scheduling medically necessary care appointments for enrolled pregnant members to obtain initial and ongoing prenatal care within the timeframes as stated in this manual under Appointment Standards, **Chapter 13**
- Coordinating covered services for members
- Counseling members and their families regarding members' medical care needs, including family planning and advance directives
- Initiating medically necessary referrals for specific covered services to contracted health care practitioners or care providers
- Monitoring progress, care and managing utilization of services to facilitate the return of care to the PCP after delivery
- Scheduling time-specific office visits during an uncomplicated pregnancy based upon the

recommended standards from the ACOG

- Maintaining responsibility for care until the first day of the first month following the 60th day after delivery with a minimum of 1 postpartum visit at approximately 6 weeks postpartum. Patients at high risk shall have a return visit scheduled appropriate to their individual need
- Adhering to reproductive health and wellness guidelines contained within UnitedHealthcare Community Plan Policies and Procedure, such as including perinatal and postpartum depression and anxiety screening completed at least once during pregnancy and then repeated at the postpartum visit. If a positive screening is obtained, refer to appropriate behavioral health care provider.
- Utilization of toll free Arizona Perinatal Psychiatry Access Line (A-PAL) for questions about mental health or substance use treatment, including medication management, when needed. Care providers will be connected to a perinatal psychiatrist. Call 1-888-290-1336, Monday-Friday, 8:30 a.m. -4:30 p.m. For additional information, please visit: apal.arizona.edu.
- The PCO will share health information about lifestyle habits that promote healthy pregnancies, including spacing of births and smoking cessation
- Educating members regarding potential complications and adverse outcomes related to cesarean sections and elective inductions prior to 39 weeks gestation
- Referring members for support services to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), as well as other community-based resources, to support healthy pregnancy outcomes. In the event a member loses eligibility, the member must be notified where they may obtain low-cost or no-cost maternity services.
- Cooperating with Healthy First Steps, the maternity program and/or other perinatal support programs that may be authorized by UnitedHealthcare Community Plan
- Faxing the OB clinical record as a referral to UHC Dual Complete AZ-S001 and Dual Complete AZ-Y001 Healthy First Steps program. Referrals can be made by faxing any of the following forms to the Healthy First Steps at: **1-877-353-6913**
- Completing and sending ACOG prenatal forms pages 1 and 2 as well as other prenatal forms that sufficiently document past and present medical, psychosocial and obstetrical history
- Sending any other OB Risk Assessment or OB Notification form to Healthy First Steps

Follow the Obstetrical Services Policy, Professional Reimbursement Policy - UnitedHealthcare Community Plan, found at **UHCprovider.com/policies** > medicaid-comm-plan-reimbursement > UHCCP-Obstetrical-Services-Policy.pdf.

Perinatology referrals

A PCO or PCP may refer a member for a consult to a contracted perinatologist when a high-risk need is identified. The PCO or PCP may transfer the member's care to a perinatiologist by calling Provider Customer Service for reassignment.

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

Licensed midwife services

UHC Dual Complete programs cover maternity care and coordination services provided by contracted licensed midwives. The members must have an uncomplicated prenatal course and an expected low-risk labor and delivery. Members who choose to receive maternity services from this provider type must meet eligibility and medical criteria specified in the AHCCCS Medical Policy Manual, Chapter 400, Policy 410. Risk status must initially be determined at the time of the first visit. It must be evaluated at each trimester, thereafter, using the current standardized assessment criteria and protocols for high-risk pregnancies outlined.

A new risk assessment must be completed if a new complication or concern is identified, and a referral

will be made to a qualified physician if necessary.

Labor and delivery services provided by a licensed midwife cannot be provided in a hospital or other licensed health care institution. Licensed midwives must have a plan of action, including the name and address of an AHCCCS-registered care provider and acute care hospital in close proximity to the planned location of labor and delivery for referral, in the event a complication should arise. Licensed Midwives shall submit this plan of action to UHCCP for each member.

The licensed midwife must notify UnitedHealthcare Community Plan or the AHCCCS Newborn Reporting Line of the birth no later than 3 days.

Doula services

A doula is a trained nonmedical professional who may provide continuous physical, emotional, and informational support to families before, during, and after childbirth for a period of 1 year after birth or in the case of loss and who may serve as a liaison between the birth parents and medical and social services staff to improve the quality of medical, social, and behavioral outcomes.

Doula services are covered during pregnancy, labor and delivery, and up to 1 year postpartum when provided by contracted doulas who meet eligibility criteria specified in the AHCCCS Medical Policy Manual, Chapter 400, Policy 410.

Doulas services are provided in complement to, and cannot replace a trained, licensed medical professional or perform clinical tasks.

A care provider referral is required for doula services; however, members do not need to have a complication or high-risk pregnancy. Prior authorization is not required. Medical necessity is met if the member is pregnant or within 1 year postpartum. Doula services are reimbursed separately from the global OB bundle. Doula services are not included in the OB global bundle.

For more information, please view the AHCCCS website, Doula FAQs.

Family planning

Family planning services are covered when provided by contracted physicians or practitioners to members who voluntarily choose to delay or prevent pregnancy. Family planning services include specified covered medical, surgical, pharmacological and laboratory benefits. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available. Physicians and other practitioners with members of reproductive age must document in the medical record they have notified the member, either verbally or in writing, of the family planning services available. Members (male and female) eligible to receive full health care coverage and are enrolled with UHC Dual Complete programs may elect to receive family planning services in addition to other covered services. Family planning services for members eligible to receive full health care coverage may receive the following medical, surgical, pharmacological and laboratory services:

- Contraceptive counseling, medication, supplies, including, but not limited to oral and injectable contraceptives, Long Acting Reversible Contraception (LARC), diaphragms, condoms, foams and suppositories
- Associated medical and laboratory examinations including ultrasound studies related to family planning
- Treatment of complications resulting from contraceptive use, including emergency treatment
- Natural family planning education or referral to qualified health professionals, and postcoital emergency oral contraception within 72 hours after unprotected sexual intercourse (RU 486 is not postcoital emergency oral contraception)

Hysteroscopic tubal sterilization (Essure) is a covered service under the UnitedHealthcare Community Plan. The procedure does not render a woman immediately sterile, and another form of birth control will be required minimally for 3 months. Only report sterilization of SOBRA members who have undergone this procedure for at least 3 months and only after confirmatory hysterosalpingogram produces satisfactory results. The hysterosalpingogram must be billed on the same claim as the hysteroscopic tubal sterilization to help ensure both services were rendered.

AMPM 420 - Family Planning Services and Supplies states:

Sterilization:

a. Clarification related to hysteroscopic tubal sterilization:

i. The Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected that the procedure will be an effective sterilization procedure 3 months following insertion. Therefore, during the first 3 months the member must continue using another form of birth control to prevent pregnancy,

and

ii. At the end of the 3 months, it is expected that a hysterosalpingogram will be performed confirming that the member is sterile. After the confirmatory test, the member is considered sterile."

The following are not covered for the purpose of family planning services:

- Infertility services, including diagnostic testing, treatment services or reversal of surgically induced infertility
- Pregnancy termination counseling

Pregnancy termination services

UHC Dual Complete programs cover pregnancy termination if 1 of the following conditions is present:

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

As the attending care provider, you must acknowledge a pregnancy termination has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination. The certificate can be obtained online at azahcccs.gov, from the AHCCCS Medical Policy Manual, Chapter 400, Exhibit 410 Attachment C. The certificate must be submitted via prior authorization to the UHC Dual Complete programs medical director or designee. It must certify that, in the care provider's professional judgment, 1 or more of these criteria have been met. Additional required documentation includes:

- A written informed consent must be obtained by the care provider and kept in the member's chart for all pregnancy terminations. If the pregnant member is younger than 18 years old, or is 18 years old or older and considered an incapacitated adult (as defined in A.R.S. § 14-5101), a dated signature of the pregnant member's parent or legal guardian indicating approval of the pregnancy termination procedure is required
- When the pregnancy is the result of rape or incest, documentation must be obtained that the incident was reported to the proper authorities. This includes the name of the agency to which it was reported, the report number if available, and the date the report was filed. Except in cases of medical emergencies, the care provider must obtain prior authorization for all covered pregnancy terminations from the UHC Dual Complete programs medical director or designee. A completed Certificate of Necessity for Pregnancy Termination and Verification of Diagnosis by Contractor for Pregnancy Termination Request must be submitted with the request for prior authorization.

The certificates can be obtained online at azahcccs.gov, from the AHCCCS Medical Policy Manual Dual Complete programs, Chapter 400, Exhibit 410 Attachment C and 410 Attachment D.

In cases of medical emergencies, you must submit all documentation of medical necessity to UHC Dual Complete programs within 2 working days of the date on which the pregnancy termination procedure was performed.

Sterilization

You must comply with the following requirements before performing a sterilization procedure. Prior authorization is not required unless the member is younger than 21 years. Sterilization of a member younger than 21 years of age must be medically necessary. A completed Federal Consent Form must be submitted with claims for all voluntary sterilization procedures. Federal consent requirements for voluntary sterilization require:

- The recipient to be at least 21 years at the time of consent is signed
- The recipient to be mentally competent
- Consent is to be voluntary and obtained without duress
- 30 days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery. Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.
- Copy of the signed Federal Consent Form must be submitted by each care provider involved with the hospitalization and/or the sterilization procedure and with a witness present when the consent is obtained
- Suitable arrangements must be made to help ensure the information in the consent form is effectively communicated to members with limited English proficiency or reading skills and as well as members with visual and/or auditory limitations

  Prior to signing the consent form, the member must first have been offered the following
- Answers to questions asked regarding the specific procedure to be performed
- Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits
- A description of available alternative methods
- A full description of the discomforts and risks that may accompany or follow the performing of the procedure including an explanation of the type and possible effects of any anesthetic to be used
- A full description of the advantages or disadvantages that may be expected as a result of the sterilization
- Notification that sterilization cannot be performed for at least 30 days after consent
- That sterilization consents may not be obtained when an eligible member
  - Is in labor or childbirth
  - Is seeking to obtain or obtaining an abortion
  - Is under the influence of alcohol or other substances which affect the member's state of awareness

The Sterilization Consent Form is available online at azahcccs.gov, in the AHCCCS Medical Policy Manual, Chapter 400, exhibit 420 Attachment A.

Hysterectomy claims

Claims for hysterectomy procedures are reimbursable if:

- The service was prior authorized per the prior authorization list
- Documentation is provided to show the procedure is consistent with prior authorization information and claim information
- Documentation is provided to show the patient gave voluntary consent for the hysterectomy. The physician must certify that the procedure was medically necessary by submitting 1 of the following:
  - AHCCCS Certificate of Medical Necessity: documentation of medical reason for the hysterectomy, type and direction of all medical treatment attempted to avoid surgery, intensity and duration of the symptoms
  - Pathology Report from the surgery showing the procedure met hysterectomy criteria
  - Operative report
- The physician must also submit documentation of 1 of the following:

  - Request for Hysterectomy form signed by the patient showing that she understands the sterilization will be permanent. You may obtain a copy of the Hysterectomy Consent form the AHCCCS website at azahcccs.gov, Chapter 800 of the Medical Policy Manual, Exhibit 820 Attachment A.
  - Documentation of previous sterility, if applicable. If the patient is sterile at the time of the hysterectomy, no consent is required. However, it must be confirmed by a record of the exam on the history and physical, the pathology report, or other documentation.

Prior to signing consent form, the member must first have been offered the following information:

- Answers to questions asked regarding the procedure to be performed
- Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits
- A description of available alternative methods
- A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used
- A full description of the advantages or disadvantages that may be expected as a result of the hysterectomy
- Notification that a hysterectomy cannot be performed for at least 30 days after consent
- That hysterectomy consents may not be obtained when an eligible member
  - Is in labor or childbirth
  - Is seeking to obtain or obtaining an abortion
  - Is under the influence of alcohol or other substances which affect the member's state of awareness

Hospital services

Acute inpatient admissions

All elective inpatient admissions require prior authorization from the UHC Dual Complete programs Prior Notification Service Center.

UHC Dual Complete programs Concurrent Review nurses and staff, in coordination with admitting physicians and hospital-based physicians (hospitalists), will be in charge of coordinating and conducting Continued Stay Reviews. This involves providing appropriate referrals for extended care facilities and coordinating services required for adequate discharge. UHC Dual Complete programs case managers will assist in coordinating services identified as necessary in the discharge planning process as well as coordinating the required follow-up by the corresponding PCPs.

Inpatient concurrent review: clinical information

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, treatment plan, admission order, patient 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 the 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.

Absent superseding state and/or Centers for Medicare and Medicaid Services (CMS)-required guidelines, UnitedHealthcare Community Plan uses InterQual, SAMHSA and American Society of Addiction Medicine (ASAM) clinical criteria to make medical care determinations for members with substance abuse and co-occurring disorders.

Then UnitedHealthcare Community Plan applies evidence-based, peer-reviewed concurrent review criteria. Hospital system review criteria are not adopted by UnitedHealthcare Community Plan and are not acceptable.

UnitedHealthcare Community Plan also uses

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

Credentialed family support partner

Credentialed family support partner (CFSP) should be a parent or primary caregiver with lived experience who has raised or currently raising a child with mental health and or substance use disorders or an individual who has lived experience as a primary natural support for an adult with mental health and or substance use disorders and has at a minimum, 1 year experience in the role of a family support partner, and who has experience navigating the Adult System of Care and or the Children's System of Care.

Individuals seeking credentialing and employment as a PRSS or CFSP must pass a competency exam with a minimum score of 80% upon completion of required training.

For more information regarding curriculum standards and requirements please visit AHCCCS AMPM 900 sections 963 and 964: azahcccs.gov AHCCCS Medical Policy Manual (AMPM).

Deliverable submissions

AHCCCS approved training agencies and providers who employ credentialed PRSS and CFSP are required to maintain current and ongoing documentation verifying that all individuals delivering Medicaid-reimbursed PRSS and CFSP support services are reported in compliance with AMPM 963 and 964 by uploading AMPM 963 attachments A and C and 964 attachment A. The attachments will be uploading utilizing the AHCCCS QM Portal OIFA page, located on the AHCCCS website.

UnitedHealthcare in collaboration with the OIFA Alliance provides agencies QM OIFA portal training. For more information, please reach out to our OIFA team at **Advocate.OIFA@uhc.com**.

UnitedHealthcare OIFA requests evidence of inclusion of member and/or family member voice and choice in service delivery and decision-making procedures. Random samples of how providers are operationalizing these items may be solicited by notification from UHCCP OIFA.

Audit information

UnitedHealthcare Community Plan's audit team conducts credentialed PRSS and CFSP employee files audits.

Agencies must keep documentation of required qualifications and credentialing for CFSPS and or PRSS in employee files.

Documenting at least 8 hours of continuing education or ongoing learning opportunities. At least 1 hour of the required 8 hours shall cover ethics and boundaries relevant to the role of an employed PRSS and CFSPs.

Care providers employing PRSS and CFSPs, shall have policies and procedures to establish the minimum professional, educational and or experiential qualifications for BHPPs and BHTs.

Care providers shall have policies and procedures which establish the minimum required amount and duration of supervision for PRSS/CFSPs qualifying as BHPPs and BHTs in accordance with AMPM 310-B including inclusivity of both clinical and administrative supervision.

Documenting supervisor training and ongoing learning relevant to the supervision of PRSSs and CFSPs and the delivery of peer/family support services.

For more information regarding requirements of credentialed PRSSs/CFSPs employee file requirements AHCCCS AMPM 900 sections 963 and 964: azahcccs.gov AHCCCS Medical Policy Manual (AMPM) or reach out to the OIFA team at **Advocate.OIFA@uhc.com**.

Mutual obligations- UnitedHealthcare and care provider professional conduct

Professional conduct

When we conduct business together, you will work with us to ensure that your employees, agents, and any personnel operating in our facilities or yours comply with the following:

- **Collaborate for member outcomes**: Work collaboratively to achieve the best outcomes for members, including coordinating care and sharing necessary information.
- **Respect and professionalism**: At all times, treat other providers, UnitedHealthcare members, and UnitedHealthcare and your employees with respect and professionalism.
- **Prohibit threats and harassment**: Create a safe and respectful environment. Any form of threats, harassment, or intimidation is strictly prohibited, including verbal, physical, and written forms.
- **Prohibit violence**: Prohibit acts of violence against other providers, UnitedHealthcare members, and UnitedHealthcare and your employees.
- **Protect confidential employee information**: Not publicly disclose any confidential personal information about UnitedHealth Group's or your employees, including home address, personal telephone numbers, personal and professional email addresses, medical, or employment-related details, to any third party without express written consent from the other party, unless legally required to do so.
- **Inaccurate statements**: Not make any misleading, inaccurate or untrue statements, whether oral or written, that disparage or intentionally harm the reputation or safety of the other party, its affiliates, or its employees. This includes statements made on social media, in public forums, or any other medium of communication.

If the requirements above are not met, we will collaborate and fully cooperate to address the matters. If you fail to fully cooperate with UnitedHealthcare to address any violation of these requirements, such conduct is a material breach under the Agreement. UnitedHealthcare may:

- Refuse to interact with any individual engaging in such conduct;
- Terminate any professional's participation in UnitedHealthcare's network, without terminating the Agreement between the parties;
- Terminate the Agreement between the parties upon 30 days' prior written notice; and
- Any other remedies available to the parties under the participation agreement or at law.

Any threat, attempted violence, or acts of violence will be reported to the appropriate authorities including, but not limited to, UnitedHealth Group Corporate Security, appropriate provider security, law enforcement, state and federal regulatory bodies.

Interacting with capitated/ delegated groups

In your market, you may work with entities that have capitated or delegated arrangements with UnitedHealthcare ("capitated organization"). If your patient is assigned to 1 of these capitated organizations, specific utilization management or claims processing rules may apply.

What is capitation?

Capitation is a payment model in which care providers receive a fixed per-member, per-period payment, regardless of services rendered. Common capitated entities include Independent Practice Associations (IPAs), medical groups, and occasionally hospital systems or ancillary care providers.

What is delegation?

Delegation is the transfer of authority to perform specific functions on our behalf.

We may delegate:

- Medical management
- Credentialing

- Utilization management
- Claims processing and payment
- Complex case management
- Other clinical and administrative functions

When responsibilities are delegated to a care provider, they become a "delegated entity" or "delegate." UnitedHealthcare retains accountability to regulators for all delegated activities.

Delegated entities may contract with other providers, but those agreements must follow UnitedHealthcare's product-specific regulations. To obtain and maintain delegation, care providers must comply with our standards and best practices. Non-compliance may result in revocation of delegated responsibilities.

Capitated organizations are often also delegated entities, making them responsible for both delivering care and administering delegated functions, such as processing and paying claims for other care providers.

What does it mean for you if you are not a capitated/delegated care provider?

You may enter into direct agreements with capitated or delegated organizations. These agreements may differ from your Participation Agreement with UnitedHealthcare and should clearly define applicable protocols and procedures.

Key principles:

- **If you participate with both UnitedHealthcare and a capitated organization, and provide designated covered services to a capitated member:**
  The capitated organization is solely responsible for payment, based on your agreement with them.
- **If you participate with UnitedHealthcare but not with the capitated organization, and provide designated covered services to a capitated member:**
  The capitated organization remains solely responsible for payment. Reimbursement follows your UnitedHealthcare Participation Agreement.
- **If you participate with both UnitedHealthcare and a capitated organization, and provide services to a non-capitated member:**
  UnitedHealthcare (or the financially responsible entity) is solely responsible for payment, per your UnitedHealthcare Participation Agreement.

Chapter 3: Non-covered benefits and exclusions

Some medical care and services are not covered ("excluded") or are limited. The following list describes services that are not covered under any conditions and some services that are covered only under specific conditions.

If members receive services that are not covered, they must pay for the services themselves.

UHC Dual Complete programs will not pay for the exclusions that are listed in this section and neither will Original Medicare, unless they are found upon appeal to be services that we should have paid or covered.

Services not covered by UHC Dual Complete AZ-S001 and Dual Complete One AZ-Y001

- Services not covered under Original Medicare, unless such services are specifically listed as covered
- Services members receive from non-plan care providers, except for care for a medical emergency and urgently needed care, renal (kidney) dialysis services received when members are temporarily outside the plan's service area, and care from non-plan care providers arranged or approved by a plan care provider
- Services that members receive without prior authorization, when prior authorization is required for getting those services
- Services that are not reasonable and necessary under Original Medicare Plan standards unless otherwise listed as a covered service
- Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency
- Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those UHC Dual Complete programs and Original Medicare determines are not generally accepted by the medical community.
- Surgical treatment of morbid obesity unless medically necessary and covered under Original Medicare
- Private room in a hospital, unless medically necessary
- Private-duty nurses
- Personal convenience items, such as a telephone or television in the member's room at a hospital or SNF
- Nursing care on a full-time basis in the member's home
- Charges imposed by immediate relatives or members of the household
- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, unless medically necessary
- Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery is covered for all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast.
- Orthopedic shoes, unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Supportive devices for the feet. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services

- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)
- Naturopath services (covered under Medicaid for members younger than 21)
- Services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under UHC Dual Complete programs, we reimburse veterans for the difference. Members are still responsible for the UHC Dual Complete programs cost-sharing amount.

Chapter 4: Care provider responsibilities

General care provider responsibilities

UnitedHealthcare Community Plan Dual Complete programs does not prohibit or otherwise restrict you from advising or advocating on behalf of a member who is your patient for the following:

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
- Any information the member needs to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The member's right to participate in decisions about their health care, including the right to refuse treatment and to express preferences about future treatment decisions

You are responsible for:

- Verifying the enrollment and assignment of the member via UHC Dual Complete programs roster, using the Interactive Voice Response (IVR), UnitedHealthcare Community Plan's care provider portal, or contacting **Provider Services** prior to the provision of covered services. Failure to verify member enrollment and assignment may result in claim denial.
- Rendering covered services to UHC Dual Complete programs members in an appropriate, timely, and cost-effective manner and in accordance with your specific contract and CMS requirements
- Maintaining all licenses, certifications, permits, or other prerequisites required by law to provide covered services. You must submit evidence that each is current and in good standing upon the request of UHC Dual Complete programs.
- Rendering services to members diagnosed as being infected with the human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) in the same manner and to the same extent as other members and under the compensation terms set forth in your contract.
- Meeting all applicable Americans with Disabilities Act (ADA) requirements when providing services to members with disabilities who may request special accommodations such as interpreters, alternative formats, or assistance with physical accessibility
- Educating members about the proper utilization of the practitioner's office in lieu of hospital emergency rooms. The practitioner shall not refer members to hospital emergency rooms for non-emergent medical services at any time.
- Abiding by the UHC Dual Complete programs referral and prior authorization guidelines
- Admitting members in need of hospitalization only to contracted hospitals unless: (1) prior authorization for admission to some other facility has been obtained from UHC Dual Complete programs; or (2) the member's condition is emergent, and the use of a contracted hospital is not feasible for medical reasons. The practitioner agrees to provide covered services to members while in a hospital as determined medically necessary by the practitioner or a medical director.
- Using contracted hospitals, specialists, and ancillary care providers. A member may be referred to a non-contracted practitioner or care provider only if the medical services required are not available through a contracted practitioner or care provider and if prior authorization is obtained.
- Reporting all services provided to UHC Dual Complete programs members in an accurate and timely manner
- Obtaining authorization from UHC Dual Complete programs for all hospital admissions
- Providing culturally competent care and services
- Compliance with the Health Insurance Portability and Accountability Act (HIPAA) provisions

- Adhering to advance directives (Patient Self-Determination Act). The federal Patient Self-Determination Act requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult members (age 21 and older) written information about their right to have an advance directive.

Advance directives are oral or written statements either outlining a member's choice for medical treatment or naming a person who should make choices if the member loses the ability to make decisions.

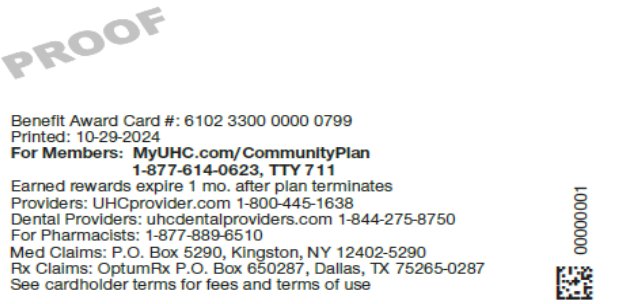
Member eligibility and enrollment

Medicare and AHCCCS (Medicaid) beneficiaries who become members of UHC Dual Complete programs must meet the following qualifications:

- Members must be entitled to Medicare Part A and be enrolled in Medicare Part B
- Members must be entitled and enrolled in AHCCCS (Medicaid) Title XIX benefits
- Members must reside in the Dual Complete programs service area:
  - Dual Complete AZ-S001: Apache, Cochise, Coconino, Gila, Graham, Greenlee, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai and Yuma
  - Dual Complete One AZ-Y001: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pima, Pinal, and Yavapai
- A member must maintain a permanent residence within the service area and must not reside outside the service area for more than 6 months.
- Members of all ages who have end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant) that were participating in UnitedHealthcare Community Plan's AHCCCS plan at the time of their enrollment in Dual Complete programs

Each UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 member will receive an identification (ID) card containing the member's name, member number, PCP name and information about their benefits. The ID membership card does not guarantee eligibility. It is for identification purposes only. UHC Dual Complete programs members are assigned a specialist to act as advocates. Members who lose their AHCCCS eligibility have 180 days to regain certification.

If recertification is not obtained, the member may be disenrolled from the plan.



Primary care provider member assignment

UHC Dual Complete programs manage the member's care on the date that the member is enrolled with the plan and until the member is dis-enrolled. Each enrolled member can choose a primary care provider (PCP) within the UHC Dual Complete programs care Provider Directory. Medicare members are required to select a PCP at the time of enrollment. If this does not happen, a PCP is then assigned. Members then have opportunity to change the PCP if not satisfied by calling Member Services.

Members receive a letter notifying them of the name of their PCP, office location, telephone number, and the opportunity to select a different PCP should they prefer someone other than the PCP assigned. If the member elects to change the initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UHC Dual Complete programs to change their PCP at any other time, the change will be made effective on the date of the request.

Verifying member enrollment

Once a member has been assigned to a PCP, UHC Dual Complete programs documents the assignment and provides each PCP a roster indicating the members assigned to them. PCPs should verify eligibility by using their rosters in conjunction with:

- UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 Interactive Voice Response (IVR) 1-800-445-1638
- MediFAX
- UnitedHealthcare Community Plan Provider Service Center available Monday-Friday, 8 a.m.-5 p.m. local time **1-800-445-1638**
- AHCCCS (Medicaid) web-based eligibility verification system

At each office visit, your office staff should:

- Ask for the member's ID card and have a copy of both sides in the member's office file
- Determine if the member is covered by another health plan to record information for coordination of benefits purposes
- Refer to the member's ID card for the appropriate phone number to verify eligibility in the UHC Dual Complete AZ-S001 and Dual Complete One AZ-Y001, deductibles, coinsurance amounts, copayments and other benefit information
- Check the UHC Dual Complete programs panel listing to be sure the PCP is the member's PCP. If the member's name is not listed, your office staff should contact UHC Dual Complete programs Customer Service to verify PCP selection before the member is seen by the participating care provider

You should verify member eligibility prior to providing services. All Dual Complete AZ-S001 and Dual Complete One AZ-Y001 members may receive new member ID cards. Verify these member ID cards online at **UHCprovider.com**.

Coordinating 24-hour coverage

PCPs are expected to provide coverage for UHC Dual Complete programs members anytime. When a PCP is unavailable to provide services, the PCP must help ensure they have coverage from another participating care provider. Hospital emergency rooms or urgent care centers are not substitutes for covering participating care providers. Consult your UHC Dual Complete AZ-S001 and Dual Complete AZ-Y001 Provider Directory, or contact UHC Dual Complete AZ-S001 and Dual Complete AZ-Y001 Member Services with questions regarding which care providers participate in the UHC Dual Complete programs network.

Behavioral health benefits for members with both Medicare and Medicaid coverage

UnitedHealthcare Community Plan may provide the behavioral health services covered by Medicaid for Dual Complete programs members. These members will be enrolled with AHCCCS for their Medicaid benefit in addition to Medicare A/B benefit coverage. Non-DD/ALTCS members determined to be Seriously Mentally Ill (SMI) will receive their Medicaid coverage under the Regional Behavioral Health Authority (RBHA) of which they are assigned. Those DD/ALTCS EPD members receiving their Medicaid coverage under UnitedHealthcare Community Plan do not require a referral when contacting a behavioral health care provider for services. Members can call **Member Services** at **1-800-348-4058** and ask for the contact information for a behavioral health care provider. Referrals to behavioral health care providers are based on where member resides, member request, care provider specialty and expertise.

Both members and care providers can find the list of behavioral health network care providers by using the Searchable Directory feature on Live and Work Well (Medicaid) or Live and Work Well (Medicare) at provider.liveandworkwell.com. This website provides you a list of participating behavioral health care providers. You and members can also get a copy of the care provider directory by contacting Member Services.

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

- Behavioral health counseling
- Medication services
- Case management
- Evaluation and assessment
- Individual, group and family therapy and counseling
- Inpatient hospital services (The contractor may provide services in alternative inpatient settings licensed by the Arizona Department of Health Services, Division of Assurance and Licensure, the office of Behavioral Health Licensure, in lieu of services in an inpatient hospital. These alternative settings must be lower in cost than traditional inpatient settings. The cost of the alternative settings will be considered in capitation rate development.
- Non-hospital inpatient psychiatric facilities services (level 1 residential treatment centers and sub-acute facilities)
- Psychotropic medication adjustment and monitoring
- Respite care (with limitations)
- Rural substance abuse transitional agency services
- Behavioral health therapeutic home care

For a complete list of covered services, please refer to the AHCCCS website in the Covered Service Guide section of azahcccs.gov.

Chapter 5: Claims process, coordination of benefits, claims

Claims submission requirements

UHC Dual Complete programs require that you initially submit your claim within your contracted deadline which may vary from what is documented in this manual. Please consult your contract to determine your initial filing requirement. The standard timely filing limit is set at 90 days after the date of service for participating care providers and 365 days from date of service for non-participating care providers.

A "clean claim" is defined in Arizona Revised Statutes as 1 processed without obtaining additional information from the care provider of service or from a third party. It does not include a claim from a care provider under investigation for fraud or abuse or a claim selected for medical review by UHC Dual Complete programs.

Please mail your paper claims to:

UHC Dual Complete AZ-S001 and
UHC Dual Complete AZ-Y001
P.O. Box 5290
Kingston, NY 12402-5290

For electronic submission of claims, please access the Claims, Billing and Payments section on **UHCprovider.com** and sign up for electronic claims submission. You can register by going to **UHCprovider.com** and clicking on New User in the top right hand corner of the screen. Our Electronic Payer ID is 03432

Practitioners

You should submit claims to UHC Dual Complete programs as soon as possible after service is rendered, using the standard CMS-1500 claim form or electronically as follows.

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

- Prior authorization number, when applicable (on specialist's referral claims)
- Member name
- Member's date of birth and sex
- Member's UHC Dual Complete AZ-S001 and Dual Complete AZ-Y001 ID number
- Member's Group ID Number
- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details
- ICD-10 Codes
- CPT-4 Procedure Codes
- Place of Service Code
- Date of services
- Charge for each service
- National Provider Identifier (NPI)
- Care provider's ID number and locater code, if applicable
- Care provider's Tax Identification Number
- Name/address of care provider
- Signature of care provider rendering services

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

Hospitals

Hospitals should submit claims to the UHC Dual Complete programs claims address as soon as possible after service is rendered, using the standard UB-04 form.

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

- Member name
- Member's date of birth and sex
- Member's UHC Dual Complete programs ID number

- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details
- Appropriate diagnosis, procedure and service codes
- Date of services (including admission and discharge date)
- Charge for each service
- Care provider's ID number and locator code, if applicable
- Care provider's Tax Identification Number
- Care provider's name/address
- Current principal diagnosis code (highest level of specificity) with the applicable present on admission (POA) indicator on hospital inpatient claims
- Current other diagnosis codes, if applicable (highest level of specificity), with the applicable present on admission (POA) indicator on hospital inpatient claims

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

Participating care providers should submit ambulatory surgical center (ASC) claims according to their contract. Non-participating care providers should follow CMS billing guidelines.

Corrected claims and resubmission requirements

UHC Dual Complete participating and non-participating care providers have 1 year from the date of service to submit a corrected claim unless otherwise stated in the participating care providers' contract. A corrected claim is a claim meant to replace a previously submitted claim with changes or corrections applied.

Claim resubmissions can be submitted by participating care providers up to 1 year from the date of service for those claims originally denied or rejected due to missing documentation. Non-participating care providers have 65 days from the date of the remittance advice showing the denial to submit necessary medical records or additional information through a claim resubmission.

Corrected claims changing the DRG for a non-participating inpatient facility claim must be submitted within 65 days from the date of remittance. Otherwise, or the correction will be rejected.

How to use:

Use the claims submission application on the Provider Portal. To access the Provider Portal, sign in to **UHCprovider.com** using your One Healthcare ID. You may also submit the claim by mail with the appropriate frequency code or bill type as shown below. Allow up to 30 days to receive payment for initial claims and a response.

For corrected medical claims, mail to:

UnitedHealthcare Community Plan
P.O. Box 5290
Kingston, NY 12402-5290

Submit corrected dental claims to:

UnitedHealthcare Community Plan
Corrected Claims
P.O. Box 481
Milwaukee, WI 53201

Additional Information:

Enter the appropriate frequency code or bill type to indicate whether the claim is a resubmission of a previously processed claim or a void request of a previously processed claim. Enter the Original Claim Number of the claim being corrected, replaced or voided as shown below.

When submitting a corrected electronic CMS-1500 claim, be sure to:

- **Loop 2300 (Claim Information), Segment CLM**
  - Use CLM05-3- '7' to process as a replacement claim and reverse the original claim on file
  - Use CLM05-3- '8' to void the original claim on file. Any previous payments will be recouped
- **REF*F8 ; must include the original claim number ID**
  - Confirm the original claim reference number (CRN) does not have additional characters. This means if the original claim ID is 22A23xxxxxxx, additional characters such as CLM 22A23xxxxxxx are incorrect

When submitting a corrected paper CMS-1500 claim, along with the UB-04 information, be sure to include:

- **Box 22 - Claim Resubmission Code**
  - Use the appropriate resubmission code:

    1 – Original claim submission

    7 or H– Replacement

    8 – Void
- **Box 22 – Original Ref. Num. (Claim ID)**
  - Include the Original Claim Number. Do not include additional characters. This means if the original claim ID is 22A23xxxxxxx, additional characters such as CLM 22A23xxxxxxx are incorrect.

Corrected claims submitted without this information are rejected and not processed in the claims system. For a list of rejected claims, refer to the claim rejection report your clearinghouse provides.

If any previously paid lines are blanked out or removed the system will assume that those lines should not be considered for reimbursement and payment will be recouped. When submitting a corrected claim, you must resubmit any documentation that was sent with the denied or previously paid claim.

Reconsiderations

Reconsiderations are the first step in the Medicare appeal process. UHC Dual Complete participating care providers have 1 year from the date of service to submit a reconsideration request unless otherwise stated in their contract. A reconsideration can be submitted after a care provider has been notified about the claim status (e.g., Provider Remittance Advice [PRA], 835 electronic remittance), and the care provider disagrees with the outcome. This includes a reimbursement rate or denial. When submitting a reconsideration, also send supporting documentation.

Non-participating care providers have 60 days from the date on the PRA to submit a reconsideration request on a zero-pay denied claim. They have 120 days to submit a reconsideration for all other reasons.

Coordination of benefits

If a member has coverage with another plan primary to Medicare, please submit a claim for payment to that plan first. The amount payable by UHC Dual Complete programs will be governed by the amount paid by the primary plan and Medicare secondary payer law and policies.

Medicaid cost-sharing policy

A group of UnitedHealthcare Community Plan members are dually eligible for both Medicaid and Medicare services. Claims for dual-eligible members will be paid according to the Medicare Cost-Sharing policy. UnitedHealthcare Community Plan will not be responsible for cost-sharing should the payment from the primary payer be equal to or greater than what you would have received under Medicaid. Please refer to the Appendix UHC Dual Complete programs cost-sharing and prior authorization for contracted care providers.

CMS requires that Special Needs Plans for dual-eligible members (eligible for both Medicare and Medicaid) pay the cost-share for members who temporarily lose their Medicaid coverage. During the first 6 months of a patient's loss of Medicaid coverage, the Dual-Eligible Special Needs Plan pays the cost-share amount. For example, if a patient has a claim for date of service 8/22/25 with a $10 copay, and they lose Medicaid eligibility on 8/1/25, the Dual-Eligible Special Needs Plan will pay the $10 copay since the date of service is within the first 6 months of Medicaid eligibility loss. However, if this same patient has a claim for date of service 2/15/25 with a $10 copay, then you may bill the patient for the $10 copay since their loss of Medicaid coverage was more than 6 months ago.

Claims for dual-eligible members will be paid according to the AHCCCS Contractor Operations Manual Policy 202: Medicare Cost Sharing policy.

Excerpt from AHCCCS Contractor Operations Manual Policy 202: Medicare Cost Sharing. Contractors have cost-sharing responsibility for all AHCCCS-covered services provided to members by a Medicare Risk HMO. For those services that have benefit limits, the contractor shall reimburse you for all AHCCCS and Medicare-covered services when the member reaches the Medicare Risk HMO's benefit limits.

Contractors only have cost-sharing responsibility for the amount of the member's coinsurance, deductible or copayment. Total payments to you shall not exceed the Medicare allowable amount which includes Medicare's liability and the member's liability. For those Medicare services which are also covered by AHCCCS, there is no cost-sharing obligation if the contractor has a contract with you as the Medicare care provider, and your contracted rate includes Medicare cost-sharing as specified in the contract.

Contractors shall have no cost-sharing obligation if the Medicare payment exceeds the contractor's contracted rate for the services. The contractor's liability for cost-sharing plus the amount of Medicare's payment shall not exceed the contractor's contracted rate for the service. With respect to copayments, the contractor may pay the lesser of the copayment, or their contracted rate.

The exception to these limits on payments as noted is that the contractor shall pay 100% of the member's copayment amount for any Medicare Part A SNF days (21 through 100) even if the contractor has a Medicaid nursing facility rate less than the amount paid by Medicare for a Part A SNF day.

Qualified Medicare beneficiaries duals

Medicaid pays the cost-sharing for Medicare beneficiaries, including deductibles, coinsurance and copayment amounts for Medicare Part A and B covered services. Once Medicare pays primary, you should bill cost-sharing amounts to UnitedHealthcare Community Plan or the member's Medicaid plan. Members are responsible for payment of their prescription drug copayments.

You may not bill a qualified Medicare beneficiaries (QMB) for either the balance of the Medicare rate or your customary charges for Part A or B services. The QMB is protected from liability for Part A and B charges, even when the amounts you receive from Medicare and Medicaid are less than the Medicare rate or less than your customary charges as specified in the Balanced Budget Act of 1997 (BBA). Billing for QMB amounts the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions. You may not accept QMB patients as "private pay" to bill the patient directly. You must accept Medicare assignment for all Medicaid patients, including a QMB.

Non-qualified Medicare beneficiaries duals

Medicaid pays the cost-sharing for Medicare beneficiaries, including copayments, coinsurance and deductibles for Medicaid-covered benefits. Once Medicare pays primary, bill cost-sharing amounts to UnitedHealthcare Community Plan or the member's Medicaid plan. Members are responsible for their prescription drug copayments. Non-QMB dual eligible members may be billed for Medicare cost-sharing amounts for non-covered Medicaid services.

Balance billing

The balance billing amount is the difference between Medicare's allowed charge and your actual charge to the patient.

UnitedHealthcare Community Plan members cannot be billed for covered services based on A.A.C R9-22-702 and A.A.C R9-27-702. Services to members cannot be denied for failure to pay copayments. If a member requests a service not covered by UnitedHealthcare Community Plan, have the member sign a release form indicating they understand the service is not covered by UnitedHealthcare Community Plan. The member is financially responsible for all applicable charges.

Do not bill a member for a non-covered service unless:

- You have informed the member in advance that the service is not covered
- The member has agreed in writing to pay for the services if they are not covered

6-month grace period

The "grace period" is the time a member who becomes ineligible for our Special Needs Plan due to loss of their Medicaid eligibility has to regain Medicaid eligibility. Dual-eligible members that lose Medicaid eligibility may remain enrolled in UHC Dual Complete programs for up to 6 months without Medicaid coverage to allow the member time to regain eligibility. UnitedHealthcare Community Plan no longer covers the members, coinsurance or copays. The member is responsible for covered services that would have been paid by their Medicaid plan.

Care provider appeals

If you are not able to resolve a processed claim through a claim resubmission or adjustment request, communication with Provider Service Center, or the PCSU, you may challenge the claim denial or adjudication by filing a formal appeal with the health plan.

UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 policy requires all claim appeals from participating care providers challenging claim payments, denials or recoupments must be filed in writing no later than 12 months from the date of service, 12 months after the date of eligibility posting. Failure to timely request an appeal is deemed as a waiver of all rights to further administrative review.

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

Mail formal written claim appeal to:

UHC Dual Complete AZ-S001 and
UHC Dual Complete AZ-Y001
Provider Appeals Department
P.O. Box 6103, CA124-0187
Cypress, CA 90630-0023

Non-submission or incomplete submission may result in a decision that upholds our original claim decision. A formal resolution letter notifying you of our final decision regarding the appeal will be sent within 30 calendar days of appeal receipt. If additional research time is needed, UHC Dual Complete programs have the right to request a 14-day extension. We will notify you in writing if extension is needed.

Non-contracted care providers

All non-contracted care providers must submit written appeals with supporting documentation of the initial claim denial within 120 calendar days from the initial determination date.

In addition, non-contracted care providers must submit a signed Medicare Waiver of Liability form. UHC Dual Complete programs will not process any appeals from a non-contracted care provider without this form. The Medicare Waiver of Liability form is located in the appendix of the UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 care provider manual. The Waiver of Liability form, may also be accessed at **UHCprovider.com** in the Provider Forms, Programs and References section. UnitedHealthcare Community Plan will respond within 30 calendar days from the receipt of the appeal or dispute.

Non-contracted care providers claim payment dispute

Claim Payment Dispute – Any decision where a non-contracted Medicare health plan care provider contends the amount paid by the Medicare health plan for a Medicare-covered service is less than the amount that would have been paid under Original Medicare. Non-contracted care provider claim payment disputes also include instances where there is a disagreement between a non-contracted Medicare health plan care provider and the Medicare health plan about the plan's decision to pay for a different service or level than that billed. You have 120 calendar days from the initial determination date to file a claim dispute when either you disagree with the amount paid, or with UnitedHealthcare Community Plan's decision to pay for different services other than what was billed.

Some examples are:

- Bundling issues
- Disputed rate of payment
- Diagnostic Related Groups (DRG) payment dispute
- Down coding

Payment appeal

A challenge or an "appeal" related to benefit/payment denials by the Medicare health plan that results in zero payment being made to the non-contracted Medicare health plan care provider. The first level of the Medicare appeal process is referred to as the reconsideration level. The Medicare health plan has 30 calendar days to review and respond to a claim payment dispute.

Valid proof of timely filing attachments

Following is a list of documents accepted as proof of timely filing:

Note: Letters of appeal will not be accepted as valid proof of timely filing. Documents must be computer-generated, not hand-written:

A. UnitedHealth Group correspondence (data entry send back letter) OR

B. A computer-generated activity page/print screen listing the date the claim was submitted to UHC Dual Complete programs.

C. Electronic claims acceptance report.

Submission must contain: Member name, identifying information, DOS, billed amount, date submitted to insurance.

D. Other insurance carrier denial/rejection EOB or letter (e.g. terminated coverage, not their member).

Filing an appeal on behalf of a member

This applies to "Appeals for In-Patient Administrative Denials and Medical Necessity Determinations by Practitioner".

You may assist members in filing an appeal on their behalf. UHC Dual Complete programs do not restrict or prohibit you from advocating on behalf of a member.

Part C

On Part C appeals, treating physicians, other physicians or the physician's office staff will not need to complete an Appointment of Representative (AOR) form if they are appealing on behalf of the member. **All requests for pre-service reconsiderations do require a signature of the appealing party on it. If there is not a signature, one must be obtained.**

The following are examples of care providers (not otherwise defined as a physician) who require an AOR to be on file:

- Hospitals
- SNFs
- Long-term care facilities
- Durable medical equipment suppliers
- Critical care access hospitals

Part D

If anyone other than the member or the treating physician, other physician or their office staff is appealing on behalf of the member, an AOR must be in the file. (The completion time frame does not start until this document is received.) To process a member, member representative or treating physicians (including the prescribing physician, other prescriber and their respective office staff) request for redetermination of a denied coverage determination for a medication within 7 calendar days from the date of the redetermination request.

The appeal may be filed either verbally or in writing and must be received within 60 calendar days from the date of the notice of action letter. Expedited appeals may also be requested if you feel the member's health is in jeopardy and must be submitted within 60 calendar days after the occurrence.

Reasons for filing an appeal include:

- A denied authorization
- A denied payment for a service either in whole or part resulting in member liability
- UHC Dual Complete programs reducing or terminating services

- UHC Dual Complete programs failing to provide services to a member in a timely manner
- UHC Dual Complete programs failing to act within the time frame given for grievances and appeals

You may send written appeals and documentation of member's authorization to appeal on behalf of members to:

UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001
Attention: Appeals Department
1 East Washington, Suite 900
Phoenix, AZ 85004

Inquiries about appeals are directed to **Provider Services** at: **1-800-445-1638**.

Chapter 6: Medical management, quality improvement, and utilization review

UHC Dual Complete programs seek to improve the quality of care provided to its members. Thus, UHC Dual Complete programs encourage your participation in health promotion and disease-prevention programs. You are encouraged to work with UHC Dual Complete programs in their efforts to promote healthy lifestyles through member education and information sharing. The programs seek to accomplish the following objectives through its Quality Improvement and Medical Management programs.

You must comply and cooperate with all UHC Dual Complete programs medical management policies and procedures and in our quality assurance and performance-improvement programs.

Referrals and prior authorization

Contracted health care professionals are required to coordinate member care within the care provider network. If possible, all UHC Dual Complete programs members should be seen by contracted care providers. Services provided outside of the network are permitted, but only with prior authorization from UHC Dual Complete programs. Referrals are not required for Dual Complete programs members when they are seeing a network care provider.

The prior authorization procedures are particularly important to the UHC Dual Complete programs managed care program. Prior authorization is 1 of the tools we use to monitor the medical necessity and cost-effectiveness of the health care members receive. Contracted and non-contracted health professionals, hospitals, and other care providers are required to comply with UHC Dual Complete programs' prior authorization policies and procedures. Non-compliance may result in delay or denial of reimbursement. Because the PCP coordinates most services provided to a member, it is typically the PCP who initiates requests prior authorization. However, specialists and ancillary care providers also request prior authorization for services within their specialty areas.

Unless another department or unit has been specially designated to authorize a service, requests for prior authorization are routed through UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 programs Prior Authorization department where nurses and medical directors are available at any time.

Requests are made by calling Prior Authorization at **1-800-445-1638.**

Primary care provider referral responsibilities

If the PCP is coordinating with the member a referral to a specialist, the PCP should check the UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 Provider Directory to help ensure the specialist is a contracted care provider.

The PCP should provide the specialist with the following clinical information:

- Member's name
- Referring PCP
- Reason for the consultation

Chapter 7: Dental

UHC Dual Complete welcomes you as a participating dental care provider in providing dental services for our members. We are committed to providing accessible quality, comprehensive dental services in the most cost-effective and efficient manner possible. We realize strong partnerships with our care providers are critical, and we value you as an important part of our program.

See the following quick reference grid. For more information, please call **1-800-822-5353**. You may also access our website **UHCprovider.com** and register as a participating care provider. Once registered, you may conduct a claim history search by surfaced tooth, verify eligibility and check benefits. The full Dental care provider manual and Dental training are also available on the website.

Resource: **You want to:**	**Provider Services line dedicated service representatives.** **Phone: 1-800-275-8750** **Hours: Monday-Friday, 8:00 a.m. -6:00 p.m. E.T. (IVR: 24/7)**	**Online UHCprovider.com**	**Interactive voice response**
Inquire about a claim	√	√	√
Ask a benefit/plan question including prior authorization requirements	√	√	
Inquire about eligibility	√	√	√
Request an EOB	√	√	
Request a fee schedule	√	√	
Request a copy of your contract	√		
Ask a question about your contract	√		
Inquire about the in-network practitioner listing	√	√	√
Nominate a care provider for participation	√	√	
Request a participation status change	√		
Request an office visit (e.g., staff training)	√		
Request documents	√	√	
Request benefit information	√	√	

Chapter 8: Care provider performance standards and compliance obligation

Care provider evaluation

When evaluating the performance of a care provider, UHC Dual Complete will review at a minimum the following areas:

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

Care provider compliance to standards of care

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

- Guidelines established by the federal Center for Disease Control (or any successor entity)
- All federal, state, and local laws regarding the conduct of their profession

You must also comply with UHC Dual Complete policies and procedures regarding the following:

- Participation on committees and clinical task forces to improve the quality and cost of care
- Prior authorization requirements and timeframes
- Participating care provider credentialing requirements
- Referral policies
- Case management program referrals
- Appropriate release of inpatient and outpatient utilization and outcomes information
- Accessibility of member medical record information to fulfill the business and clinical needs of UHC Dual Complete
- Cooperating with efforts to assure appropriate levels of care
- Maintaining a collegial and professional relationship with UHC Dual Complete personnel and fellow participating care providers
- Providing equal access and treatment to all Medicare members

Compliance process

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

- Out-of-network referrals/utilization without prior authorization by UHC Dual Complete
- Failure to pre-notify UHC Dual Complete of admissions
- Member complaints/grievances that are determined against the care provide.
- Underutilization, overutilization, or inappropriate referrals
- Inappropriate billing practices
- Non-supportive actions and/or attitude participating care provider noncompliance is tracked, on a calendar year basis. Using an educational approach, the compliance process is composed of 4 phases, each with a documented educational component.

Corrective actions will be taken.

You, acting within the lawful scope of practice, are encouraged to advise patients who are members of UHC Dual Complete about:

1. The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options.
2. The risks, benefits, and consequences of treatment or non-treatment.
3. The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.
4. The importance of preventive changes at no cost to the member.

Such actions shall not be considered non-supportive of UHC Dual Complete.

Laws regarding federal funds

Payments you receive for furnishing services to UHC Dual Complete members are, in whole or part, from federal funds. Therefore, as a participating care provider, you, and any subcontractors must comply with certain laws that are applicable to individuals and entities receiving federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84, the Age Discrimination Act of 1975 as implemented by 45 CFR part 91, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

Marketing

You may not develop and use any materials that market UHC Dual Complete without the prior approval of UHC Dual Complete in compliance with Medicare Advantage requirements. Under Medicare Advantage law, generally, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials are prior approved by CMS or are submitted to CMS and not disapproved within 45 days.

Sanctions under federal health programs and state law

You must ensure you do not employ or subcontract management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other federal health care programs.

You must disclose to UHC Dual Complete whether you or any staff member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws, the rules or regulations of Arizona, the federal government, or any public insurer. You must notify UHC Dual Complete immediately if any such sanction is imposed on a participating care provider, a staff member or subcontractor.

Selection and retention of participating care providers

UHC Dual Complete is responsible for arranging covered services provided to thousands of members through a comprehensive care provider network of independent practitioners and facilities. The network includes health care professionals such as PCPs, specialist physicians, medical facilities, allied health professionals, and ancillary service providers.

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

UHC Dual Complete continuously reviews and evaluates participating care provider information and recredentials every 3 years. The credentialing guidelines are subject to change based on industry requirements and UHC Dual Complete standards.

Termination of participating care provider privileges

Termination without cause

UHC Dual Complete and a contracting care provider must provide at least 60 days' written notice to each other before terminating a contract without cause.

Appeal process for care provider participation decisions

Physicians - If UHC Dual Complete decides to suspend, terminate or non-renew a physician's participation status, UHC Dual Complete must:

- Give the affected physician written notice of the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by UHC Dual Complete
- UHC Dual Complete will allow the physician to appeal the action to a hearing panel, and give the physician written notice their right to a hearing and the process and timing for requesting a hearing
- UHC Dual Complete will help ensure the majority of the hearing panel members are peers of the affected care provider

If a suspension or termination is the result of quality of care deficiencies, UHC Dual Complete must give written notice of that action to the National Practitioner Data Bank, the Department of Professional Regulation, and any other applicable licensing or disciplinary body to the extent required by law.

Subcontracted physician groups must provide that these procedures apply equally to physicians within those subcontracted groups.

Other care providers

UHC Dual Complete decisions subject to appeal include decisions regarding reduction, suspension, or termination of a participating care provider's participation resulting from quality deficiencies. UHC Dual Complete will notify the National Practitioner Data Bank, the Department of Professional Regulation, and any other applicable licensing or disciplinary body to the extent required by law. Written communication to the participating care provider will detail the limitations and inform them of their rights to appeal.

Notification of members of care provider termination

You should make every effort to provide as much advance notice as possible when preparing to terminate participation with the UHC Dual Complete provider network. CMS requires the notification of members affected by termination a minimum of 30 days' notice prior to the termination effective date. Advance notice is tantamount to a safe and orderly transition of care.

Chapter 9: Medical records

Medical record review

A UHC Dual Complete programs representative may visit the participating care provider's office to review the medical records of UHC Dual Complete programs members to obtain information regarding medical necessity and quality of care. Medical records and clinical documentation will be evaluated based on the following Standards for Medical Records. The Quality and Utilization Management subcommittee, the Provider Affairs Subcommittee and the Quality Management Oversight Committee review the medical record results quarterly. The results will be used in the re-credentialing process.

Standards for medical records

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

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

You are required to participate in and cooperate with the UnitedHealthcare Quality Management program. The UnitedHealthcare Community Plan Quality Management program is allowed to use your performance data to conduct quality activities.

Proper documentation and medical review

Medical review is performed to determine if services were provided according to policy, particularly related issues of medical necessity and emergency services. Medical review also is performed to audit appropriateness, utilization, and quality of the service provided.

The following are scenarios where the appropriate documentation is required to process the claim:

- Out-of-state care providers who submit corrected claims must include itemization of charges
- Inpatient claims with extraordinary cost-per-day thresholds may qualify for an outlier reimbursement. For an inpatient claim to be paid the outlier payment, the facility must bill a Condition Code 61
- All Medicare inpatient claims require medical records. Please be sure to include them with your claim submission.
- All care providers when unlisted procedures are being billed, including any documentation, including: the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used that details what service was provided

- Medicare services:
  - Cardiology services
  - Radiological service interpretation
  - Home health visits
  - Injectable drugs
  - Home IV therapy
  - Surgical procedures with Modifier 22 indicating unusual procedural service
- Itemized bill for claims where member is eligible for part of the date span but not the entire date span

In addition, you must document in a prominent part of the member's current medical record whether the member has executed an advance directive.

Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under the law of Arizona and signed by a patient. They explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

Confidentiality of member information

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

Member record retention

You must retain the original or copies of patient's medical records as follows:

- Keep records for at least 10 years after last medical or health care service for all patients. You must comply with all state (A.R.S. 12-2297) and federal laws on record retention.

Chapter 10: Reporting obligations

Centers for Medicare & Medicaid Services - requirements

UHC Dual Complete programs must provide to Centers for Medicare & Medicaid Services (CMS) information that is necessary for CMS to administer and evaluate the Medicare Advantage program and to establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services. Such information includes plan quality and performance indicators such as disenrollment rates, information on member satisfaction and information on health outcomes. You must cooperate with UHC Dual Complete programs in its data-reporting obligations by providing any information that they need to meet obligations.

Certification of diagnostic data

UHC Dual Complete programs are specifically required to submit to CMS data necessary to characterize the context and purposes of each encounter between a member and a care provider, supplier, physician, or other practitioner (encounter data). You must certify (based on best knowledge, information and belief) the accuracy, completeness and truthfulness of the data you submit.

Risk adjustment data

You are encouraged to comprehensively code all members' diagnoses to the highest level of specificity possible. All members' medical encounters must be submitted to UHC Dual Complete programs.

Chapter 11: Initials decisions, appeals, and grievances

Initial decisions

The “initial decision” is the first decision UHC Dual Complete programs makes regarding coverage or payment for care. In some instances, you acting on behalf of UHC Dual Complete programs may make an initial decision regarding whether a service will be covered.

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

UHC Dual Complete programs will generally make decisions regarding payment for care that members have already received within 30 days.

A decision about whether UHC Dual Complete programs will cover medical care can be a “standard initial decision” that is made within the standard time frame (typically within 7 days). The decision can also be expedited (typically within 72 hours).

A member can ask for an expedited initial decision only if the member or care provider believes waiting for a standard initial decision could seriously harm the member’s health or ability to function. The member or you can request an expedited initial decision. If you request an expedited initial decision, or supports a member in asking for one, and you indicate waiting for a standard initial decision could seriously harm the member’s health or ability to function, UHC Dual Complete programs will automatically provide an expedited initial decision.

At each patient encounter with a UHC Dual Complete programs member, the care provider must notify the member of their right to receive, upon request, a detailed written notice from UHC Dual Complete programs regarding the member’s services. The care provider’s notification must provide the member with the information necessary to contact UHC Dual Complete programs and must comply with any other requirements specified by CMS. If a member requests UHC Dual Complete programs to provide a detailed notice of a care provider’s decision to deny a service in whole or part, UHC Dual Complete programs must give the member a written notice of the initial determination.

If UHC Dual Complete programs do not make a decision within the time frame and do not notify the member regarding why the time frame must be extended, the member can treat the failure to respond as a denial. They may appeal.

Appeals and grievances

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. “Appeals” and “grievances” are the 2 different types of complaints they can make. You must cooperate in the Medicare appeals and grievances process.

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

Resolving appeals

A member may appeal an adverse initial decision by UHC Dual Complete programs or a care provider concerning authorization for, or termination of coverage of a health care service. A member may also appeal an adverse initial decision concerning payment for a health care service. A member's appeal of an initial decision about authorizing health care or terminating coverage of a service within 30 calendar days or sooner, if the member's health condition requires. An appeal concerning payment must generally be resolved within 60 calendar days.

You must also cooperate with UHC Dual Complete programs and members in providing necessary information to resolve the appeals within the required time frames. Provide the pertinent medical records and any other relevant information to UHC Dual Complete programs. In some instances, you must provide the records and information very quickly to allow UHC Dual Complete programs to make an expedited decision.

If the normal time period for an appeal could result in serious harm to the member's health or ability to function, the member or the member's care provider may request an expedited appeal. Such an appeal is generally resolved within 72 hours unless it is in the member's interest to extend this time. If you request the expedited appeal and indicate the normal time for an appeal could result in serious harm to the member's health or ability to function, we will automatically expedite the appeal.

Special types

A special type of appeal applies only to hospital discharges. If the member thinks UHC Dual Complete programs coverage of a hospital stay is ending too soon, the member can appeal directly and immediately to the Quality Improvement Professional Research Organization (QIPRO). In Arizona that organization is the Health Services Advisory Group (HSAG). However, such an appeal must be requested no later than noon on the first working day after the day the member gets notice that UHC Dual Complete programs coverage of the stay is ending.

If the member misses this deadline, the member can request an expedited appeal.

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

Resolving member grievances

If a UHC Dual Complete programs member has a grievance about UHC Dual Complete programs, you or any other issue, you should instruct the member to contact **Member Services** at **1-877-614-0623** (TTY/TDD users should call 711). Mail a written grievance to:

Member Grievance Part C:
Appeals and Grievance Department
P.O. Box 6103 CA124-0187
Cypress, CA 90630-0023

Fax: 1-844-226-0356

Member Grievance Part D:
Part D Appeal and Grievance Department
P.O. Box 6103 CA124-0197
Cypress, CA 90630-0023

Fax: 1-877-960-8235

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

We may extend the time frame by up to 14 calendar days if you request the extension or if we justify a need for additional information, and the delay is in your best interest.

UHC Dual Complete programs members may ask for an expedited grievance upon initial request. We will respond to “expedited” or “fast” grievance requests within 24 hours.

Further appeal rights

If UHC Dual Complete programs denies the member’s appeal in whole or part, except for Part D claims, we will forward the appeal to an Independent Review Entity (IRE) that has a contract with the federal government and is not a part of UHC Dual Complete programs. This organization will review the appeal and, if the appeal involves authorization for health care service, make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision.

If the IRE issues an adverse decision, and the amount at issue meets a specified dollar threshold, the member may appeal to an administrative law judge (ALJ). If the member is not satisfied with the ALJ’s decision, the member may request review by the Department Appeal Board (DAB). If the DAB refuses to hear the case or issues an adverse decision, the member may appeal to a district court of the United States.

Chapter 12: Member rights and responsibilities

UHC Dual Complete programs members have the right to timely, high-quality care and treatment with dignity and respect. You must respect the rights of all UHC Dual Complete programs members. Specifically, UHC Dual Complete programs members have been informed that they have the following rights:

Timely quality care

- Choice of a qualified contracting PCP and contracting hospital
- Candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage
- Timely access to their PCP and referrals and recommendations to specialists when medically necessary
- To receive emergency services when the member, as a prudent layperson, acting reasonably would believe that an emergency medical condition exists
- To actively participate in decisions regarding their health and treatment option
- To receive urgently needed services when traveling outside UHC Dual Complete's AZ-Y001 service area or in UHC Dual Complete's AZ-Y001 service area when unusual or extenuating circumstances prevent the member from obtaining care from a participating care provider
- To request the number of grievances and appeals and dispositions in aggregate
- To request information regarding physician compensation
- To request information regarding the financial condition of UHC Dual Complete programs

Treatment with dignity and respect

- To be treated with dignity and respect and to have their right to privacy recognized
- To exercise these rights regardless of the member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care
- To confidential treatment of all communications and records pertaining to the member's care.
- To access, copy and/or request amendment to the member's medical records consistent with the terms of HIPAA
- To extend their rights to any person who may have legal responsibility to make decisions on the member's behalf regarding the member's medical care
- To refuse treatment or leave a medical facility, even against the advice of physicians (providing the member accepts the responsibility and consequences of the decision)
- To complete an advance directive, living will or other directive to the member's medical care providers

Member satisfaction

UHC Dual Complete programs periodically survey members to measure overall customer satisfaction as well as satisfaction with the care received from participating care providers. Survey information is reviewed by UHC Dual Complete programs and results are shared with the participating care providers.

CMS conducts annual surveys of members to measure their overall customer satisfaction as well as satisfaction with the care received from you. Survey results are available upon request.

Member responsibilities

Member responsibilities include:

- Reading and following the Evidence of Coverage (EOC)
- Treating all UHC Dual Complete programs staff and health care providers with respect and dignity
- Protecting their AHCCCS or DDD ID card and showing it before obtaining services
- Knowing the name of their PCP
- Seeing their PCP for their health care needs
- Using the emergency room for life-threatening care only and going to their PCP or urgent care center for all other treatment
- Following their doctor's instructions and treatment plan and telling the doctor if the explanations are not clear
- Bringing the appropriate records to the appointment, including their immunization records until the child is 18 years old
- Making an appointment before they visit their PCP or any other UHC Dual Complete programs care provider
- Arriving on time for appointments
- Calling the office at least 1 day in advance if they must cancel an appointment
- Being honest and direct with their PCP, including giving the PCP the member's health history as well as their child's
- Telling their AHCCCS, UHC Dual Complete programs, and their DDD Support Coordinator if they have changes in address, family size, or eligibility for enrollment
- Tell UHC Dual Complete programs if they have other insurance
- Give a copy of their living will to their PCP

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 our Cultural Competency Program. For more information, go to **UHCprovider.com/resourcelibrary** > Health Equity Resources > **Cultural Competency**.

Translation/interpretation/auxiliary aide and services

You must provide language services and auxiliary aide and services, 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:

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.**

I Speak language assistance card: This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare members.

Language interpretation line:

- We provide interpreter services Monday–Friday, 8 a.m.–5 p.m.
- To arrange for interpreter services, please call **1-877-842-3210**, TTY 711

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.**

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 the **digital solutions comparison guide**. Care providers in the UnitedHealthcare network will conduct business with us electronically. This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents. This includes appeals prior authorization requests and decisions. Using electronic transactions is fast, efficient and supports a paperless work environment. Use Application Programming Interface (API), electronic data interchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

Member complaints/ grievances

UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 tracks all complaints and grievances to identify areas of improvement. This information is reviewed in the Quality Improvement Committee, Service Improvement Subcommittee and reported to the UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 board of directors. Please refer to **Chapter 11** for members' appeal and grievances rights.

Chapter 13: Access to care/appointment availability

Member access to health care guidelines

UHC Dual Complete programs monitor the adequacy of appointment processes and help ensure a member's waiting time for a scheduled appointment at the PCP's or specialist's office is no more than 15 minutes, except when you are is unavailable due to an emergency. For purposes of this section, "urgent" is defined as an acute, but not necessarily life-threatening disorder, which, if not attended to, could endanger the patient's health.

You must meet the following appointment standards:

- Urgent care PCP appointments – within 2 business days of request
- Routine care PCP appointments – within 21 calendar days of request

For specialty referrals, the following standards must be met:

- Urgent care appointments – within 2 business days of referral
- Routine care appointments – within 45 calendar days of referral

For dental appointments, you must meet the following standards:

- Urgent care appointments – within 3 business days of request
- Routine care appointments – within 45 calendar days of referral

General behavioral health appointment standards:

1. Urgent need: as immediately as the member's health condition requires but no later than 24 hours from identification of need.

2. Routine care.

- Initial assessment: 7 calendar days of referral or request for service
- First behavioral health service: as immediately as the member's health condition requires but no later than 23 calendar days after initial assessment
- Subsequent behavioral health services: as immediately as the member's health condition requires but no later than 45 calendar days from identification of need

3. Referrals for psychotropic medications:

- Assess the urgency of the need immediately
- Provide an appointment within the time frame indicated by clinical need, no later than 30 calendar days from identification of need

You must offer a range of appointment availability per the appointment timeliness standards for intakes and ongoing services based upon the clinical need of the member. Exclusive use of "same-day only" appointment scheduling and/or "open access" is prohibited within our network.

Adherence to member access guidelines will be monitored through the office site visits, long-term care visits and the tracking of complaints/grievances related to access and/or discrimination.

Variations from the policy will be reviewed by network management for educational and/or counseling opportunities and tracked for participating care provider re-credentialing.

All providers and hospitals will treat all UHC Dual Complete programs members with equal dignity and consideration as their other patients.

Care provider availability

PCPs shall provide coverage 24 hours a day, 7 days a week. When a participating care provider is unavailable to provide services, they must help ensure another participating care provider is available.

The member should normally be seen within 45 minutes of a scheduled appointment or be informed of the reason for delay (e.g. emergency cases) and be provided with an alternative appointment.

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

Care provider office confidentiality statement

UHC Dual Complete programs members have the right to privacy and confidentiality regarding their health care records and information in accordance with the Medicare Advantage Program. Participating care providers and each staff member will sign an employee confidentiality statement to be placed in the staff member's personnel file.

Transfer and termination of members from participating physician's panel

UHC Dual Complete programs will determine reasonable cause for a transfer based on written documentation submitted by the participating care provider. Participating care providers may not transfer a member to another participating care provider due to the costs associated with the member's covered services. Participating care providers may request termination of a member due to fraud, disruption of medical services, or repeated failure to make the required reimbursements for services.

Closing of care provider panel

When closing a practice to new UHC Dual Complete AZ-S001 and Dual Complete AZ-Y001 members or other new patients, participating care providers are expected to:

- Give UHC Dual Complete programs prior written notice that the practice will be closing to new members as of the specified date
- Keep the practice open to UHC Dual Complete AZ-S001 and Dual Complete AZ-Y001 members who were members before the practice closed
- Close the practice to all new patients, including private payers, commercial or governmental insurers
- Give UHC Dual Complete programs prior written notice of the reopening of the practice, including a specified effective date

Prohibition against discrimination

Neither UHC Dual Complete programs or participating care providers may deny, limit, or condition the coverage or furnishing of services to members on the basis of any factor that is related to health status, including, but not limited to the following:

- Medical condition including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability including conditions arising out of acts of domestic violence
- Disability

Chapter 14: Prescription Benefits

Network pharmacies

With a few exceptions, UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 members must use network pharmacies to get their outpatient prescription drugs covered. A network pharmacy is a pharmacy where members can get their outpatient prescription drugs through their prescription drug coverage. We call them "network pharmacies" because they contract with our plan. In most cases, prescriptions are covered only if they are filled at 1 of our network pharmacies. Once a member goes to 1, they are not required to continue going to the same pharmacy to fill their prescription; they can go to any of our network pharmacies.

Covered Drugs is the general term we use to describe all of the outpatient prescription drugs that are covered by our plan. Covered drugs are listed in the Prescription Drug List (PDL).

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before a prescription is filled at an out-of-network pharmacy, please contact **Member Services** at **1-877-614-0623** to see if there is a network pharmacy available.

- We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, members will have to pay the full cost (rather than paying just the copayment) when they fill their prescription. They can ask us for reimbursement for their share of the cost by submitting a paper claim form.
- If our member is traveling within the U.S., but outside of the plan's service area and becomes ill, loses or runs out of their prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy. In this situation, the member will have to pay the full cost (rather than paying just their copayment) when they fill their prescription. The member can ask us to reimburse them for our share of the cost by submitting a claim form. Remember, prior to filling a prescription at an out-of-network pharmacy, call **Member Services** at **1-877-614-0623** to find out if there is a network pharmacy in the member's area where they are traveling. If there are no network pharmacies in that area, our **Member Services** department may make arrangements for the member to get their prescriptions from an out-of-network pharmacy.
- If our member is unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service
- If a member is trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail store. (These drugs include orphan drugs or other specialty pharmaceuticals.)

Paper claim submission

When our members go to a network pharmacy, their claims are automatically submitted to us by the pharmacy. However, if they go to an out-of-network pharmacy for 1 of the reasons listed, the pharmacy may not submit the claim directly to us. When that happens, members will have to pay the full cost of their prescription. Call **Member Services** at **1-877-614-0623** (TTY/TDD users should call **711**) for a direct member reimbursement claim form and instructions on how to obtain reimbursement for covered prescriptions. Mail the claim form and receipts to:

OptumRx ®
P.O. Box 29044
Hot Springs, AR 71903

Prescription drug list

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

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

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

To find out what drugs are on the PDL or to request a copy of our PDL, please call **Member Services** at **1-877-614-0623**. (TTY/TDD users should call 711.)

You can also get updated information about the drugs covered by us by visiting our website at **UHCCommunityPlan.com**.

Exception request

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make:

- You can ask us to cover your drug even if it is not on our PDL
- You can ask us to waive coverage restrictions or limits on your drugs. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.

Generally, we will only approve your request for an exception if the alternative drugs included on the plan's PDL would not be as effective in treating the member's condition and/or would cause them to have adverse medical effects.

Please call our **Member Services** at **1-877-614-0623** (TTY/TDD users should call 711) to request a PDL exception. If we approve your exception request, our approval is valid for the remainder of the plan year, as long as the physician continues to prescribe the drug and it continues to be safe and effective for treating the patient's condition.

All new Dual Complete programs members may receive a 30-day transition supply of a non-PDL/non-covered drug when a prescription is presented to a network pharmacy. The pharmacist will fill the script. A letter will be automatically generated to you and the member advising that either a PDL alternative should be chosen or a request for exception should be submitted.

- You may request an exception for coverage (or continuation of coverage post-transition fill) of a non-formulary drug, or you may ask to waive quantity limits or restrictions. Exception requests require you to provide documentation that the patient has unsuccessfully tried a regimen of a PDL medication or that such medication would not be as effective as the non-formulary alternative.
- Exception requests will be evaluated based on the information you provide. Please call **1-800-711-4555** to initiate the exception process.

Drug management programs (utilization management)

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

1. **Prior Authorization**: We require our members to get prior authorization for certain drugs. This means that a participating physician or pharmacist will need to get approval from us before a member fills their prescription. If they don't get approval, we may not cover the drug.
2. **Quantity Limits**: For certain drugs, we limit the amount of the drug that we cover per prescription or for a defined period of time. For example, we will provide up to 90 tablets per prescription for ALTOPREV. This quantity limit may be in addition to a standard 30-day supply limit.
3. **Step Therapy**: In some cases, we require members to first try 1 drug to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.
4. **Generic Substitution**: When there is a generic version of a brand-name drug available, our network pharmacies will automatically give the member the generic version, unless their doctor has told us that they must take the brand-name drug.

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

Find medical policies and coverage determination guidelines at **UHCprovider.com/policies > AZcommunityplan > Medicaid Policies and Clinical Guidelines**.

Chapter 15: Fraud, waste, and abuse

Our company is committed to preventing fraud, waste, and abuse in Medicare benefit programs. If any such actions, activities, or behaviors come to your attention, please contact UHC Dual Complete AZ-S001 immediately at **1-877-614-0623** TTY **711**, 8 a.m.- 8 p.m. local time, 7 days a week.

You may also report potential prescription drug fraud cases to 1-877-772-3379.

The Medicare Drug Integrity Contractor (MEDIC) can be contacted at 1-877-7SAFERX (1-877-772-3379). This contractor is responsible for investigating suspected fraud, waste, and abuse related to Medicare drug plans. If you suspect fraud, you can report it by calling this number and providing details such as your name, Medicare number, and the service or item in question. or to the Medicare program directly at 1-800-Medicare (1-800-633-4427). TTY users can call 1-877-486-2048. The website is Medicare.gov.

This hotline allows you to report cases anonymously and confidentially. All information provided to UHC Dual Complete AZ-S001 regarding potential fraud or abuse occurrence will be maintained in the strictest confidence in accordance with the terms and conditions of UnitedHealthcare Community Plan Dual Complete's AZ-S001 Confidentiality Policy. A copy of this policy is available upon request. Any information developed, obtained or shared among participants in an investigation of a potential fraud and abuse occurrence is maintained specifically for this purpose and no other. Any questions or concerns a care provider may have regarding confidentiality should be addressed to the attention of the UHC Dual Complete AZ-S001 compliance officer.

UnitedHealthcare Community Plan members are instructed through the Member Handbook to safeguard their member ID cards as they would any other private and personal identification information, such as a driver license or checkbook. If you have any concerns regarding a member's enrollment when they present for non-emergent or non-urgent services:

- Ask for another form of identification, preferably one with a photograph
- Use the **UnitedHealthcare Provider Portal** or the IVR phone line to confirm enrollment
- Contact the Member Services Department for verification

Federal False Claims Act

The federal False Claims Act prohibits knowingly submitting (or causing to be submitted) to the federal government a false or fraudulent claim for payment or approval. It also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by a state Medicaid program, the federal government or its agents, such as a carrier or other claims processor. Civil penalties can be imposed on any person or entity that violates the federal Civil Division | The False Claims Act is liable for 3 times the government's damages plus a penalty that is linked to inflation.

Federal fraud civil remedies

The Program Fraud Civil Remedies Act of 1986 also allows the government to impose civil penalties against any person who makes, submits or presents false, fictitious or fraudulent claims or written statements to designated federal agencies, including the U.S. Department of Health and Human Services, which is the federal agency that oversees the Medicare and Medicaid programs.

State false claims acts

Several states, including Arizona, have enacted broad false claims laws modeled after the federal False Claims Act or have legislation pending that is similar to the federal False Claims Act. Other states have enacted false claims laws that have provisions limited to health care fraud.

Whistleblower and whistleblower protections

The federal False Claims Act and some state false claims acts permit private citizens with knowledge of fraud against the U.S. government or state government to file suit on behalf of the government against the person or business that committed the fraud. Individuals who file such suits are known as a "qui tam" plaintiff or "whistleblower." The federal False Claims Act and some state false claims acts also prohibit retaliation against an employee for investigating, filing or participating in a whistleblower action. You must establish an effective training program for all staff on the following aspects of the federal False Claims Act provisions:

- The administrative remedies for false claims and statements
- Any state laws relating to civil or criminal penalties for false claims and statements
- The whistleblower protections under such laws

All training must be appropriately documented and may be requested at any time by UHC Dual Complete AZ-S001.

Waiver of liability statement

Waiver of Liability Statement

Member / HIC Number
Enrollee's Name
Provider
Date of Service
Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600

Signature _____ Date: _____

Case management referral form

UnitedHealthcare Community Plan

UnitedHealthcare Community Plan Dual Complete Health Services Case Management Referral Form

Member Name:	Member ID:
Date of Birth:	Address:
City:	Zip:
Phone:	Cell:
PCP:	Phone:
Referred By:	Phone:
Language: English Spanish Other:	
MSR:	Date:
Ext/Phone:	

Check Appropriate CM Request:

ASTHMA CM	BEHAVIORAL HEALTH CM	DIABETES CM	SDOH NEEDS
CHF CM	PAIN CM	GENERAL CM	ER DIVERSION
TRANSPLANT/HEMOPHILIA CM	HIV CM	MOMS CM	MISSED APPOINTMENTS
BENEFIT EXPLANATION	OTHER:		

Reason for Case Management: _____

Goal: _____

Glossary

Appeal

Any of the procedures that deal with the review of adverse organization determinations on the health care services a member is entitled to receive or any amounts that the member must pay for a covered service. These procedures include reconsiderations by UHC Dual Complete programs, an independent review entity, hearings before an ALJ, review by the Medicare Appeals Council, and judicial review.

Basic benefits

All health and medical services that are covered under Medicare Part A and Part B, except hospice services and additional benefits. All members of UHC Dual Complete programs receive all basic benefits.

CMS

The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Contracting hospital

A hospital that has a contract to provide services and/or supplies to UHC Dual Complete programs members.

Contracting medical group

Physicians organized as a legal entity for the purpose of providing medical care. The contracting medical group has an agreement to provide medical services to UHC Dual Complete programs members.

Contracting pharmacy

A pharmacy that has an agreement to provide UHC Dual Complete programs members with medication(s) prescribed by the members' participating care providers in accordance with UHC Dual Complete programs.

Cost-Sharing

Refers to UnitedHealthcare Community Plan's obligation for payment of applicable Medicare coinsurance, deductible, and copayment amounts for Medicare Parts A and B covered services.

Covered services

Those benefits, services or supplies which are:

- Provided or furnished by participating care providers or authorized by UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001 or its participating care providers
- Emergency services and urgently needed services that may be provided by non-participating care providers
- Renal dialysis services provided while you are temporarily outside the service area
- Basic and supplemental benefits

Emergency medical condition

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

Emergency services

Covered inpatient or outpatient services 1) Furnished by a care provider qualified to furnish emergency services; and 2) Needed to evaluate or stabilize an emergency medical condition.

Experimental procedures and items

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

Fee-for-service Medicare

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

Grievance

Any complaint or dispute other than one involving an organization determination. Examples of issues that involve a complaint that will be resolved through the grievance rather than the appeals process are waiting times in physician offices and rudeness or unresponsiveness of customer service staff.

Home health agency

A Medicare-certified agency which provides intermittent skilled nursing care and other therapeutic services in your home when medically necessary, when members are confined to their home and when authorized by their PCP.

Hospice

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

Hospital

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

Hospitalist

A hospitalist is a member of a growing medical specialty who has chosen a field of medicine that specifically focuses on the care of the hospitalized patient. Before selecting this new medical specialty, hospitalists must complete education and training in internal medicine. As a key member of the health care team and an experienced medical professional, the hospitalist takes primary responsibility for inpatient care by working closely with the patient's PCP.

Independent Physicians Association

IPA - A group of physicians who function as a contracting medical provider/group yet work out of their own independent medical offices.

Medically necessary

Medical services or hospital services that are determined by UHC Dual Complete programs to be:

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

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

Medically 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; or
- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body

Medicare

The federal government health insurance program established by Title XVIII of the Social Security Act.

Medicare Part A

Hospital insurance benefits including inpatient hospital care, SNF care, home health agency care and hospice care offered through Medicare.

Medicare Part A premium

Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the Self-Employment Tax paid by self-employed persons. If members are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, island, or local

government employment to be insured, members do not have to pay a monthly premium. If members do not qualify for premium-free Part A benefits, they may buy the coverage from Social Security if members are at least 65 years old and meet certain other requirements.

Medicare Part B

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

Medicare Part B premium

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

Medicare Advantage plan

MA -A policy or benefit package offered by a Medicare Advantage Organization (MAO) under which a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area covered by UHC Dual Complete programs. An MAO may offer more than one benefit plan in the same service area. UHC Dual Complete programs are MA plans.

Member

The Medicare beneficiary entitled to receive covered services, who has voluntarily elected to enroll in the UHC Dual Complete programs and whose enrollment has been confirmed by CMS.

Non-contracting medical provider or facility

Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by Arizona or Medicare to deliver or furnish health care services; and who is neither employed, owned, operated by, nor under contract to deliver covered services to UHC Dual Complete programs members.

Non-qualified Medicare beneficiary Dual

QMB - An individual who is eligible for Medicaid and has Medicare coverage, but who is not eligible for QMB benefits.

Participating care provider

Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by Arizona or Medicare to deliver or furnish health care services. This individual or institution has a written agreement to provide services directly or indirectly to UHC Dual Complete programs members pursuant to the terms of the agreement.

Primary care provider

PCP - The participating care provider who a member chooses to coordinate their health care. The PCP is responsible for providing covered services for UHC Dual Complete programs members and coordinating referrals to specialists. PCPs are generally participating care providers of internal medicine, family practice or general practice.

Qualified Medicare beneficiary Dual

QMB - An individual who is eligible for QMB Benefits as well as Medicaid benefits.

Please contact UHC Dual Complete programs if you have any questions regarding the definitions listed or any other information listed in the manual. Our representatives are available anytime at 1-800-445-1638.

Comments and suggestions

UHC Dual Complete programs welcome your comments and suggestions about this care provider manual. Please complete this form if you would like to see additional information, or expansions on topics, or if you find inaccurate information. Please mail this form to:

UHC Dual Complete AZ-S001 and UHC Dual Complete AZ-Y001

Attn: Medicare Vice President of Operations

1 East Washington, Suite 900

Phoenix, AZ 85004

Comments & Suggestions:

Submitted By:

Name:

Address: