2023
Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary

New Jersey

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United Healthcare® Community Plan

Welcome

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

Click the following links to access different manuals:

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

Easily find information in this manual using the following steps:

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

If you have questions about the information or material in this manual, or about our policies, please call Provider Services.

Important information about the use of this manual

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

This manual will be amended as policies change.

Terms and definitions as used in this manual:

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

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Table of Contents

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Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	888-362-3368
Training	UHCprovider.com/training	888-362-3368
Provider Portal	UHCprovider.com, then Sign In using your One Healthcare ID or go to Provider Portal Self Service: UHCprovider.com/en/resource-library/link-provider-self-service.html New users: UHCprovider.com > New User and User Access	888-362-3368
Provider Portal Support	ProviderTechSupport@uhc.com	855-819-5909
CommunityCare Provider Portal Training	CommunityCare Provider Portal User Guide	
Resource Library	UHCprovider.com > Resources > Resource Library	

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

UnitedHealthcare Community Plan supports the New Jersey state goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits to the following members:

- Children, from birth through 18 years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act.
- Pregnant women eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act.
- Children eligible for the Children's Health Insurance Program (CHIP).
- Categorically needy — blind and disabled children and adults who are not eligible for Medicare.
- Medicaid Expansion 19–64 years old who are not eligible for another type of Medicaid and who have an income of less than 138% of the federal poverty level (FPL).
- Medicaid-eligible families.

The health program offers the following plans:

- NJ FamilyCare
- UnitedHealthcare Dual Complete® ONE (Medicare)

NJ FamilyCare (Medicaid)

NJ FamilyCare is a state and federally funded program. It offers free or low-cost health insurance for uninsured children, pregnant women, parents/caretaker relatives, and single adults/childless couples who live in New Jersey. The program helps families who do not have or cannot afford employer-funded or private insurance.

Eligibility

NJ FamilyCare members must live in New Jersey. Lawful permanent residents or those in a qualified immigrant status may be eligible if they have been in the country for at least 5 years. Children may be eligible regardless of their date of entry into the United States.

Eligibility is based on family size and income only. For income eligibility levels, visit njfamilycare.org > Income Eligibility and Cost.

Cost

For many families, NJ FamilyCare costs nothing. For families with higher incomes, the state uses a sliding

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scale for small copayments and monthly premiums. For more information, visit njfamilycare.org > Income Eligibility and Cost.

Covered services

NJ FamilyCare Medicaid

NJ FamilyCare has 4 plans (A, B, C & D). Enrollment in the plan is based on the family's income and household size. If applicable, premiums and copays associated with each plan are shown on the member's UnitedHealthcare Community Plan ID card.

Eligibility groups include:

- NJ FamilyCare A:
  - Uninsured children younger than age 19 with family incomes up to and including 142% of the FPL.
  - Pregnant women up to 200% of the FPL.
  - Beneficiaries eligible for MLTSS services.
  - This group may access certain other services which are paid fee-for-service (FFS) by the state.
- NJ FamilyCare B: Uninsured children younger than 19 years with family incomes above 142% and up to and including 150% of the FPL. This group may access certain other services which are FFS and not covered under this contract.
- NJ FamilyCare C:
  - Uninsured children younger than 19 years with family incomes above 150% and up to and including 200% of the FPL.
  - Eligibles must take part in cost-sharing in the form of a personal contribution to care for most services. However, Eskimos and Native American Indians younger than 19 years old, identified by Race Code 3, do not take part in cost-sharing and do not have to pay a personal contribution to care.
  - This group also has access to certain other services, which are paid FFS.
- NJ FamilyCare D:
  - Uninsured children younger than age 19 with family incomes between 201% and up to and including 350% of the FPL.
  - Eligibles with incomes above 150% FPL must pay monthly premiums and/or copayments for most services except for both Eskimos and Native American Indians younger than 19 years. These groups are identified by Program Status Codes (PSCs) or Race Code on the eligibility system.
- NJ FamilyCare Alternative Benefit Plan (ABP):
  - Parents between ages 19-64 with income up to and including 133% FPL.
  - Childless adults between 19-64 with income up to and including 133% FPL.
  - These members may also access certain other services, which are paid FFS by the state.

Applicants are eligible for NJ FamilyCare only if they have been uninsured for 3 months or more. However, there are exceptions to this rule. This includes if they lose their insurance because their place of work went out of business or they were laid off. Depending on income, other exceptions may apply for families privately paying for health insurance or for Continuation of Health Coverage (COBRA) benefits. Pre-existing conditions do not affect eligibility.

Managed Long Term Services and Supports

Certain NJ FamilyCare members may receive enhanced services provided through the Managed Long Term Services and Supports (MLTSS) program.

MLTSS applies to individuals who meet MLTSS eligibility requirements and encompasses the NJ FamilyCare Plan A benefit package, Home and Community Based Services (HCBS) and institutionalization for long-term care in a nursing facility or special care nursing facility. It helps promote quality and cost-effective coordination of care for members with chronic, complex health care, social service and custodial needs.

The MLTSS program includes both nursing facility and HCBS care coordination. Detailed information on the MLTSS program is in "Chapter 6: Managed Long Term Services and Supports (MLTSS)".

UnitedHealthcare Dual Complete® ONE (Medicare)

UnitedHealthcare Dual Complete® ONE is a Fully Integrated Dual-Eligible Special Needs Plan (Medicare) for people with Medicare Parts A & B and full Medicaid eligibility under Title XIX. UnitedHealthcare Dual Complete® ONE offers qualified individuals all the benefits of Medicaid and Medicare. It also includes extra services at no added costs, such as:

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- Transportation (24 round trips or 48 one-way routine medical trips) for visits to any health care appointment, including trips to the pharmacy at no additional cost to the member.
- Benefit credits to choose from more than 150 health care products from our Personal Health Care Catalog. Credits can be used to order vitamins, bandages, aspirin, blood pressure monitors, digital thermometers, bath safety items and much more at no cost to the member.
- Personal Emergency Response System (PERS) - This emergency response services through an electronic monitoring system is ready any time.
- NurseLine℠ – Members can speak with a registered nurse (RN) at any time.

UnitedHealthcare Dual Complete® ONE (Medicare), services members in Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union and Warren counties. The New Jersey Department of Human Services (DHS) determines enrollment eligibility.

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com** or call **Provider Services** at 888-362-3368.

How to join our network

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

Already in network and need to make a change?

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

Approach to health care

Care Model

The Care Model program is our comprehensive continuum of care strategy that focuses on care coordination for vulnerable members and those most likely to need help. It seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community to improve care coordination and elevate outcomes. Targeting UnitedHealthcare Community Plan members with chronic complex conditions who often use health care, the program helps address their needs holistically. Care Model examines medical, behavioral and social/ environmental concerns to help members get the right care from the right care provider in the right place and at the right time.

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

- Market-specific care management encompassing medical, behavioral and social care.
- An extended care team including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist.
- Options that engage members, connecting them to needed resources, care and services.
- Individualized and multidisciplinary care plans.
- Assistance with appointments with PCP and coordinating appointments. The Clinical Health Advocate (CHA) refers members to an RN, Behavioral Health Advocate (BHA) or other specialists as required for complex needs.
- Education and support with complex conditions.
- Tools for helping members engage with providers, such as appointment reminders and help with transportation.

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- Foundation to build trust and relationships with hard-to-engage members.

The Care Model program goals are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates.
- Improve access to PCP and other needed services, measured by number of PCP visit rates within identified time frames.
- Identify and discuss behavioral health (BH) needs, measured by number of BH care provider visits within identified time frames.
- Improve access to pharmacy.
- Identify and remove social and environmental barriers to care.
- Improve health outcomes, measured by improved Healthcare Effectiveness Data and Information Set (HEDIS®) and Centers for Medicare & Medicaid Services (CMS) Star Ratings metrics.
- Empower the member to manage their complex/chronic illness or problem and care transitions.
- Improve coordination of care through dedicated staff resources and to meet unique needs.
- Engage community care and care provider networks to help ensure access to affordable care and the appropriate use of services.

To refer your patient who is a UnitedHealthcare Community Plan member to the Care Model program, call **Member Services** at **800-941-4647**, TTY 711. You may also call **Provider Services** at **888-362-3368**.

Compliance

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

Cultural resources

To help you meet membership needs, we have developed a Cultural Competency Program. Linguistic and cultural barriers can negatively affect access to health care participation. You must support UnitedHealthcare Community Plan's Cultural Competency Program. For Cultural Competency training visit UHCprovider.com > Resources > Resource Library > Patient Health and Safety > **Cultural Competency**.

We provide members with access to interpreter services, including the Deaf, hard of hearing or those who need of interpreter services due to language barriers:

- **TDD/TYY:** Call 771
- **Interpreter Access**: We provide free anytime access to oral interpreter services for all enrollees/potential enrollees at provider sites within our network where technical, medical or treatment information is to be discussed, or where use of a family member or friend as interpreter is inappropriate. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical. This is available through phone language services or in-person interpreters. We also identify and report the linguistic capability of interpreters or bilingual employed and contracted staff (clinical and nonclinical). We provide training for care providers on using interpreters.
- **Interpreter Listing**: We keep a list of interpreter agencies/oral interpreters who provide interpreter services free to each enrollee/potential enrollee.
- **Language Threshold**: In addition, we provide translated signage and written materials as well as referrals to culturally and linguistically appropriate community services programs. To access a professional interpreter during regular business hours, they can call the phone number on their ID card.

These tools support members' cultural and linguistic needs. Please document when these services are required. For more information, go to **uhc.com/legal/nondiscrimination-and-language-assistance-notices**.

Guide to providing effective communication and language assistance services

Visit **thinkculturalhealth.hhs.gov/education** to download a free, online communication guide for health care administrators and care providers. It helps you and your organization interact more effectively with culturally and linguistically diverse individuals. The guide covers

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strategies for communicating in a way that considers the cultural, health literacy, and language needs of your patients and their families.

For information on cultural sensitivity for transgender patients, visit **thinkculturalhealth.hhs.gov** > Resources > Presentations > Resources > Presentations > Exploring Culture in CLAS: Sexual Orientation and Gender Identity.

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses Interqual care guidelines for medical care determinations. We previously used MCG.

Online resources

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

Application Programming Interface

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

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

Electronic data interchange

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

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

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

Visit **UHCprovider.com/EDI** for more information. Learn how to optimize your use of EDI at **UHCprovider.com/en/resource-library/edi/edi-optimization.html**.

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Getting started

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

Read our Clearinghouse Options page for more information.

Point of Care Assist™

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

UHCprovider.com

The Provider Portal provides a secure online portal featuring self-service tools that support your administrative tasks. Once you sign in, you can review including eligibility, claims and prior authorization and notifications. Go to UHCprovider.com and click Sign In on the upper right corner.

For more information about all online services, go to the UnitedHealthcare Provider Portal Resources page at UHCprovider.com/en/resource-library/link-provider-self-service.html.

For Provider Portal training, go to Community Care Provider Portal User Guide.

To access the Provider Portal, go to UHCprovider.com and either sign in or create a user ID. You will receive your user ID and password within 48 hours.

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The secure website lets you:

- Verify member eligibility, including secondary coverage.
- Review benefits and coverage limits.
- Check prior authorization status.
- Access remittance advice and review recoveries.
- Review your preventive health measure report.
- Access the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) toolset.
- Search for CPT codes. Type the CPT code in the header search box titled "What can we help you find?" on UHCprovider.com. The search results will display all documents and/or web pages containing that code.

The following are the most frequently used self-service transactions on the Provider Portal:

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

Watch for the most current information on our self-service resources by email or in the Network Bulletin. You can also go to UHCprovider.com/EDI or the Provider Portal at UHCprovider.com then click Sign In.

For more instructions, visit UHCprovider.com/Training or the UnitedHealthcare Provider Portal resources for online self- service training and information.

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

Direct Connect

Direct Connect is a free online portal that lets you securely communicate with payers to address errant claims. This portal has the ability to 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 time frames.
- Real-time reporting to track statuses of inventories in resolution process.
- Provide control over financial resolution methods.
- All users will access Direct Connect using the Provider Portal. On-site and online training is available.

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

Privileges

To help our members access appropriate care and minimize out-of-pocket costs, you must have privileges at applicable in-network facilities or arrangements with

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an in-network provider to admit and provide facility services. This includes full admitting hospital privileges, ambulatory surgery center privileges and/or dialysis center privileges.

Provider Services

Provider Services is the primary contact for care providers who require assistance. It is staffed with representatives trained specifically for UnitedHealthcare Community Plan.

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

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How to contact us

UnitedHealth Group contacts

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

Contact	Service Area	Contact Information	Additional Information
UnitedHealthcare Community Plan of New Jersey	Provider Services	888-362-3368	• Assist care providers with issues or concerns. • Ask whether a service may require prior authorization. • Confirm a patient's eligibility on UHCprovider.com. • Ask about covered benefits. • Check claim status.
	Member Services	NJ FamilyCare: **UHCCommunityplan.com/nj** > NJFamilyCare 800-941-4647 UnitedHealthcare Dual Complete® ONE: **UHCCommunityplan.com/nj** > UnitedHealthcare Dual Complete® ONE (HMO D-SNP) 800-514-4911	Assist members with issues or concerns. Available at any time. Available 8 a.m.-8 p.m. daily Oct. to March; Monday-Friday April to Sept.
	Multilingual/ Telecommunication Device for the Deaf (TDD) Services	800-941-4647 TTY 711	Available at any time.
	Prior Authorization Requests & Advance Admission Notification	To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N Online Tool: **UHCprovider.com/paan** Phone: Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications." Or call 888-362-3368 Monday through Friday 8 a.m.-5 p.m. ET.	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required. • Complete the notification or prior authorization process. • Upload medical notes or attachments. • Check request status. Information and advance notification/prior authorization lists: Visit UHCprovider.com/NJcommunityplan > **Prior Authorization and Notification**

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Contact	Service Area	Contact Information	Additional Information
UnitedHealthcare Community Plan of New Jersey	Prior Authorization/ Notification for Pharmacy	UHCprovider.com > Prior Authorization > Clinical Pharmacy and Specialty Drugs 800-310-6826	Request authorization for medications as required. Use the Provider Portal to access the PreCheck MyScript tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives.
	Cardiology	UHCprovider.com/cardiology 866-889-8054	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information. Available 7 a.m.-7 p.m., Monday through Friday.
	Care Model (Care Management/Disease Management)	888-362-3368	Refer high-utilization, high-risk members with complex care needs.
	Radiology	UHCprovider.com/radiology 866-889-8054	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information. Available 9 a.m.-6 p.m. Eastern Time
	Oncology	UHCprovider.com/oncology 888-397-8129	Review prior authorization requirements for injectable chemotherapy, therapeutic radiopharmaceuticals, related cancer therapies and radiation therapy services. Available 8 a.m.–5 p.m. local time, Monday through Friday
	Provider Resources	UHCprovider.com/njcommunityplan	• Access your state-specific Community Plan information • Stay up-to-date with our latest care provider bulletins • Read about new programs and educational articles in the newsletters • Reference the most current payment policies • Find useful forms
	Care Management	NJ FamilyCare/Medicaid: 888-362-3368 MLTSS NJ FamilyCare/ Medicaid: 888-702-2168	Refer members with complex conditions who frequently use health care services.
	Provider Services Managed Long Term Services and Supports (MLTSS)	For credentialing and contracting, email NJ_MLTSS_CRED@uhc.com. 888-702-2168	Ask about the MLTSS program.

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Contact	Service Area	Contact Information	Additional Information
UnitedHealthcare Community Plan of New Jersey	PCA, Medical Day Care, and MLTSS Services Intake	800-262-0305	Notify us of all personal care services and/or medical day care that require prior authorization.
	Special Needs and Care Management Referral	877-704-8871	Refer high-risk members to the Care Management program.
	Healthy First Steps	800-599-5985, TTY 711	Refer pregnant and high-risk OB members Monday through Friday, from 8 a.m.-5 p.m. Eastern Time.
	NurseLine (Dual Complete® ONE and MLTSS members only)	866-351-6827	• Reach a nurse to provide care management advice • Available at any time • UnitedHealthcare Dual Complete® ONE (Medicare) and MLTSS members only
	Referrals	UHCprovider.com > **Referrals**	Submit new referral requests and check the status of referral submissions.
	Reimbursement Policy Updates	UHCprovider.com/njcommunityplan > **Payment Policy Notifications**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
	Technical Help	**UHCprovider.com/en/contact-us/technical-assistance.html** **ProviderTechSupport@uhc.com** 866-209-9320 for Optum support or 866-842-3278, Option 1 for web support	Call if you have issues logging in to the Provider Portal, you cannot submit a form, etc.
	Tobacco Free Quit Line	800-784-8669	Ask about services for quitting tobacco/smoking.
	Utilization Management (UM)	888-362-3368	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 procedures, go to UHCprovider.com > Resources > **Health Plans, Policies, Protocols and Guides**.

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Contact	Service Area	Contact Info	Information
UnitedHealthcare Networks	UHC Provider	UHCprovider.com	• Review a patient's eligibility and plan benefits • Submit claims, claim reconsiderations and prior authorizations • Check claims status • Download the most recent patient panel roster (for PCPs) • Find tools and training to enhance your practice
	UnitedHealthcare Online Help Desk	UHCprovider.com > Contact Us 866-842-3278	• Report any technical problems • Receive assistance on how to use the website • Ask questions related to transaction results, data displayed or claims submitted through UHCprovider.com • Available Monday through Friday, 8 a.m. – 8 p.m. Eastern Time.
	One Healthcare ID Support Center	ProviderTechSupport@uhc.com 855-819-5909	Contact if you have issues with your ID. Available 7 a.m. – 9 p.m. Central Time, Monday through Friday; 6 a.m. – 6 p.m. Central Time, Saturday; and 9 a.m. – 6 p.m. Central Time, Sunday.
	Electronic Data Interchange (EDI)	UHCprovider.com/EDI 800-210-8315 Select option 1	EDI Support Services provides support for all electronic transactions involving claims, electronic remittances and eligibility. Please call us for assistance with any of these transactions.
	Electronic Data Intake Log-on Issues	ac_edi_ops@uhc.com 800-842-1109	Get help for EDI concerns.
	Eligibility	To access eligibility information, go to UHCprovider.com then Sign In to the Provider Portal or go to UHCprovider.com/eligibility. 888-362-3368	Confirm member eligibility.

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Contact	Service Area	Contact Information	Additional Information
UnitedHealthcare Networks	Fraud and Abuse (Payment Integrity)	Payment Integrity Information: UHCprovider.com/ NJcommunityplan > **Integrity of Claims, Reports, and Representations to the Government** Reporting: **uhc.com/fraud** 800-455-4521 or 877-401-9430	Notify us of suspected fraud or abuse by a care provider or member.
	Provider Relations and Network Management Resource Team (NMRT)	**northeastprteam@uhc.com**	Ask about contracting and care provider services.
	United Enterprise Voice Portal	**networkhelp@uhc.com** 877-842-3210	Use self-service functionality to update or check credentialing information.
UnitedHealthcare Ancillary	Laboratory Services	UHCprovider.com > Our Network > **Preferred Lab Network**	LabCorp is the preferred network laboratory.
OptumRx	Pharmacy Services	**professionals.optumrx.com** 800-866-0931	• Ask whether a prescription drug may require prior authorization • Ask if a prescription drug is covered under a member's plan • Check claim status
Optum Behavioral Health	Behavioral Health Services	**providerexpress.com** 888-362-3368	• Ask about whether a service may require prior authorization • Check claim status
Optum Physical Health	Physical, Occupational, Speech Therapy and Chiropractic Care	**myoptumhealthphysicalhealth.com** 800-873-4575	.
UnitedHealthcare Dental	Dental Benefits Provider	**uhcproviders.com** 800-508-4881	• Ask whether a service may require prior authorization • Confirm a patient's eligibility • Ask about covered benefits • Check claim status • Request a peer-to-peer discussion

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Government contacts

Contact	Service Area	Contact Information	Additional Information
New Jersey Medicaid	Provider portal for New Jersey Medicaid providers	njmmis.com	Apply for a Medicaid ID, check the latest newsletters & alerts, Medicaid standard reimbursement fees, access the NJ FamilyCare Clinical Criteria Grid for Dental Services and Policy and keep up-to-date with New Jersey Medicaid provider requirements.
Centers for Medicaid and Medicare (CMS)	Federal and state government health programs	cms.gov	An official website of the United States government.
NJ Hotline	Medicaid Eligibility	800-676-6562	Call to determine a patient's Medicaid eligibility. UnitedHealthcare is identified as – 082II. NJ FamilyCare members use the Medicaid ID number (CIN).
Department of Human Services and NJ FamilyCare	Medicaid	New Jersey DHS state.nj.us/humanservices NJ FamilyCare njfamilycare.org 800-701-0710	Contact New Jersey Medicaid directly.
Centers for Disease Control (CDC)	Department of Health and Human Services	cdc.gov	The CDC is one of the major operating components of the Department of Health and Human Services.
Department of Health Services	Vaccines for Children (VFC) Program	VFC@doh.state.nj.us 609-826-4862	You must participate in the VFC Program administered by the Department of Health Services (DHS). You must also use the free vaccine when administering vaccine to qualified eligible children. You must enroll as VFC providers with DHS to bill for the administration of the vaccine.
National Credentialing Center VETTS Line	Credentialing	877-842-3210	Use self-service functionality to update or check credentialing information.

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Contact	Service Area	Contact Information	Additional Information
National Plan and Provider Enumeration System (NPPES)	National Provider Identifier (NPI)	nppes.cms.hhs.gov 800-465-3203	Apply for an NPI through NPPES. New registrants should go to the section titled "Create a new account."

Vendor contacts

External Contact	Service Area	Contact Info	Information
eviCore	Radiology Prior Authorization	UHCprovider.com 866-889-8054	• Submit prior authorizations. • Ask about prior authorizations needed for MRIs, MRAs, CTs, PETs through eviCore National.
MARCH Vision Care	Vision Services	marchvisioncare.com 844-686-2724	• Ask whether a service may require prior authorization. • Confirm a patient's eligibility. • Ask about covered benefits. • Check claim status.
ModivCare	Transportation	866-527-9933	Call ModivCare Monday through Friday, 8 a.m. - 4:30 p.m. local time to schedule transportation or for transportation assistance. Representatives are also available on the ride assist line and to schedule urgent reservations at any time.
Optum	Chemotherapy Prior Authorization	UHCprovider.com/paan 888-397-8129	• Submit prior authorizations for cancer diagnosis. • Ask about prior authorization for injectable chemotherapy drugs, therapeutic radiopharmaceuticals, colony-stimulating factors, bone modifying agent and anti-emetic drugs.
	Radiology Therapy Prior Authorization	UHCprovider.com/paan 888-397-8129	• Submit prior authorizations. • Ask about prior authorizations needed for IMRT, PBT, SBRT/SRS, IGRT, special and associated therapies, fractionation using IMRT, PBT and standard 2D/3D, SIRT and Y90.

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Chapter 2: Care Provider Standards and Policies

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	888-362-3368
Enterprise Voice Portal		877-842-3210
Eligibility	UHCprovider.com/eligibility	888-362-3368
Referrals	UHCprovider.com > Referrals	888-362-3368
Provider Directory	UHCprovider.com > Our Network > Find a Provider	888-362-3368

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

General care provider responsibilities

By being a network care provider (e.g., physicians, other health professionals, hospitals, facilities, and agencies), you agree to:

- Never bill or balance bill UnitedHealthcare Community Plan members for covered services. Billing members for covered services violates your provider Agreement as well as New Jersey law and regulation. Ask for documentation of a patient's insurance coverage and accurately maintain this information in all billing systems.
- Advise members of what services members' plans do and do not cover and how much they cost before providing the services.
- Collect copayments as shown on the member's card for NJ FamilyCare Plan C and D members.
- Bill primary insurance carriers for rendered services before billing us.
- Offer member appointments that aligns with the standards in this chapter.
- Maintain medical records based on UnitedHealthcare Medical Records Documentation Standards in this manual.
- Maintain all licenses and certifications required to practice and provide services without restrictions. Provide us with copies for verification and recredentialing purposes.
- Transfer medical records upon request. Copies of members' medical records must be provided to them upon request at no charge.
- Provide covered benefits in a manner consistent with professionally recognized standards of health care based on our standards.
- Respect our members' rights, including honoring their beliefs, sensitivity to cultural diversity, and fostering respect for cultural background.
- Notify us of any change in office location, office hours, or additional office location at least 30 days before services will be rendered at the new location(s). This change may generate a new provider ID number to be used when billing for a new site.
- Notify us promptly of any changes in the information originally submitted in the application to participate in our network.
- Submit to us all data necessary to characterize the content and purpose of each member encounter. This submission of a claim or encounter information is your certification that the data are accurate and complete.
- Never employ or contract with individuals who are excluded from participation in any federal health care program or with entities that employ or contract with such individuals.
- Keep information about members confidential.
- Help ensure that all individuals and entities the provider hires or contracts with to provide services to UnitedHealthcare Dual Complete® ONE members comply with Medicare regulations and requirements.

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- Perform criminal background checks on all employees or agents who provide direct care to members based on federal and state law.
- Give Medicare members the Notice of Discharge and Medicare Appeal Rights (NODMAR) letter when they are discharged from an inpatient hospitalization. Also send a copy of the signed NODMAR to UnitedHealthcare Dual Complete® ONE.
- Cooperate with and participate in UnitedHealthcare Quality Management and Utilization Management (UM) Programs.

You must also comply with:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 C.F.R. Part 84
- The Age Discrimination Act of 1975, as implemented by regulations at 45 C.F.R. Part 91
- The Rehabilitation Act of 1973
- The Americans with Disabilities Act
- The informed consent procedures for Hysterectomy and Sterilization specified in 42 C.F.R., Par 441, sub-part F, and 18 NYCRR Section 505.13
- Other laws applicable to recipients of federal funds
- Standards set forth by the UnitedHealthcare Compliance program
- All other applicable laws and rules
- Critical Incident Reporting requirements.

Non-discrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them based on age, sex, race, physical or mental handicap, national origin, religion, type of illness or condition. You may only direct the member to another care provider type if that illness or condition may be better treated by someone else. You may not discriminate against an enrollee or attempt to disenroll for filing a complaint, grievance or appeal against the health plan.

Communication between care providers and members

The UnitedHealthcare Community Plan Agreement is not intended to interfere with your relationship with members as patients or with UnitedHealthcare Community Plan's ability to administer its quality improvement, UM or credentialing programs. Instead, we require communication between PCPs and other participating care providers. This helps ensure UnitedHealthcare Community Plan members receive both quality and cost-effective health services.

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

1. Educate members, and/or their representative(s) about their health needs.
2. Share findings of history and physical exams.
3. Discuss options (without regard to plan coverage), treatment side effects and symptoms management. This includes any self-administered alternative or information that may help them make care decisions.
4. Recognize members (and/or their representatives) have the right to choose the final course of action among treatment options.
5. Collaborate with the plan care manager in developing a specific care plan for members enrolled in high-risk care management.

Provide official notice

Notify us in writing within 10 calendar days if any of the following events happen:

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

You may use the Care Provider Demographic Information Update Form for demographic changes or to update NPI information for care providers in your office. This form is located at UHCprovider.com > Our Network > Demographics and Profiles > **Care Provider Demographic Information Update Form.**

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Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. Until then, provide covered services to members based on your Agreement:

- Any member receiving inpatient care from you as of the date of termination will continue coverage until they are transferred or discharged.
- Where it is medically necessary for the member to continue treatment with you, coverage shall continue for up to 4 months.
- Pregnant members may receive medically necessary postpartum care for up to 6 weeks after delivery.
- You must provide post-operative care for our members for up to 6 months.
- Coverage for oncology treatment shall continue for up to 1 year.
- Coverage for psychiatric treatment shall continue for up to 1 year.
- In the case of a hospital care provider whose contract is not renewed or terminated by either party, you must adhere to the contract terms for up to 4 months from the contract termination date, or some other mutually agreed upon date. UnitedHealthcare Community Plan members must be able to receive non-emergency services from the hospital during the 4 month period. Emergency services will continue to be available after the 4 month period ends.

We are not required to continue coverage by the care provider if the reason for termination was:

- That the care provider is a danger to members or public health, safety, and welfare.
- A determination of fraud.
- The care provider is subject to disciplinary action by the State Board of Medical Examiners.

Arrange substitute coverage

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

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

Administrative terminations for inactivity

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

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

Changing an existing TIN or adding a health care provider

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

- Download the W-9 form at irs.gov > Forms & Instructions > **Form W-9**.
- Download the Care Provider Demographic Information Update Form at UHCprovider.com > Our Network > Demographics and Profiles > **Care Provider Demographic Information Update Form**.
- To update your care provider information online, go to **UHCprovider.com** > Sign In > MyPractice Profile.

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

Updating your practice or facility information

You can update your practice information through the Provider Data Management application on

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UHCprovider.com > Sign In > My Practice Profile. Or submit your change by:

- Completing the Care Provider Demographic Change Form and emailing it to the appropriate address listed on the bottom of the form.
- Calling our United Enterprise Voice Portal at **877-842-3210**.
- For MLTSS providers, email your requests to NJ_MLTSS_CRED@uhc.com.

Participate in quality initiatives

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

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for diseases and conditions. This is determined by United States government agencies and professional specialty societies. See “Chapter 13: Quality Management (QM) Program and Compliance Information”for more details on the initiatives.

Provide access to your records

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 6 years or longer if required by applicable statutes or regulations.

Performance data

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

Comply with protocols

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

You must also use the most current diagnosis and treatment protocols and standards established by the DHSS and the medical community. This means you must follow evidence-based treatment guidelines for treatment and diagnosis where available. Such guidelines are available from professional societies (e.g., American College of Cardiology, American College of Physicians), government funded agencies (e.g., National Institute of Health, U.S. Preventive Services Task Force, National Guideline Clearinghouse).

You may view protocols at UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans.

Background check requirements

You must comply with N.J.S.A. 45:1-30 et seq. This requires a criminal history background check for every person with a license or certificate as a health care professional.

All care providers who provide direct support and/or services to members must have policies and procedures that show compliance with state requirements to have a pre-employment criminal history check and/or background investigation on all staff members. All employees and/or agents of a care provider or subcontractor and all care providers who provide direct care must have a criminal background check as required by federal and state law.

Nursing facilities (NFs) should perform background checks based on CMS survey requirements.

Office hours

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

Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve

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our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

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

Follow medical record standards

See "Chapter 12: Medical Records" for medical record standards.

Advance directives

Members have the right to make health care decisions for themselves. This includes the right to accept or refuse treatment and to execute an advance directive. An advance directive is a written instruction, such as a living will or a durable power of attorney, for health care recognized under state law and relates to the provision of health care when an individual is incapacitated. Several types of advance directives may be available to a member. You must comply with state law requirements regarding advance directives in your state.

Members are not required to have an advance directive. If a member does have one, document that in their medical record and keep a copy of it in that record. The member (or the member's designee) should keep the original. Do not send us a copy. You cannot condition the provision of care or otherwise discriminate against a member based on whether they have executed an advance directive.

Under the federal Patient Self-Determination Act (PSDA), you must provide written information to members on state laws about advance treatment directives, their rights and your own policies regarding advance directives. To comply with this requirement, we inform members of state laws on advance directives through the Member Handbooks and other communications.

Your Agreement

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

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

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. You may locate the Member Handbook at **UHCCommunityPlan.com/nj**.

Also read "Chapter 15: Claims, Reconsiderations and Appeals" of this manual for information on provider claim reconsiderations, appeals, and grievances.

New Jersey timeliness standards for appointment scheduling

Comply with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- After-hours care: at any time
- Emergency care: immediately or referred to an emergency facility
- Urgent care appointment: within 24 hours
- Routine care appointment: within 28 days of request

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- Preventive care: within 4 weeks of request
- Initial office visit for Aged, Blind, and Disabled (ABD) elderly and disabled enrollees: contacted within 45 days of enrollment and offered an appointment based on their needs
- Initial office visit for an enrollee identified with special needs: contacted within 10 days of enrollment and offered an expedited appointment
- Well-child care: within 3 months of enrollment
- Baseline physicals for new adult enrollees: within 180 days of enrollment
- Baseline physicals for new children enrollees: within 90 days of enrollment
- Baseline physicals for adult clients of Division of Developmental Disabilities (DDD): within 90 days of enrollment
- Routine physicals for school, sports, camp or work: within 4 weeks of request

Specialty care

Specialists should arrange appointments for:

- Urgent care: within 24 hours of request
- Non-urgent care: within 4 weeks of request, as clinically indicated

Behavioral health (mental health and substance use)

Behavioral and MLTSS health providers should arrange appointments for DDD members for:

- Emergency care (dangerous to self or others): immediately upon presentation
- Urgent care: within 24 hours of request
- Non-urgent care: within 10 days of request

Prenatal and postnatal care

Prenatal care providers should arrange appointments for:

- Positive pregnancy test: within 3 weeks of request
- Identification of high risk: within 3 days of identification of high risk
- First or second trimester: within 7 days of request
- Third trimester: within 3 days of request
- Postpartum: between 21–56 days after delivery

Dental care

Dental providers should arrange appointments for:

- Emergency care: no later than 48 hours, or earlier as condition warrants
- Urgent care: within 3 days of request
- Elective or routine care: within 30 days of request

Within the care provider's service area, dental providers also help ensure members:

- Have access to emergency dental services at any time.
- Bear full responsibility for providing emergency dental services.
- Get access to a backup provider if an on-call provider is unavailable.

UnitedHealthcare Community Plan of New Jersey must help members get emergency dental services from a licensed dental provider without the need for prior authorization from the provider while members are outside the service area (including out-of-state services covered by the Medicaid program). Call **Member Services** at 800-941-4647 for assistance in finding a dental provider.

Lab and radiology

Care providers should arrange appointments for:

- Routine care: within 3 weeks of request
- Urgent care: within 48 hours of request

Surveys for appointment scheduling

We periodically survey care providers about these access and availability standards. A surveyor calls their office, identifies themselves and asks the front desk personnel appointment availability questions from the view of the member.

We notify care providers by mail, email or phone if they fail the survey and request they develop an action plan to fix the issues. We survey them again within 90 days.

PCPs are required to participate in all activities related to these surveys.

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We also conduct an annual after-hours availability audit. We contact care providers after business hours or on weekends to determine their availability and phone coverage.

Allowable office waiting times

Members with appointments should not wait longer than 45 minutes. The maximum number of intermediate/limited patient encounters should be 4 per hour.

24-hour, 7-days-a-week coverage

PCPs, primary care dental (PCD) providers and obstetric specialists must be available to members by phone 24 hours a day, 7 days a week. Or they must have arrangements for phone coverage by another network PCP, PCD or dentist. A medical director must approve coverage arrangements that vary from this requirement.

PCPs and PCDs are expected to respond to after-hour patient calls within 30-45 minutes for non-emergent symptomatic conditions and within 15 minutes for crisis situations.

We track and follow up on all instances of PCP unavailability.

The following are examples of acceptable and unacceptable responses as defined by UnitedHealthcare Community Plan of New Jersey, per state requirements.

Acceptable:

- Your phone is answered by care provider, office staff, answering service or voice mail permitting immediate contact.
- The answering service you use either:
  - Connects the caller directly to the care provider.
  - Contacts the care provider on behalf of the caller and the provider returns the call.
  - Provides a phone number where the care provider or covering provider can be reached.
- Your answering machine message provides a phone number to contact the care provider responsible for maintaining care provider coverage.
- Your answering machine instructs the caller to dial 911 for life-threatening emergencies at the beginning of the call, or to go to the ER if needed.

Unacceptable care provider responses include:

- Office/answering service hangs up.
- Answering machine message:
  - Instructs the caller to go to the ER for non-emergent situations.
  - Instructs the caller to leave a message for the care provider for any urgent situation.
  - There is no answer.
  - The caller is placed on hold for longer than 5 minutes.
  - The phone lines are busy despite multiple attempts to contact the care provider.

Unacceptable:

- Office/answering service hangs up.
- The care provider's answering machine message:
  - Instructs the caller to go to the ER for non-emergent situations.
  - Instructs the caller to leave a message for the care provider for any urgent situation.
  - There is no answer.
  - The caller is placed on hold for longer than 5 minutes.
  - The phone lines are persistently busy despite multiple attempts to contact the care provider.

Provider directory

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

We are required to contact all participating care providers annually and independent physicians every 6 months. We require you to confirm your information is accurate or provide us with applicable changes.

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

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

In addition to outreach for annual or bi-annual attestations, we are required to reach out if we receive

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a report of incorrect care provider information. We are required to confirm your information. To help ensure we have your most current provider directory information, fill out and submit the **Care Provider Demographic Change Submission Form**.

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

Use the following table to look up different types of providers.

Provider Type	Online Directory
Doctors, Medical groups, Other Professionals by Specialty, Hospitals, Clinics, Medical Suppliers	UHCprovider.com > Our Network > Find a Provider > Under Search for Doctors, Clinics or Facilities by Plan Type, click on Search for a Provider > Medical Directory > Medicaid Plans > **New Jersey** > (select plan)
Dental	UHCprovider.com > Our Network > Find a Provider > Under Search for Doctors, Clinics or Facilities by Plan Type click on Search for a Provider > Medical Directory > Medicaid Plans > **New Jersey** > (select plan) > Under Looking for Dental Providers? choose a Dental Provider Directory for NJ FamilyCare/LTC or Dual Complete Plans®
Mobile Dental Services	UHCCommunityPlan.com/nj > NJ FamilyCare > Dentist > Find a Dentist > **New Jersey Directory of Mobile Dental Services**
Dentists Treating Members with Intellectual and Developmental Disabilities	UHCCommunityPlan.com/nj > NJ FamilyCare > Dentist > Find a Dentist > **New Jersey Directory of Dentists Treating Members with Intellectual and Developmental Disabilities** There are seperate directories for adults and children.
Dentists Treating Children Younger Than 6 Years	UHCCommunityPlan.com/nj > NJ FamilyCare > Dentist > Find a Dentist >**The NJFC Directory of Dentists Treating Children under the Age of 6**
Behavioral Health/Mental Health	UHCprovider.com > Our Network > Find a Provider > Under Search for Doctors, Clinics or Facilities by Plan Type click on Search for a Provider > Medical Directory > Medicaid Plans > **New Jersey** > (select plan) > Under Looking for Mental Health? choose a Mental Health Directory for NJ FamilyCare/LTC or UnitedHealthcare Dual Complete® ONE
Vision	UHCprovider.com > Our Network > Find a Provider > Under Search for Doctors, Clinics or Facilities by Plan Type click on Search for a Provider > Medical Directory > Medicaid Plans > New Jersey > (select plan) > Under Looking for Vision Providers? click on **Vision Provider Directory**
Pharmacy	UHCprovider.com > Find Dr. > Under Search for Doctors, Clinics or Facilities by Plan Type click on Search for a Provider > Medical Directory > Medicaid Plans > **New Jersey** > (select plan) > Under Looking for a Pharmacy? choose a Pharmacy Directory for NJFamilyCare / LTC or Dual Complete® Plan
Laboratory	UHCprovider.com > Our Network > Find a Provider > Under Search for Doctors, Clinics or Facilities by Plan Type click on Search for a Provider > Medical Directory > Medicaid Plans > New Jersey > (select plan) > Under Looking for a Lab? > choose **LabCorp Directory**

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Provider Type	Online Directory
Home Delivered Meals - UnitedHealthcare Dual Complete® ONE plan only	UHCprovider.com > Our Network > Find a Provider > Under Search for Doctors, Clinics or Facilities by Plan Type click on Search for a Provider > Medical Directory > Medicaid Plans > New Jersey > (select plan) > Under Looking for Home Delivered Meals? click on Home Meal Provider – Dual Eligible Special Needs Plans (DSNP) Plans

Provider attestation

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

Prior authorization request

The prior authorization request process involves getting approval from UnitedHealthcare Community Plan to cover costs. Prior authorization requests may include procedures, services, and/or medication.

Coverage may only be provided if the service or medication is deemed medically necessary, or meets specific requirements provided in the benefit plan. For more information about requirements or submission, visit UHCprovider.com/priorauth.

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

- Verify eligibility at UHCprovider.com/eligibility or by calling Provider Services. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice. Verify UnitedHealthcare Dual Complete® ONE (Medicare) member eligibility using their Medicare number.
- Get prior authorization:
  - To access the Prior Authorization app, go to UHCprovider.com, then Sign In.
  - Select the **Prior Authorization and Notification app**.
  - View notification requirements.
- Call Provider Services at **888-362-3368**.

If you have questions, please call UnitedHealthcare Online Help Desk at **866-842-3278**, option 3, 8 a.m.–8 p.m. Eastern Time, Monday through Friday.

Timeliness standards for notifying members of test results

- Urgent or emergent cases: within 24 hours of receipt of results. Arranging an appointment to discuss the laboratory and/or radiology results is acceptable.
- Rapid strep test: within 24 hours of the test
- Routine results (non-urgent or non-emergent): within 5 business days of receipt

Requirements for PCP and specialists serving in PCP role

Specialists include internal medicine, pediatrics, or obstetrician/gynecology

The PCP is the point of entry into the delivery system. The exceptions are services allowing self-referral, emergencies and out-of-area urgent care. We expect PCPs to communicate with specialists about referrals, including the reason for the referral. Note this in the member's medical record.

PCPs are an important partner in the delivery of care, and UnitedHealthcare Community Plan members may seek services from any participating care provider. The New Jersey DHS program requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home." UnitedHealthcare Community Plan expects specialists to communicate with the PCP by having

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consultations, reporting significant findings, and offering recommendations for continuing care. A specialist may refer the patient directly to another specialist; however, a separate referral must be generated from the patient's PCP for that specialist.

The PCP plays a vital role as a case manager in the UnitedHealthcare Community Plan system by improving health care delivery in 4 critical areas: access, coordination, continuity and prevention. As such, the PCP manages initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide anytime coverage and backup coverage when they are not available.

If a member has a life-threatening or disabling condition that requires prolonged specialized care, we may authorize the member's specialist to also serve as the PCP. In these cases, a medical director must approve a treatment plan created by all parties. We will approve only in-network specialists unless no qualified specialist can be identified in our network.

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

- General practice
- Internal medicine
- Family practice
- Pediatrics
- Specialist physicians

PCPs may employ NPs and PAs to see UnitedHealthcare Community Plan members, subject to their scope of practice limitations under New Jersey State law. The use of NPs and PAs does not relieve the PCP of their obligations for member access and availability.

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

Members may change their assigned PCP by contacting **Member Services** at any time during the month. Member Services is available at any time.

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

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

Consult with appropriate care providers to develop personalized treatment plans for members with special health care needs.

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who may be due preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.
- Provide all EPSDT services to NJ FamilyCare members younger than 21 years.
  - Screen all children ages 0 months to 6 years for lead toxicity.
  - Screen members for behavioral health problems using the Screening Tool for Substance Use and Mental Health. File the completed screening tool in the member's medical record.
- Coordinate each member's overall course of care.
- Identify and reschedule broken and no-show appointments.
- Document procedures for monitoring patients' missed appointments as well as outreach attempts to reschedule missed appointments. You must reach out to the member at least 3 times, 1 of which must be in writing. You may try to reach the member by phone or through New Jersey's MEDM System, the Medical Assistance Customer Center (MACC), DDD, or DYFS/DCF regional offices.
- Triage medical and dental conditions and special behavioral needs for non-compliant individuals with intellectual and developmental disabilities.
- Contact members at least 5 days, but not later than 48 hours, before admission or surgery.
- Inform our Care Management team by calling **Provider Services** at **888-362-3368** if any member shows signs of end-stage renal disease or who

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requires a referral to a Medicare-certified hospice.

- Refer women ages 35–39 for a baseline mammogram and women 40 and older for an annual mammogram.
- Refer men ages 65–75 to prostate cancer screening every 2 years.
- Refer members to PCD providers using the Dental link on UHCprovider.com > Our Network > **Find a Provider**:
  - Under Search for Doctors, Clinics or Facilities by Plan Type, click on Search for a Provider
  - Select Medical Directory > Medicaid Plans > New Jersey > (select plan).
  - Under Looking for Dental Providers, choose a Dental Provider Directory for NJ FamilyCare/LTC or Dual Complete® Plans.
- Refer pediatric members to a dentist by age 1 or soon after the eruption of the first tooth.
- Admit members to the hospital when necessary and coordinate their medical care.
- Help the UnitedHealthcare Community Plan Care Manager assess a member's needs and develop a plan for continuing care beyond discharge, if medically necessary.
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a 1-MD practice and at least 30 hours per week for a 2 or more MD practice.
- Be available to members by phone or phone service any time.
- Tell members about appropriate use of hospital-based emergency services.
- Discuss available treatment options with members.
- Document in the member's medical record the reason for a specialist referral and the outcome of the specialist intervention.
- Refer to participating specialists for health problems the PCP doesn't manage. The PCP should complete a referral using the referral link.

Responsibilities of PCPs and specialists serving in PCP role

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

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

- Offer office visits on a timely basis, based on the standards outlined in the **Timeliness Standards for Appointment Scheduling** section of this chapter.
- Conduct a baseline exam during the member's first appointment. This should occur within 90 days of enrollment for children and DDD clients and within 180 days for adult NJ FamilyCare members. Schedule this appointment if the member does not.
- Treat members' general health care needs. Use nationally recognized clinical practice guidelines (CPGs). See the CPGs at UHCprovider.com/njcommunityplan > Policies and Clinical Guidelines > Clinical Guidelines > **UnitedHealthcare Community Plan Medical & Drug Policies and Coverage Determination Guidelines**.
- Refer services requiring prior authorization to our **Provider Services**, Clinical, or **Pharmacy** departments as appropriate.
- Admit members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized health care standards and UnitedHealthcare Community Plan's. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.

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- Allow timely access to member medical records per contract requirements. Purposes include record keeping audits, HEDIS® or other quality measure reporting and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards. Visit adachecklist.org for more about facility requirements.
- Comply with the New Jersey Timeliness Standards for Appointment Scheduling for emergency, urgent care and routine visits.
- Maintain staff privileges with at least 1 participating hospital.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws and regulations.

Rural health clinic, federally qualified health center or primary care clinic

Members may choose a care provider who meets the PCP requirements and performs PCP-type services within a rural health clinic (RHC) or federally qualified Health Center (FQHC) as their PCP.

- **Rural Health Clinic:** The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be in underserved areas.
- **Federally Qualified Health Center:** An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a care provider, PA, NP and/or social worker.
  - Mental health services.
  - Immunizations (shots).
  - Home nurse visits.
- **Primary Care Clinic:** A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a PCC that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

PCP checklist

- Verify eligibility and benefits on UHCprovider.com. Click “Sign In” in the top right corner to access the Provider Portal, or call Provider Services.
- Check the member’s ID card at the time of service. Verify member with photo identification.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/paan.
- Refer patients to UnitedHealthcare Community Plan participating specialists when needed.
- Identify and bill other insurance carriers when appropriate.
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form.

Specialist responsibilities

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

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

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- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care.
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at 1 participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the **New Jersey Timeliness Standards for Appointment Scheduling**.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone at any time. Or they must have arrangements for phone coverage by another participating PCP or obstetrician. We track and follow up on all instances of PCP or obstetrician unavailability.
- Communicate to the PCP significant findings and recommendations for continuing care. A specialist may refer the member directly to another specialist.

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

Ancillary provider responsibilities

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

Participating ancillary providers should maintain enough facilities, equipment, and personnel to provide timely access to medically necessary covered services.

Ancillary provider checklist

- Verify the member's enrollment before rendering services. Sign in to the Provider Portal at UHCprovider.com or contact Provider Services.
- Check the member's ID card at the time of service. Verify against photo ID if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/paan.
- Identify and bill other insurance carriers when appropriate.

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Chapter 3: Care Provider Office Procedures and Member Benefits

Key contacts

Topic	Link	Phone Number
Member Benefits	UHCCommunityPlan.com/NJ	800-941-4647
Member Handbook	UHCCommunityPlan.com/NJ > Go to Plan Details, then Member Resources, View Available Resource	
Provider Services	UHCprovider.com	888-362-3368
Prior Authorization	UHCprovider.com/paan	888-362-3368
UnitedHealthcare Dual Complete® ONE (Medicare)	UHCprovider.com/njcommunityplan > Dual Complete® Special Needs Plan	888-362-3368

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

Benefit information

Call Provider Services to obtain prior authorization when needed. Non-participating care providers always require prior authorization for all covered services.

NJ FamilyCare/Medicaid

Click UHCCommunityPlan.com/NJ to view member benefit coverage information. Click "Medicaid Plans" for NJ FamilyCare benefit information and "Dual Eligible Plans" for UnitedHealthcare Dual Complete® ONE.

Benefits are also listed in the Member Handbook starting on page 32. Find the Member Handbook on UHCCommunityPlan.com/NJ > NJ FamilyCare > Member Handbook (under Member Information).

Dual Complete® ONE (Medicare)

For a full picture of covered UnitedHealthcare Dual Complete® ONE (Medicare) benefits, review the chart found in the plan's Evidence of Coverage (EOC) found on UHCCommunityPlan.com/NJ > UnitedHealthcare Dual Complete® ONE (HMO D-SNP) > Downloadable Resources > Evidence of Coverage. Chapter 4, Medical Benefits Chart (what is covered) of the EOC outlines covered Medicare services, services where both Medicare and Medicaid are covered, and services not covered. Or you can visit UHCprovider.com/eligibility to view detailed benefits information.

For a summary of benefits, go to UHCCommunityplan.com/nj > UnitedHealthcare Dual Complete® ONE (HMO D-SNP) > Downloadable Resources > Summary of Benefits.

Dual Complete® ONE (Medicare) members may also receive additional benefits such as:

- Renew Active® Fitness Program
- Credit for over-the-counter (OTC) medications and food
- 24/7 nurse hotline
- Personal emergency response system (PERS)

Visit UHCprovider.com/njcommunityplan > UnitedHealthcare Dual Complete® Special Needs Plans > Resource Materials > Benefit Flyer.

For more information about UnitedHealthcare Dual Complete® ONE (Medicare), visit uhcprovider.com/njcommunityplan > Plan Resource Materials for Frequently Asked Quetions (FAQs) and Quick Reference Guides (QRGs).

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NJ FamilyCare/Medicaid Benefits

The following charts display UnitedHealthcare Community Plan of New Jersey NJ FamilyCare/Medicaid benefits.

Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Abortions	Covered by FFS. Abortions and related services, including surgical procedure; anesthesia; history and physical exam; and lab tests.	Covered by FFS. Abortions and related services, including surgical procedure; anesthesia; history and physical exam; and lab tests.	Covered by FFS. Abortions and related services, including surgical procedure; anesthesia; history and physical exam; and lab tests.	Covered by FFS. Abortions and related services, including surgical procedure; anesthesia; history and physical exam; and lab tests.
Acupuncture	Covered by UnitedHealthcare Community Plan.	Covered by UnitedHealthcare Community Plan.	Covered by UnitedHealthcare Community Plan.	Covered by UnitedHealthcare Community Plan.
Autism Services	Covered by UnitedHealthcare Community Plan and FFS. Only covered for members under 21 years of age with Autism Spectrum Disorder. Covered services include Applied Behavioral Analysis (ABA) treatment; augmentative and alternative communication services and devices; Sensory Integration (SI) services; allied health services (physical therapy, occupational therapy and speech therapy); and developmental relationship-based services, including Developmental, Individual-differences, and Relationship-based model (DIR®), DIRFloortime and the Greenspan approach therapy.	Covered by UnitedHealthcare Community Plan and FFS. Only covered for members under 21 years of age with Autism Spectrum Disorder. Covered services include ABA treatment; augmentative and alternative communication services and devices; SI services; allied health services); and developmental relationship-based services, including DIR®, DIRFloortime and the Greenspan approach therapy.	Covered by UnitedHealthcare Community Plan and FFS. Only covered for members under 21 years of age with Autism Spectrum Disorder. Covered services include ABA treatment; augmentative and alternative communication services and devices; SI services; allied health services; and developmental relationship-based services, including DIR®, DIRFloortime and the Greenspan approach therapy.	Covered by UnitedHealthcare Community Plan and FFS. Only covered for members under 21 years of age with Autism Spectrum Disorder. Covered services include ABA treatment; augmentative and alternative communication services and devices; SI services; allied health services; and developmental relationship-based services, including DIR®, DIRFloortime and the Greenspan approach therapy.

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Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Blood and Blood Products	Covered. Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.	Covered. Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.	Covered. Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.	Covered. Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.
Bone Mass Measurement	Covered. Covers 1 measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.	Covered. Covers 1 measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.	Covered. Covers 1 measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.	Covered. Covers 1 measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.
Cardiovascular Screenings	Covered. For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary.	Covered. For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary.	Covered. For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary.	Covered. For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary.
Chiropractic Services	Covered. Covers manipulation of the spine.	Covered. Covers manipulation of the spine.	Covered. Covers manipulation of the spine.	Covered. Covers manipulation of the spine.
Colorectal Screening	Covered. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 45 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer.	Covered. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 45 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer.	Covered. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 45 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer.	Covered. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 45 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer.

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Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
• Barium Enema	Covered. When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months.	Covered. When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months.	Covered. When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months.	Covered. When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months.
• Colonoscopy	Covered. Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy.	Covered. Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy.	Covered. Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy.	Covered. Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy.
• Fecal Occult Blood Test	Covered. Covered once every 12 months.	Covered. Covered once every 12 months.	Covered. Covered once every 12 months.	Covered. Covered once every 12 months.
• Flexible Sigmoidoscopy	Covered. Covered once every 48 months.	Covered. Covered once every 48 months.	Covered. Covered once every 48 months.	Covered. Covered once every 48 months.

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Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Dental Services	Covered. Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity. Examples of covered services include oral evaluations (examinations), X-rays and other diagnostic imaging, dental cleaning (prophylaxis), topical fluoride treatments, fillings, crowns, root canal therapy, scaling and root planing, complete and partial dentures, oral surgical procedures (to include extractions), intravenous anesthesia/ sedation (where medically necessary for oral surgical procedures).	Covered. Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity. Examples of covered services include oral evaluations (examinations), X-rays and other diagnostic imaging, dental cleaning (prophylaxis), topical fluoride treatments, fillings, crowns, root canal therapy, scaling and root planing, complete and partial dentures, oral surgical procedures (to include extractions), intravenous anesthesia/ sedation (where medically necessary for oral surgical procedures).	Covered. Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity. Examples of covered services include oral evaluations (examinations), X-rays and other diagnostic imaging, dental cleaning (prophylaxis), topical fluoride treatments, fillings, crowns, root canal therapy, scaling and root planing, complete and partial dentures, oral surgical procedures (to include extractions), intravenous anesthesia/sedation (where medically necessary for oral surgical procedures).	Covered. Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity. Examples of covered services include oral evaluations (examinations), X-rays and other diagnostic imaging, dental cleaning (prophylaxis), topical fluoride treatments, fillings, crowns, root canal therapy, scaling and root planing, complete and partial dentures, oral surgical procedures (to include extractions), intravenous anesthesia/sedation (where medically necessary for oral surgical procedures).

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Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Dental Services (continued)	Dental examinations, cleanings, fluoride treatment and any necessary X-rays are covered twice per rolling year. Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity. Children should have their first dental exam when they are 1 year old or when they get their first tooth, whichever comes first.	Dental examinations, cleanings, fluoride treatment and any necessary X-rays are covered twice per rolling year. Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity. Children should have their first dental exam when they are 1 year old or when they get their first tooth, whichever comes first.	Dental examinations, cleanings, fluoride treatment and any necessary X-rays are covered twice per rolling year. Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity. Children should have their first dental exam when they are 1 year old or when they get their first tooth, whichever comes first. NJ FamilyCare C and D members have a $5 copay per dental visit (except for diagnostic and preventive services).	Dental examinations, cleanings, fluoride treatment and any necessary X-rays are covered twice per rolling year. Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity. Children should have their first dental exam when they are 1 year old or when they get their first tooth, whichever comes first. NJ FamilyCare C and D members have a $5 copay per dental visit (except for diagnostic and preventive services).

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Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Diabetes Screenings	Covered. Screening is covered (including fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to 2 diabetes screenings every 12 months.	Covered. Screening is covered (including fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to 2 diabetes screenings every 12 months.	Covered. Screening is covered (including fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to 2 diabetes screenings every 12 months.	Covered. Screening is covered (including fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to 2 diabetes screenings every 12 months.
Diabetes Supplies	Covered. Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or pedorthist.	Covered. Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or pedorthist.	Covered. Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or pedorthist.	Covered. Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or pedorthist.

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Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Diabetes Testing and Monitoring	Covered. Covers yearly eye exams for diabetic retinopathy, as well as foot exams every 6 months for members with diabetic peripheral neuropathy and loss of protective sensations.	Covered. Covers yearly eye exams for diabetic retinopathy, as well as foot exams every 6 months for members with diabetic peripheral neuropathy and loss of protective sensations.	Covered. Covers yearly eye exams for diabetic retinopathy, as well as foot exams every 6 months for members with diabetic peripheral neuropathy and loss of protective sensations.	Covered. Covers yearly eye exams for diabetic retinopathy, as well as foot exams every 6 months for members with diabetic peripheral neuropathy and loss of protective sensations.
Diagnostic and Therapeutic Radiology and Laboratory Services	Covered. Covered, including CT scans, MRIs, EKGs, and X-rays.	Covered. Covered, including CT scans, MRIs, EKGs, and X-rays.	Covered. Covered, including CT scans, MRIs, EKGs, and X-rays.	Covered. Covered, including CT scans, MRIs, EKGs, and X-rays.
Durable Medical Equipment (DME)	Covered.	Covered.	Covered.	Covered.
EmergencyCare	Covered. Covers emergency department and physician services.	Covered. Covers emergency department and physician services.	Covered. Covers emergency department and physician services. NJ FamilyCare C members have a $10 copayment.	Covered. Covers emergency department and physician services. NJ FamilyCare D members have a $35 copayment.

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Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
EPSDT (Early and Periodic Screening, Diagnostic and Treatment)	Covered. Coverage includes (but is not limited to) well child care, preventive screenings, medical examinations, dental, vision and hearing screenings and services (as well as any treatment identified as necessary as a result of examinations or screenings), immunizations (including the full childhood immunization schedule), lead screening, and private duty nursing services. Private duty nursing is covered for eligible EPSDT beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need. The NJ Smiles program allows non-dental providers to perform oral screenings, caries risk assessments, anticipatory guidance and fluoride varnish applications for children through 5 years old.	Covered. For NJ FamilyCare B, C, and D members, coverage includes early and periodic screening and diagnostic medical examinations, dental, vision, hearing, and lead screening services. For NJ FamilyCare B, C, and D members, coverage for treatment services identified as necessary through an examination is limited to those services that are available under the plan's benefit package, or specified services under the FFS program. The NJ Smiles program allows non-dental providers to perform oral screenings, caries risk assessments, anticipatory guidance and fluoride varnish applications for children through 5 years old.	Covered. For NJ FamilyCare B, C, and D members, coverage includes early and periodic screening and diagnostic medical examinations, dental, vision, hearing, and lead screening services. For NJ FamilyCare B, C, and D members, coverage for treatment services identified as necessary through an examination is limited to those services that are available under the plan's benefit package, or specified services under the FFS program. The NJ Smiles program allows non-dental providers to perform oral screenings, caries risk assessments, anticipatory guidance and fluoride varnish applications for children through 5 years old.	Covered. For NJ FamilyCare B, C, and D members, coverage includes early and periodic screening and diagnostic medical examinations, dental, vision, hearing, and lead screening services. For NJ FamilyCare B, C, and D members, coverage for treatment services identified as necessary through an examination is limited to those services that are available under the plan's benefit package, or specified services under the FFS program. The NJ Smiles program allows non-dental providers to perform oral screenings, caries risk assessments, anticipatory guidance and fluoride varnish applications for children through 5 years old.

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Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Family Planning Services and Supplies	Covered. The plan shall reimburse family planning services provided by non-participating network providers based on the Medicaid fee schedule. The family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, or a medical visit to change the method of contraception. Also includes, but is not limited to: sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing.	Covered. The plan shall reimburse family planning services provided by non-participating network providers based on the Medicaid fee schedule. The family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, or a medical visit to change the method of contraception. Also includes, but is not limited to: sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing.	Covered. The plan shall reimburse family planning services provided by non-participating network providers based on the Medicaid fee schedule. The family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, or a medical visit to change the method of contraception. Also includes, but is not limited to: sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing.	Covered. The plan shall reimburse family planning services provided by non-participating network providers based on the Medicaid fee schedule. The family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, or a medical visit to change the method of contraception. Also includes, but is not limited to: sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing.

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Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Family Planning Services and Supplies (continued)	Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered (whether furnished by in-network or out-of-network providers).	Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered (whether furnished by in-network or out-of-network providers).	Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered (whether furnished by in-network or out-of-network providers).	Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered (whether furnished by in-network or out-of-network providers).
Federally Qualified Health Centers (FQHC)	Covered. Includes outpatient and primary care services from community-based organizations.	Covered. Includes outpatient and primary care services from community-based organizations.	Covered. Includes outpatient and primary care services from community-based organizations.	Covered. Includes outpatient and primary care services from community-based organizations.

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Hearing Services/ Audiology	Covered. Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration. Hearing aids, as well as associated accessories and supplies, are covered.	Covered. Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration. Hearing aids, as well as associated accessories and supplies, are covered.	Covered. Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration. Hearing aids, as well as associated accessories and supplies, are covered.	Covered. Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration. Hearing aids, as well as associated accessories and supplies, are covered.
Home Health Agency Services	Covered. Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.	Covered. Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.	Covered. Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.	Covered. Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.

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Hospice Care Services	Covered. Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling. • Covered in the community as well as in institutional settings • Room and board included only when services are delivered in institutional (non-residence) settings. Hospice care for enrollees under 21 years of age shall cover both palliative and curative care **NOTE:** Any care unrelated to the enrollee's terminal condition is covered in the same manner as it would be under other circumstances.	Covered. Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling. • Covered in the community as well as in institutional settings • Room and board included only when services are delivered in institutional (non- residence) settings. Hospice care for enrollees under 21 years of age shall cover both palliative and curative care **NOTE:** Any care unrelated to the enrollee's terminal condition is covered in the same manner as it would be under other circumstances.	Covered. Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling. • Covered in the community as well as in institutional settings • Room and board included only when services are delivered in institutional (non-residence) settings. Hospice care for enrollees under 21 years of age shall cover both palliative and curative care **NOTE:** Any care unrelated to the enrollee's terminal condition is covered in the same manner as it would be under other circumstances.	Covered. Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling. • Covered in the community as well as in institutional settings • Room and board included only when services are delivered in institutional (non-residence) settings. Hospice care for enrollees under 21 years of age shall cover both palliative and curative care **NOTE:** Any care unrelated to the enrollee's terminal condition is covered in the same manner as it would be under other circumstances.
Immunizations	Covered. Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered as a component of EPSDT.	Covered. Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered as a component of EPSDT.	Covered. Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered as a component of EPSDT.	Covered. Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered as a component of EPSDT.

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Inpatient Hospital Care	Covered. Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private room accommodations; physicians' and surgeons' services; anesthesia; lab, X-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital.	Covered. Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private room accommodations; physicians' and surgeons' services; anesthesia; lab, X-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital.	Covered. Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private room accommodations; physicians' and surgeons' services; anesthesia; lab, X-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital.	Covered. Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private room accommodations; physicians' and surgeons' services; anesthesia; lab, X-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital.
• AcuteCare	Covered. Includes room and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance).	Covered. Includes room and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance).	Covered. Includes room and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance).	Covered. Includes room and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance).
• Psychiatric	For coverage details, please refer to the Behavioral Health chart.	For coverage details, please refer to the Behavioral Health chart.	For coverage details, please refer to the Behavioral Health chart.	For coverage details, please refer to the Behavioral Health chart.

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Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Mammograms	Covered. Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary.	Covered. Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary.	Covered. Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary.	Covered. Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary.
Maternal and Child Health Services	Covered. Covers medical services for perinatal care and related newborn care and hearing screenings. This includes midwifery care, CenteringPregnancy, immediate postpartum long-acting reversible contraception (LARC) and all dental services. Dental services include dental preventive care and medically necessary treatment services. Also covers childbirth education, doula care, lactation support. Breastfeeding equipment, including breast pumps and accessories, are covered as a DME benefit.	Covered. Covers medical services for perinatal care and related newborn care and hearing screenings. This includes midwifery care, CenteringPregnancy, immediate postpartum LARC and all dental services. Dental services include dental preventive care and medically necessary treatment services. Also covers childbirth education, doula care, lactation support. Breastfeeding equipment, including breast pumps and accessories, are covered as a DME benefit.	Covered. Covers medical services for perinatal care and related newborn care and hearing screenings. This includes midwifery care, CenteringPregnancy, immediate postpartum LARC and all dental services. Dental services include dental preventive care and medically necessary treatment services. Also covers childbirth education, doula care, lactation support. Breastfeeding equipment, including breast pumps and accessories, are covered as a DME benefit.	Covered. Covers medical services for perinatal care and related newborn care and hearing screenings. This includes midwifery care, CenteringPregnancy, immediate postpartum LARC and all dental services. Dental services include dental preventive care and medically necessary treatment services. Also covers childbirth education, doula care, lactation support. Breastfeeding equipment, including breast pumps and accessories, are covered as a DME benefit.

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Medical Day Care (Adult Day Health Services)	Covered. A program that provides preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory (outpatient) care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.
Nurse Midwife Services	Covered.	Covered.	Covered. $5 copayment for each visit (except for prenatal care visits).	Covered. $5 copayment for each visit (except for prenatal care visits).
Nursing Facility Services	Covered. Members may have patient pay liability.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.
• Long Term (Custodial Care)	Covered. Covered for those who need Custodial Level of Care (MLTSS). Members may have patient pay liability.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.
• Nursing Facility (Hospice)	Covered. Hospice care can be covered in a Nursing Facility setting. *See Hospice Care Services.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.
• Nursing Facility (Skilled)	Covered. Includes coverage for Rehabilitative Services that take place in a Nursing Facility setting.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.

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• Nursing Facility (SpecialCare)	Covered. Care in a Special Care Nursing Facility (SCNF) or a separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility is covered for members who have been determined to require intensive nursing facility services beyond the scope of a conventional nursing facility.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.
Organ Transplants	Covered. Covers medically necessary organ transplants including liver, lung, heart, heart-lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants). Includes donor and recipient costs.	Covered. Covers medically necessary organ transplants including liver, lung, heart, heart-lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants). Includes donor and recipient costs.	Covered. Covers medically necessary organ transplants including liver, lung, heart, heart-lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants). Includes donor and recipient costs.	Covered. Covers medically necessary organ transplants including liver, lung, heart, heart-lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants). Includes donor and recipient costs.
Outpatient Surgery	Covered.	Covered.	Covered.	Covered.
Outpatient Hospital/Clinic Visits	Covered.	Covered.	Covered. $5 copayment per visit (no copayment if the visit is for preventive services).	Covered. $5 copayment per visit (no copayment if the visit is for preventive services).
Outpatient Rehabilitation (Occupational Therapy, Physical Therapy, Speech Language Pathology)	Covered. Covers physical therapy, occupational therapy, speech pathology, and cognitive rehabilitation therapy.	Covered. Covers physical, occupational, and speech/language therapy. For NJ FamilyCare B, C, and D members, limited to 60 days per therapy per calendar year.	Covered. Covers physical, occupational, and speech/language therapy. For NJ FamilyCare B, C, and D members, limited to 60 days per therapy per calendar year.	Covered. Covers physical, occupational, and speech/language therapy. For NJ FamilyCare B, C, and D members, limited to 60 days per therapy per calendar year.

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Pap Smears and Pelvic Exams	Covered. Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.	Covered. Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.	Covered. Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.	Covered. Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.
Personal Care Assistance	Covered. Covers health-related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a beneficiary's written plan of care.	Not covered.	Not covered.	Not covered.

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Podiatry	Covered. Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.	Covered. Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.	Covered. Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. $5 copayment per visit for NJ FamilyCare C and D members. Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.	Covered. Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. $5 copayment per visit for NJ FamilyCare C and D members. Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.
Prescription Drugs	Covered. Includes prescription drugs (legend and non- legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride), including therapeutic vitamins, such as high-potency A, D, E, iron, zinc, and minerals, including potassium and niacin. All blood clotting factors are covered.	Covered. Includes prescription drugs (legend and non- legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride), including therapeutic vitamins, such as high-potency A, D, E, iron, zinc, and minerals, including potassium and niacin. All blood clotting factors are covered.	Covered. Includes prescription drugs (legend and non- legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride), including therapeutic vitamins, such as high-potency A, D, E, iron, zinc, and minerals, including potassium and niacin. All blood clotting factors are covered. For NJ FamilyCare C and D members, there is a $1 copayment for generic drugs, and a $5 copayment for brand-name drugs.	Covered. Includes prescription drugs (legend and non- legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride), including therapeutic vitamins, such as high-potency A, D, E, iron, zinc, and minerals, including potassium and niacin. All blood clotting factors are covered. For NJ FamilyCare C and D members, there is a $1 copayment for generic drugs, and a $5 copayment for brand-name drugs.

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Physician Services – Primary and Specialty Care	Covered. Covers medically necessary services and certain preventive services in outpatient settings.	Covered. Covers medically necessary services and certain preventive services in outpatient settings.	Covered. Covers medically necessary services and certain preventive services in outpatient settings. $5 copayment for each visit (except for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment, age-appropriate immunizations; prenatal care; and pap smears when appropriate).	Covered. Covers medically necessary services and certain preventive services in outpatient settings. $5 copayment for each visit (except for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment, age-appropriate immunizations; prenatal care; and pap smears when appropriate).
Private Duty Nursing	Covered. Private duty nursing is covered for members who live in the community and whose medical condition and treatment plan justify the need. Private duty nursing is only available to EPSDT beneficiaries under 21 years of age and to members with MLTSS (of any age).	Covered. Private duty nursing is covered for members who live in the community and whose medical condition and treatment plan justify the need. Private duty nursing is only available to EPSDT beneficiaries under 21 years of age and to members with MLTSS (of any age).	Covered. Private duty nursing is covered for members who live in the community and whose medical condition and treatment plan justify the need. Private duty nursing is only available to EPSDT beneficiaries under 21 years of age and to members with MLTSS (of any age).	Covered. Private duty nursing is covered for members who live in the community and whose medical condition and treatment plan justify the need. Private duty nursing is only available to EPSDT beneficiaries under 21 years of age and to members with MLTSS (of any age).
Prostate Cancer Screening	Covered. Covers annual diagnostic examination including digital rectal exam and Prostate Specific Antigen (PSA) test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors.	Covered. Covers annual diagnostic examination including digital rectal exam and PSA test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors.	Covered. Covers annual diagnostic examination including digital rectal exam and PSA test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors.	Covered. Covers annual diagnostic examination including digital rectal exam and PSA test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors.

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Prosthetics and Orthotics	Covered. Coverage includes arm, leg, back, and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids, and dentures.	Covered. Coverage includes arm, leg, back, and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids, and dentures.	Covered. Coverage includes arm, leg, back, and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids, and dentures.	Covered. Coverage includes arm, leg, back, and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids, and dentures.
Renal Dialysis	Covered.	Covered.	Covered.	Covered.
Routine Annual Physical Exams	Covered.	Covered.	Covered. No copayments.	Covered. No copayments.
Sex Assault Examinations	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.

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Smoking/Vaping Cessation	Covered. Coverage includes counseling to help you quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers, and nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum and nicotine lozenges. The following resource is available to support members in quitting smoking/ vaping: NJ Quitline: Call toll-free 866-NJ-STOPS (866-657-8677) (TTY 711), Monday through Friday, from 8 a.m. to 9 p.m. (except holidays), Saturday, from 8 a.m. to 7 p.m., and Sunday 9 a.m. to 5 p.m. ET. The program supports 26 different languages. Learn more at njquitline.org.	Covered. Coverage includes counseling to help you quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers, and nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum and nicotine lozenges. The following resource is available to support members in quitting smoking/ vaping: NJ Quitline: Call toll-free 866-NJ-STOPS (866-657-8677) (TTY 711), Monday through Friday, from 8 a.m. to 9 p.m. (except holidays), Saturday, from 8 a.m. to 7 p.m., and Sunday 9 a.m. to 5 p.m. ET. The program supports 26 different languages. Learn more at njquitline.org.	Covered. Coverage includes counseling to help you quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers, and nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum and nicotine lozenges. The following resource is available to support members in quitting smoking/ vaping: NJ Quitline: Call toll-free 866-NJ-STOPS (866-657-8677) (TTY 711), Monday through Friday, from 8 a.m. to 9 p.m. (except holidays), Saturday, from 8 a.m. to 7 p.m., and Sunday 9 a.m. to 5 p.m. ET. The program supports 26 different languages. Learn more at njquitline.org.	Covered. Coverage includes counseling to help you quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers, and nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum and nicotine lozenges. The following resource is available to support members in quitting smoking/ vaping: NJ Quitline: Call toll-free 866-NJ-STOPS (866-657-8677) (TTY 711), Monday through Friday, from 8 a.m. to 9 p.m. (except holidays), Saturday, from 8 a.m. to 7 p.m., and Sunday 9 a.m. to 5 p.m. ET. The program supports 26 different languages. Learn more at njquitline.org.
Transportation (Emergency) (Ambulance, Mobile Intensive Care Unit)	Covered. Coverage for emergency care, including ambulance and Mobile Intensive Care Unit.	Covered. Coverage for emergency care, including ambulance and Mobile Intensive Care Unit.	Covered. Coverage for emergency care, including ambulance and Mobile Intensive Care Unit.	Covered. Coverage for emergency care, including ambulance and Mobile Intensive Care Unit.

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Transportation (Non-Emergent) (Non-Emergency Ambulance, Medical Assistance Vehicles/MAV, Livery, Clinic)	Covered by FFS. Medicaid Fee-for-Service covers all non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life support (BLS) ambulance (stretcher). Livery transportation services, such as bus and train fare or passes, car service and reimbursement for mileage, are also covered. For COVID-related services, livery/car transportation services, ambulatory, ambulatory with assistance, wheelchair, stretcher, mass transit/bus passes, and mileage reimbursement are covered. May require medical orders or other coordination by the health plan, PCP, or providers. ModivCare transportation services are covered for NJ FamilyCare A, ABP, B, C, and D members. All transportation including livery is available for all members including B, C and D.	Covered by FFS. Medicaid Fee-for-Service covers non-emergency transportation, such as MAVs, and non-emergency BLS ambulance (stretcher). Livery transportation services, such as bus and train fare or passes, car service and reimbursement for mileage, are also covered. For COVID-related services, livery/car transportation services, ambulatory, ambulatory with assistance, wheelchair, stretcher, mass transit/bus passes, and mileage reimbursement are covered. May require medical orders or other coordination by the health plan, PCP, or providers. ModivCare transportation services are covered for NJ FamilyCare A, ABP, B, C, and D members. All transportation including livery is available for all members including B, C and D.	Covered by FFS. Medicaid Fee-for-Service covers non-emergency transportation, such as MAVs, and non-emergency BLS ambulance (stretcher). Livery transportation services, such as bus and train fare or passes, car service and reimbursement for mileage, are also covered. For COVID-related services, livery/car transportation services, ambulatory, ambulatory with assistance, wheelchair, stretcher, mass transit/bus passes, and mileage reimbursement are covered. May require medical orders or other coordination by the health plan, PCP, or providers. ModivCare transportation services are covered for NJ FamilyCare A, ABP, B, C, and D members. All transportation including livery is available for all members including B, C and D.	Covered by FFS. Medicaid Fee-for-Service covers non-emergency transportation, such as MAVs, and non-emergency BLS ambulance (stretcher). Livery transportation services, such as bus and train fare or passes, car service and reimbursement for mileage, are also covered. For COVID-related services, livery/car transportation services, ambulatory, ambulatory with assistance, wheelchair, stretcher, mass transit/bus passes, and mileage reimbursement are covered. May require medical orders or other coordination by the health plan, PCP, or providers. ModivCare transportation services are covered for NJ FamilyCare A, ABP, B, C, and D members. All transportation including livery is available for all members including B, C and D.

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Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Urgent Medical Care	Covered. Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse).	Covered. Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse).	Covered. Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse). NOTE: There may be a $5 copayment for urgent medical care provided by a physician, optometrist, dentist, or nurse practitioner.	Covered. Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse). NOTE: There may be a $5 copayment for urgent medical care provided by a physician, optometrist, dentist, or nurse practitioner.

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Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Vision Care Services	Covered. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Yearly exams for diabetic retinopathy are covered for member with diabetes. A glaucoma eye test is covered every 5 years for those 35 or older, and every 12 months for those at high risk for glaucoma. Certain additional diagnostic tests are covered for members with age-related macular degeneration.	Covered. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Yearly exams for diabetic retinopathy are covered for member with diabetes. A glaucoma eye test is covered every 5 years for those 35 or older, and every 12 months for those at high risk for glaucoma. Certain additional diagnostic tests are covered for members with age-related macular degeneration.	Covered. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Yearly exams for diabetic retinopathy are covered for member with diabetes. A glaucoma eye test is covered every 5 years for those 35 or older, and every 12 months for those at high risk for glaucoma. Certain additional diagnostic tests are covered for members with age-related macular degeneration. $5 copayment per visit for optometrist services.	Covered. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Yearly exams for diabetic retinopathy are covered for member with diabetes. A glaucoma eye test is covered every 5 years for those 35 or older, and every 12 months for those at high risk for glaucoma. Certain additional diagnostic tests are covered for members with age-related macular degeneration. $5 copayment per visit for optometrist services.

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Service/ Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
• Corrective Lenses	Covered. Covers 1 pair of lenses/ frames or contact lenses every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. Covers 1 pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.	Covered. Covers 1 pair of lenses/ frames or contact lenses every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. Covers 1 pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.	Covered. Covers 1 pair of lenses/ frames or contact lenses every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. Covers 1 pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.	Covered. Covers 1 pair of lenses/ frames or contact lenses every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. Covers 1 pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.

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Behavioral health benefits

Service/ Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ Family-Care Plan A/ABP	NJ Family-Care Plan B	NJ Family-Care Plan C	NJ FamilyCare Plan D
Mental Health					
Adult Mental Health Rehabilitation (Supervised Group Homes and Apartments)	Covered.	Covered by FFS.	Not covered for NJ FamilyCare B, C and D members.	Not covered for NJ FamilyCare B, C and D members.	Not covered for NJ FamilyCare B, C and D members.
Inpatient Psychiatric	Inpatient Psychiatric services are covered by UnitedHealthcare for members in DDD, MLTSS or FIDE SNP.	Covered. Coverage includes services in a general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF) or critical access hospital.	Covered. Coverage includes services in a general hospital, psychiatric unit of an acute care hospital, STCF or critical access hospital.	Covered. Coverage includes services in a general hospital, psychiatric unit of an acute care hospital, STCF or critical access hospital.	Covered. Coverage includes services in a general hospital, psychiatric unit of an acute care hospital, STCF or critical access hospital.
Independent Practitioner Network or IPN (Psychiatrist, Psychologist, or APN)	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.
Outpatient Mental Health	Covered.	Covered by FFS. Coverage includes services received in a general hospital outpatient setting, mental health outpatient clinic/hospital services, and outpatient services received in a private psychiatric hospital. Services in these settings are covered for members of all ages.	Covered by FFS. Coverage includes services received in a general hospital outpatient setting, mental health outpatient clinic/ hospital services, and outpatient services received in a private psychiatric hospital. Services in these settings are covered for members of all ages.	Covered by FFS. Coverage includes services received in a general hospital outpatient setting, mental health outpatient clinic/ hospital services, and outpatient services received in a private psychiatric hospital. Services in these settings are covered for members of all ages.	Covered by FFS. Coverage includes services received in a general hospital outpatient setting, mental health outpatient clinic/ hospital services, and outpatient services received in a private psychiatric hospital. Services in these settings are covered for members of all ages.

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Service/ Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ Family-Care Plan A/ABP	NJ Family-Care Plan B	NJ Family-Care Plan C	NJ FamilyCare Plan D
Partial Care (Mental Health)	Covered.	Covered by FFS. Limited to 25 hours per week (5 hours per day, 5 days per week). Prior authorization required.	Covered by FFS. Limited to 25 hours per week (5 hours per day, 5 days per week). Prior authorization required.	Covered by FFS. Limited to 25 hours per week (5 hours per day, 5 days per week). Prior authorization required.	Covered by FFS. Limited to 25 hours per week (5 hours per day, 5 days per week). Prior authorization required.
Acute Partial Hospitalization Mental Health/ Psychiatric Partial Hospitalization	Covered.	Covered by FFS. Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Prior authorization required for acute partial hospitalization.	Covered by FFS. Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Prior authorization required for acute partial hospitalization.	Covered by FFS. Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Prior authorization required for acute partial hospitalization.	Covered by FFS. Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Prior authorization required for acute partial hospitalization.
Psychiatric Emergency Services (PES)/ Affiliated Emergency Services (AES)	Covered by FFS for all members.	Covered by FFS for all members.	Covered by FFS for all members.	Covered by FFS for all members.	Covered by FFS for all members.

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Service/ Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ Family-Care Plan A/ ABP	NJ Family-Care Plan B	NJ Family-Care Plan C	NJ Family-Care Plan D
Substance Use Disorder Treatment **The American Society of Addiction Medicine (ASAM) provides guidelines that are used to help determine what kind of substance use disorder (SUD) treatment is appropriate for a person who needs SUD services. Some of the services in this chart show the ASAM level associated with them (which includes "ASAM" followed by a number).**					
Ambulatory Withdrawal Management with Extended On-Site Monitoring/ Ambulatory Detoxification ASAM 2 – WM	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.
Inpatient Medical Detox/ Medically Managed Inpatient Withdrawal Management (Hospital-based) ASAM 4 – WM	Covered for all members.	Covered for all members.	Covered for all members.	Covered for all members.	Covered for all members.
Long Term Residential (LTR) ASAM 3.5	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.
Office-Based Addiction Treatment (OBAT)	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.

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Service/ Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ Family-Care Plan A/ ABP	NJ Family-Care Plan B	NJ Family-Care Plan C	NJ Family-Care Plan D
Non-Medical Detoxification/ Non-Hospital Based Withdrawal Management ASAM 3.7 – WM	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.
Opioid Treatment Services	Covered.	Covered by FFS. Includes coverage for methadone medication assisted treatment (MAT) and non-methadone MAT. Coverage for non-methadone MAT includes FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; SUD counseling; individual and group therapy; and toxicology testing.	Covered by FFS. Includes coverage for methadone MAT and non-methadone MAT. Coverage for non-methadone MAT includes FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; SUD counseling; individual and group therapy; and toxicology testing.	Covered by FFS. Includes coverage for methadone MAT and non-methadone MAT. Coverage for non-methadone MAT includes FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; SUD counseling; individual and group therapy; and toxicology testing.	Covered by FFS. Includes coverage for Methadone MAT and non-methadone MAT. Coverage for non-methadone MAT includes FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; SUD counseling; individual and group therapy; and toxicology testing.
SUD Intensive Outpatient (IOP) ASAM 2.1	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.
SUD Outpatient (OP) ASAM 1	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.
SUD Partial Care (PC) ASAM2.5	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.

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Service/ Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ Family-Care Plan A/ ABP	NJ Family-Care Plan B	NJ Family-Care Plan C	NJ Family-Care Plan D
SUD Short Term Residential (STR) ASAM 3.7	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.

Choosing a PCP

Every UnitedHealthcare Community Plan of New Jersey member must select a participating PCP. If a new member does not select a PCP, we assign the member to a PCP, based on geographic location.

Member-initiated transfers

We encourage members to select a PCP they intend to remain with for a long time. However, members may change their PCP at any time by calling **Member Services**. Clients of the Division of Youth and Family Services (DYFS) may have a limit on PCP changes.

Member requests for PCP changes are effective immediately. Capitated providers' payments will be prorated and paid retroactively based on the day of the month the change occurred.

UnitedHealthcare Dual Complete® ONE (Medicare) member requests for PCP changes are effective within 24 hours. It typically takes 1-2 weeks for the member to receive a new ID card.

We monitor the member transfer rates for each PCP and PCP site by recording the member's reason for the transfer. Our Quality Management Department investigates quality-related transfer requests.

Member assignment

Assignment to UnitedHealthcare Community Plan

New Jersey DHS assigns eligible members to UnitedHealthcare Community Plan daily. We manage the member's care on the date the member is enrolled until the member is disenrolled from UnitedHealthcare Community Plan. New Jersey DHS makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month's end, but at times may occur mid-month.

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

Download a copy of the Member Handbook online by visiting UHCCommunityPlan.com/NJ > **NJ FamilyCare** > Member Handbook or by calling **Provider Services**.

Immediate enrollment changes

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

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

Unborn enrollment changes

Encourage members to notify NJ FamilyCare when they know they are expecting. NJ FamilyCare notifies us daily of an unborn when they learn a woman enrolled with

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us is expecting. The online change report through the New Jersey website indicates the baby's birth. With that information, NJ FamilyCare verifies the birth through the mother. To help speed up the process, the mother should notify NJ FamilyCare when the baby is born.

Members may call NJ FamilyCare at **800-701-0710**.

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

PCP selection

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

Members can go to **myuhc.com/communityplan** > Find a Doctor to look up a care provider.

PCP panel rosters

Once a member has been assigned to a PCP, panel rosters can be viewed electronically on the UnitedHealthcare Provider Portal at **UHCprovider.com**:

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

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

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

We send PCP member rosters to PCPs each month. The roster lists both UnitedHealthcare Community Plan members and UnitedHealthcare Dual Complete® ONE members. It includes each member's name, Member ID number, address, phone number, date of birth, gender, the date of enrollment and a digit rate code associated with the member's category (e.g., 0142 = AFDC Male 2–20 years, 0711 = SSI Aged with Medicare). In addition, it identifies the member's line of business as either: C10, which is UnitedHealthcare Medicaid or C20, which is UnitedHealthcare Dual Complete® ONE (Medicare). At the end of the roster is a statistical summary profiling the PCP's members by line of business.

Deductibles/copayments

Members do not pay a deductible or copayments for covered benefits and services. Do not bill, charge, collect a deposit from, or reimbursement from, or have any recourse against any NJ FamilyCare/Medicaid or UnitedHealthcare Dual Complete® ONE member. UnitedHealthcare Community Plan members may not be balance billed for covered services.

Medically necessary service

UnitedHealthcare Community Plan only reimburses for medically necessary services.

According to New Jersey, medically necessary services and supplies are necessary to:

- Prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition
- Maintain health
- Prevent the onset of an illness, condition, or disability
- Prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity
- Promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age
- Prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee.

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The services provided, as well as the type of provider and setting, must be reflective of the level of services that can be safely provided. They must be consistent with the diagnosis and appropriate to the member's specific medical needs. Services may not be delivered solely for the convenience of the enrollee or service provider. They must be based on good medical practice standards and be generally recognized by the medical scientific community as effective.

Treatment may include mere observation or, where appropriate, no treatment at all. Experimental services or services the medical community generally considers unacceptable are not considered medically necessary.

Medically necessary services provided must be based on peer-reviewed publications, expert pediatric, psychiatric and medical opinion, and medical/pediatric community acceptance.

For pediatric members, the services must be appropriate for their age and health status. The services must aid the member's overall physical and mental growth and development and help achieve or maintain functional capacity. They include those found to be needed as a result of a comprehensive screening visit or an interperiodic encounter whether they are ordinarily covered services for all other Medicaid enrollees.

Member eligibility

We serve members enrolled with New Jersey's Medicaid program. The New Jersey DHS determines program eligibility. An individual who becomes eligible for the program either chooses or is assigned to one of the New Jersey DHS-contracted health plans. Verify the UnitedHealthcare Community Plan member's Medicaid eligibility on day of service before treating them. View eligibility online on the Eligibility and Benefits application on the Provider Portal at **UHCprovider.com/eligibility**.

Dual Complete® ONE (Medicare) member eligibility

If a member has Medicare and Medicaid coverage, it doesn't mean they are automatically enrolled in a dual special needs (D-SNP) plan or have that coverage. However, the member may have UnitedHealthcare Dual Complete® ONE (Medicare) because they've signed an enrollment form stating that they agree to enroll in the plan. A D-SNP member must enroll in a private health insurance plan that offers integrated coverage for both Medicare and Medicaid. UnitedHealthcare Dual Complete® ONE (Medicare) members have their Medicare and Medicaid coverage with UnitedHealthcare Community Plan.

UnitedHealthcare Dual Complete® ONE (Medicare) members are issued a single ID card, which means they're:

- Entitled to Medicare Part A and are enrolled in Medicare Part B.
- Entitled to full Medicaid.
- Enrolled in the UnitedHealthcare Dual Complete® ONE (Medicare) plan because they've signed an enrollment form.
- Familiar with the benefits of the plan because they reviewed them with a licensed UnitedHealthcare Community Plan representative.

You may not need to ask a member with the UnitedHealthcare Dual Complete® ONE (Medicare) ID card for their Medicare and/or Medicaid ID card. The UnitedHealthcare Dual Complete® ONE (Medicare) ID card already represents that they have both Medicare and Medicaid coverage.

Member ID card

We issue an ID card to each member enrolled in the plan. When more than 1 family member enrolls, we issue a separate ID card to each family member.

Check the member's ID card at each visit, and copy both sides for your files. Verify the identity of the person presenting the ID card against some form of photo ID, such as a driver's license, if this is your office practice.

If a fraud, waste and abuse event arises from a care provider or a member because of a member ID card, go to **uhc.com/fraud**. Or you may call the **Fraud and Abuse Hotline**.

The front of the ID card also shows the PCP assignment. If a member does not bring their card, call **Provider Services**. Also document the call in the member's chart. You may not deny services because members do not have their member ID card at the time of service.

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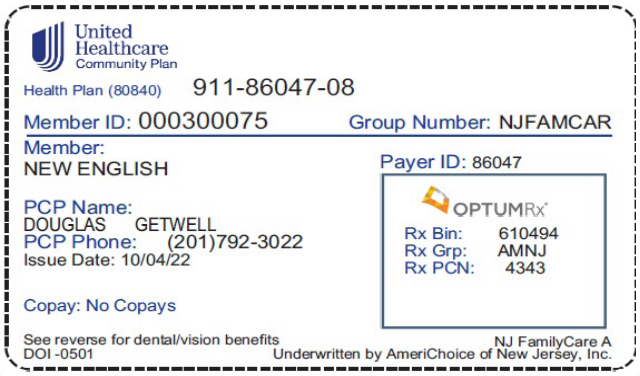
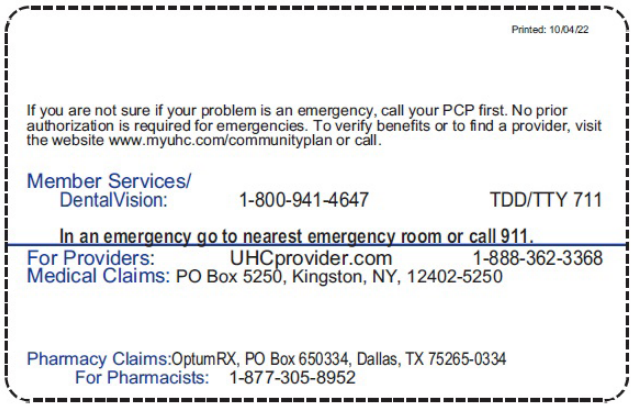
Member identification numbers

Each member receives a 9-digit UnitedHealthcare Community Plan member ID number. For New Jersey Dual Complete® ONE (Medicare), it is the 9-digit UHC Medicaid ID number. Use this number to communicate with us about a specific subscriber/member. The New Jersey DHS Medicaid Number is also on the member ID card.

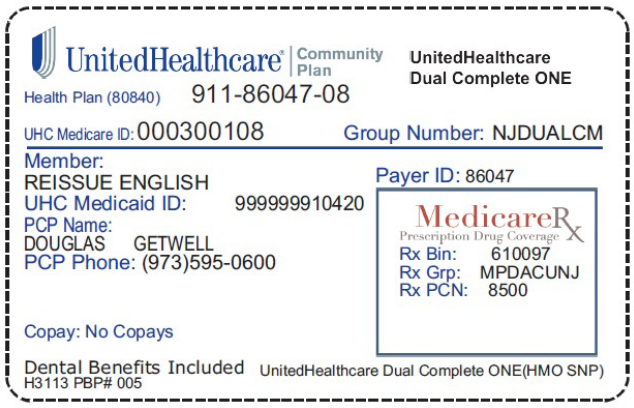
Sample member ID card

NJ FamilyCare/Medicaid





Dual Complete® ONE (Medicare)



PCP or PCD-initiated transfers

A PCP may transfer a member because they cannot start or maintain a professional relationship or if the member is non-compliant. The PCP must provide care for the member until a transfer is complete.

To start a transfer, send a request in writing to our medical director identifying the member and explaining the reason for the request. You can also call Member Services at the number on the back of the member's card. Only make the request after trying and documenting interventions. These include contacting the PCP's office and us to provide the member with education about their rights and responsibilities. Documentation must also include:

- Member ID/Medicaid ID
- Date of birth
- Member address
- Care provider name
- Care provider NPI

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- Care provider address
- Care provider tax ID
- Care provider phone number
- Dates of missed appointments

Email requests to **northeastprteam@uhc.com**. We may review and investigate this request further upon reaching a determination.

A PCP may not request a change because of the member's condition, degree of illness or amount of services required, unless the PCP can justify they cannot deliver quality care to the member. If the medical director approves the transfer, the PCP must continue providing services to the member for 30 days from the date of the letter.

We may contact the member to resolve the issue to help develop a satisfactory PCP-member relationship. If we cannot resolve the issue, we may work with the member to find another PCP. If we can't reach the member by phone, the health plan will notify the member in writing that they have 5 business days to select a new PCP by calling **Member Services**. If the member does not choose a new PCP within 5 business days, the health plan will choose one for them. A new member ID card will be mailed to the member reflecting the new PCP information.

Provider-initiated transfers may also apply to PCDs.

Managing members' disruptive behaviors

For members who exhibit inappropriate, disruptive or threatening behaviors in a care provider's office, behavioral health/substance abuse intervention may be needed. These members may have special needs.

For any member who exhibits inappropriate behavior in a care provider's office, address the immediate need by using de-escalation techniques, as appropriate. If these techniques are not fit for the situation, call 911 or direct the member to their designated county screening center or nearest hospital ER.

Once the appropriate action is addressed, refer the member to Behavioral Health Care Management by calling the Special Needs Hotline toll-free at **877-704-8871** or **973-849-1663**. Our Care Management team will follow-up with the member to assess their needs and refer them to another care provider as appropriate. It will also continue care coordination as needed to help ensure that they have access to ongoing behavioral health services.

Verifying member enrollment

You must check the member's eligibility at the time of service. This includes eligibility with UnitedHealthcare, assignment to you as a PCP, or (if you are a specialist) assignment to the PCP who referred the member to you.

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

- Provider Portal: access the portal through **UHCprovider.com/eligibility.**
- **Provider Services** is available from 8 a.m.-6 p.m. Eastern Time, Monday through Friday.
- **NJ Hotline**: Call **800-676-6562**. UnitedHealthcare is identified as – 082II. NJ FamilyCare members use the Medicaid ID number (CIN).
- PCP Member Roster: Check your current roster for the appropriate UnitedHealthcare product.

For UnitedHealthcare Dual Complete® ONE (Medicare) members, use the member's Medicare number to determine eligibility.

UnitedHealthcare Dual Complete® ONE (Medicare)

A Dual Eligible Special Needs Plan (D-SNP) is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid. For more information about D-SNP, go to **uhc.com/medicaid/dsnp**.

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

Members can learn more at **UHCCommunityPlan.com/nj** > UnitedHealthcare Dual Complete® ONE (HMO D-SNP).

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Chapter 4: Medical Management

Key contacts

Topic	Link	Phone Number
Referrals	UHCprovider.com > Referrals	888-362-3368
Prior Authorization	UHCprovider.com/paan	888-362-3368
Pharmacy	professionals.optumrx.com	800-866-0931
UnitedHealthcare Dental	uhcproviders.com	800-508-4881
Healthy First Steps	uhchealthyfirststeps.com	800-599-5985

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

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

Hospital services

Ambulance services

Air ambulance

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

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

Non-emergent air ambulance requires prior authorization.

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

Emergency ambulance transportation

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

- Injury to their overall health.
- Impairment to bodily functions.
- Dysfunction of a bodily organ or part.

Emergency transports (in- and out-of-network) are covered. They do not require an authorization.

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

Ambulance services for a member receiving inpatient hospital services are not included in the payment to the hospital. They must be billed by the ambulance provider. This includes transporting the member to another facility for services (e.g., diagnostic testing) and returning them to the first hospital for more inpatient care.

Non-emergent transportation services

UnitedHealthcare Community Plan members may get non-emergent transportation services through ModivCare for covered services. Members may get transportation when they are bed-confined before, during and after transport.

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For non-urgent appointments, members must call at least 3 days before their appointment. Members can call **Member Services** to arrange transportation. They may also make reservations by calling **ModivCare** at **866-527-9933** Monday through Friday from 8 a.m.-4:30 p.m. Representatives can schedule urgent reservations at any time.

Non-emergency medical transportation

Non-emergency medical transportation (NEMT) services are available through ModivCare. Transportation is provided by taxi, van, bus or public transit, depending on a member's medical needs. Wheelchair service is provided if required by medical necessity.

Emergency/urgent care services

An emergency medical condition is a medical condition that manifests by acute symptoms of sufficient severity, including severe pain. A prudent layperson who possesses an average knowledge of health and medicine could reasonably expect in the absence of immediate medical attention to result in:

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

Emergency services do not require prior authorization.

While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about appropriate emergency room use. A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fevers, coughs, colds and sore throats.

Covered services include:

- Hospital emergency department room, ancillary and other care service by in and out-of-network care providers.
- Medical examination.
- Stabilization services.
- Access to designated Level I and Level II trauma centers or hospitals meeting the same levels of care for emergency services.
- Emergency ground or air transportation.

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

Emergency room care

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

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

After the member has received emergency care, the hospital must seek approval within 1 hour for pre-approval for more care to make sure the member remains stable. If the hospital needs to appeal the decision or if it does not receive a decision within 1 hour and/or the hospital needs to speak with a peer (medical director), call 800-599-5985.

The treating care provider may continue with care until the health plan's medical care provider is reached, or when 1 of these guidelines is met:

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

Depending on the need, the member may be treated in the ER, an inpatient hospital room, or another setting. These are post-stabilization services. Members do not pay for them. This applies whether the member receives emergency services in or outside their service area.

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Urgent care (non-emergent)
Urgent care services are covered.

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

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

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

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

Nurses in Health Services review emergency admissions within 1 working day of notification.

UnitedHealthcare uses Interqual guidelines for determinations of appropriateness of emergency care.

UnitedHealthcare Community Plan makes utilization management (UM) determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally developed clinical criteria. UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize UM staff to support service underutilization. Care determination criteria is available upon request by contacting Provider Services (UM Department, etc.)

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

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

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

Hospital care (non-emergency): elective admissions and same-day surgery

The PCP or specialist referring a member for an elective admission or same-day surgery is responsible for contacting us for prior authorization. Please call at least 5 days, but not later than 48 hours, before the admission or surgery.

Once we receive the complete information to review the request, we make a determination. If we approve the request, the authorization is valid only if the patient is a UnitedHealthcare Community Plan member on the date of service. Cases that do not meet Interqual guidelines or are clinically questionable are referred to a medical director or physician advisor who renders a medical necessity determination.

Home care and all prior authorization services

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

Cardiology

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

You must obtain prior authorization for the following cardiology procedures:

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

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

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

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

Request prior authorization online or by phone:

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

Make sure the medical record is available.

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

Care coordination/ health education

Our care coordination program is led by our qualified, full-time care coordinators. Please work with us to help ensure members' care is coordinated. This program is a proactive approach to help members manage specific conditions and support them as they take responsibility for their health.

The program goals are to:

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

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

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

Durable medical equipment

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

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

See our Coverage Determination Guidelines at UHCprovider.com/njcommunityplan > Policies and Clinical Guidelines > UnitedHealthcare Community Plan Medical and Drug Policies and Coverage Determination Guidelines > View Current Policies.

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Facility admission notification requirements

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

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

Hearing services

Monaural and binaural hearing aids are covered, including fitting, follow-up care, batteries and repair. Bilateral cochlear implants, including implants, parts, accessories, batteries, charges and repairs are covered. Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries are covered for members 20 years or younger.

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice. These services require prior authorization.

Home hospice

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

Respite hospice

Inpatient hospital or nursing facility respite care is covered for the hospice care provider each day the member is in an inpatient facility and receiving respite care. Hospice inpatient respite care is short-term inpatient care provided to the member when necessary to relieve the caregiver. Hospice inpatient respite care is restricted to 5 days per month. This includes the day of admission but not the day of discharge.

Inpatient hospice

Inpatient care is covered during a sudden medical crisis. General inpatient care may be necessary for pain control or acute/chronic symptom management not provided in any other setting. Inpatient hospice care includes a hospital or an in-network hospice inpatient facility that meets the hospice standards for staffing and member care. Inpatient care is short-term and restricted to 10 days per month.

Members receiving inpatient hospice services through a residential facility are not covered under Managed Medicaid. DHS covers residential inpatient hospice services. DHS will cover hospice care provider benefits for both the hospice services provided and the facility residential services.

Laboratory

LabCorp is the preferred lab provider. Contact **LabCorp** directly.

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

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

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

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

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Oncology

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

Prior authorization for chemotherapy and related cancer therapies

We require notification/prior authorization for injectable outpatient chemotherapy and related cancer therapies administered in an outpatient setting, including intravenous, intravesical and intrathecal for a cancer diagnosis.

Request prior authorization online or by phone:

- Online using UHCprovider.com. Click Prior Authorization > **Prior Authorization and Notification**. Once in the tool, select Radiology, Cardiology, Oncology and Radiation Oncology Transactions > Service Type of Oncology > Product Type of Medicaid > [member state].
- Phone: 888-397-8129
  Monday through Friday 7 a.m.–7 p.m. CT

For a list of chemotherapy drugs requiring prior authorization, please refer to **UHCprovider.com**.

Physicians can submit clinical information during the authorization process for members with medical contraindications to an NCCN-recommended regimen and upload relevant documentation for the request during the submission process. Reviews are performed by medical oncologists.

Prior authorization for radiation therapy services

We require notification/prior authorization for radiation therapy treatments. For a list of radiation therapy treatments requiring prior authorization, please refer to **UHCprovider.com**.

Request prior authorization online or by phone at:

- Online using UHCprovider.com. Click Prior Authorization > **Prior Authorization and Notification**. Once in the tool, select Radiology, Cardiology, Oncology and Radiation Oncology Transactions > Service Type of Radiation Oncology > Product Type of Medicaid > [member state].
- Phone: 888-397-8129
  Monday through Friday 7 a.m.–7 p.m. CT

Physicians can submit clinical information during the authorization process for members with medical contraindications and upload relevant documentation for the request during the submission process. Reviews are performed by radiation oncologists.

Preventive health care

We work with you to help ensure members receive preventive care. Preventive health care standards and guidelines are available at UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > Clinical Guidelines > **Preventive Services - Clinical Guideline**. We monitor the provision of these services through chart reviews and analysis of encounter data.

Clinical practice guidelines for chronic conditions

UnitedHealthcare Community Plan supports evidence-based medicine and have identified sources that have received national recognition both from the government and the health care community. Visit UHCprovider.com/njcommunityplan > Current Policies and Clinical Guidelines > Clinical Guidelines > **View Clinical Practice Guidelines**.

Radiology

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

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

- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)

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- Magnetic resonance angiography (MRA)
- Positron-emission tomography (PET)
- Nuclear medicine
- Nuclear cardiology

To get or verify prior authorization:

- Online: **UHCprovider.com/priorauth** > Radiology > Go to Prior Authorization and Notification Tool.
- Phone: **866-889-8054** from 9 a.m.-6 p.m. Eastern Time, Monday through Friday. Make sure the medical record is available. An authorization number is required for each CPT code.

For a list of CPT codes that require prior authorization, a prior authorization crosswalk, and/or the evidence-based clinical guidelines, use UHCprovider.com. Or use the search option at **UHCprovider.com/radiology** > Specific Radiology Programs.

Screening, brief Interventions, and referral to treatment (SBIRT) services

SBIRT services are covered when:

- Provided by, or under the supervision of, a certified care provider or other certified licensed healthcare professional within the scope of their practice.
- Determining risk factors related to alcohol and other drug use disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed.
- SBIRT screening will occur during an Evaluation and Management (E/M) exam and is not billable with a separate code. You may provide a brief intervention on the same day as a full screen in addition to the E/M exam. You may also perform a brief intervention on subsequent days. Brief interventions are limited to 4 sessions per patient, per provider per calendar year.

What is included in SBIRT?

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

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

Referral to treatment: Refer members whose screening indicates a severe problem or dependence to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. This includes coordinating with the Alcohol and Drug Program in the County where the member resides for treatment.

SBIRT services are covered when all the following are met:

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

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

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

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

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Medication-assisted treatment

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

To prescribe Buprenorphine, you must complete the waiver through the Substance Abuse and Mental Health Services Administration (SAMHSA) and obtain a unique identification number from the United States Drug Enforcement Administration (DEA).

As a medical care provider, you may provide MAT services even if you don't offer counseling or behavioral health therapy. However, you must refer your patients to a qualified care provider for those services. If you need help finding a behavioral health provider, call the number on the back of the member's health plan ID card. Or search UHCprovider.com > Our Network > **Find a Provider**.

To find a medical MAT provider in New Jersey:

1. Visit UHCprovider.com > Our Network > **Find a Provider**.
2. Under Search for Doctors, Clinics or Facilities by Plan Type, click on Search for a Provider
3. Medical Directory > Medicaid Plans > New Jersey > (select plan)
4. Under Looking for Mental Health?, choose **Mental Health Directory - NJ Family Care/Long-Term Care (LTC)**.
5. Under Refine Results, go to Treatment Options and click then check the box stating Medication Assisted Treatment.

For more SAMHSA waiver information:
Physicians, NPs and PAs — **samhsa.gov**

If you have questions about MAT, please call **Provider Services** at **888-362-3368**.

Pharmacy

NJ FamilyCare members receive outpatient prescription drugs through us, with the following exception:

- Methadone used for substance use maintenance: cost and administration
- Generically equivalent drug products of the above

All UnitedHealthcare members must use their UnitedHealthcare member ID card to obtain covered prescription drugs at a network pharmacy. Find a network pharmacy at UHCprovider.com > Our Network > **Find a Provider.**

Coverage for outpatient prescription drugs varies by UnitedHealthcare product:

Product	Outpatient Benefit
NJ FamilyCare A NJ FamilyCare B	Medicaid covers prescription and OTC drugs No cap or copay
NJ FamilyCare C	Medicaid covers prescription and OTC drugs Copay: $1 generic, $5 brand-name
NJ FamilyCare D	Prescriptions covered. No cap Copay: $5 generic and brand; $10 if more than a 34-day supply Most OTC drugs excluded
UnitedHealthcare Dual Complete® ONE (Medicare)	Prescriptions covered by Medicare Parts B and D and Medicaid-only drug coverage. No copay.

Generic drugs

Generic drugs are provided when available as required by state mandatory generic substitution regulations. Generic drugs are FDA-approved equivalents to their brand-name counterparts. If a generic drug is available, a brand-name drug will not be provided to the member. However, a physician can provide information that documents why a brand-name drug is medically necessary through a prior authorization.

No generic substitutions will be made for mental health/substance use prescriptions written by psychiatrists or mental health/substance use providers.

To submit a request for prior authorization for brand-name drugs, call **Pharmacy Prior Authorization** at **800-310-6826**.

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Pharmacy preferred drug list

UnitedHealthcare Community Plan determines and maintains its preferred drug list (PDL) of covered medications. This list applies to all UnitedHealthcare Community Plan of New Jersey members. Specialty drugs on the PDL are identified by a "SP" in the "Requirements and Limits" section of each page.

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

If a member requires a non-preferred medication, call the **Pharmacy Prior Authorization** department at **800-310- 6826** or use the Prior Authorization and Notification tool on the Provider Portal at **UHCprovider.com**. For Pharmacy Prior Authorization, visit UHCprovider.com/njcommunityplan > **Pharmacy Resources and Physician Administered Drugs** > Pharmacy Prior Authorization.

We provide you PDL updates before the changes go into effect. Find these updates on UHCprovider.com/njcommunityplan > **Pharmacy Resources and Physician Administered Drugs** > Prescription Drug Lists / Formulary Lists, Drug Search and Updates. Locate the PDL and Pharmacy Prior Notification Request form at **UHCprovider.com/priorauth**.

Find the Dual Complete® ONE (Medicare) formulary or PDL on UHCprovider.com/njcommunityplan > Pharmacy Resources and Physician Administered Drugs > Prescription Drug Lists / Formulary Lists, Drug Search and Updates > **Pharmacy Formulary** under UnitedHealthcare Dual Complete Medicare Advantage.

Excluded drugs

We do not cover drugs used for:

- Weight loss or appetite suppression
- Cosmetic purposes
- Infertility
- Hair growth or prevent hair loss
- Investigations and experiments drugs, unless a medical director gives prior authorization
- DESI

Members may continue taking a medication that has been removed from the PDL for as long as they are a member with approval from the prescribing care provider. Members new to therapy must use a PDL medication unless otherwise authorized.

Supply limit for opioids

We implemented a 90 morphine equivalent doses (MED) supply limit for the long-acting opioid class. We updated prior authorization criteria to match the CDC's recommendations for the treatment of chronic non-cancer pain. Prior authorization applies to all long-acting opioids. The CDC guidelines on long-acting opioids are available online at **cdc.gov** > More > Injury, Violence & Safety > Applying CDC's Guideline for Prescribing Opioids > **Opioid Prescribing Guideline Resources**. For more information, visit **liveandworkwell.com**.

For short-acting opioids, we implemented a supply limit of 7 days and less than 50 MED per day for patients new to opioid therapy. For patients age 19 or younger, there is a supply limit of 3 days. Requests for opioids beyond these limits require prior authorization. For more information, call **Provider Services**.

Pharmacy lock-in

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

Pharmacy prior authorization

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

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

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hours of request receipt.

Submit the following with your request:

- Member's name and UnitedHealthcare ID number
- PCP's name and UnitedHealthcare provider ID number
- Attending provider's name and UnitedHealthcare Provider ID number
- Facility name
- Expected date of admission or service
- Diagnosis(es) or reason for treatment
- Planned procedures, services, or medications
- Other insurance information for Coordination of benefits (COB)

For a list of Pharmacy Prior Authorization Forms, visit UHCprovider.com/njcommunityplan > **Pharmacy Resources and Physician Administered Drugs**.

Specialty pharmacy medications

The Specialty Pharmacy Management Program provides high-quality, cost-effective care for our members. A specialty pharmacy medication is a high-cost drug that generally has 1 or more of the following characteristics:

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

Specialty medications are available through our specialty pharmacy network. For more information about specialty pharmacy medications, go to UHCprovider.com/priorauth > **Clinical Pharmacy and Specialty Drugs Prior Authorization Program**.

Tuberculosis (TB) screening and treatment; direct observation therapy (DOT)

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

Responsibilities

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

Vision

Vision services are covered by **MARCH Vision Care**. Please refer to their website at **marchvisioncare.com** for information such as compliance, electronic payment information, safety resources and training or call **844-686-2724**.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

- Patient name and ID number.
- Ordering health care professional name and TIN/NPI.
- Rendering health care professional and TIN/NPI.
- ICD clinical modification (CM).
- Anticipated date(s) of service.

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

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

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

Prior authorization turnaround times

The following table shows the standard determination response time(s).

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent Pre-service	Within 14 calendar days from the receipt of the request	Notification of decision (notice of determination) within 14 calendar days	Standard notice of action (denial letter) sent within 14 calendar days (contract/NCQA) from receipt of the service request (notification date/time).
Urgent/Expedited Pre-service	Within 24 hours of receipt of the necessary information, but no later than 72 hours after receipt	Within 72 hours of receipt	Within 72 hours of receipt
Concurrent Review	Within 24 hours or next business day following	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within 2 business days
Retrospective Review	Within 30 calendar days of receiving all pertinent clinical information	Within 24 hours of determination	Within 24 hours of determination and member notification within 2 business days

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Concurrent review guidelines

UnitedHealthcare Community Plan requires you to chart progress notes for each day of an inpatient stay. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. We perform a record review or phone review for each day's stay using Interqual, CMS or other nationally recognized guidelines to help clinicians make informed decisions in many health care settings. You must work with UnitedHealthcare Community Plan for all information, documents or discussion requests. This includes gathering clinical information on a member's status for concurrent review and discharge planning. When criteria are not met, the case is sent to a medical director.

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

Concurrent review details

Concurrent Review is notification within 24 hours or 1 business day of admission. It finds medical necessity clinical information for a continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone or record review.

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

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

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

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

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

We don't consider experimental treatments medically necessary.

Determination process

Benefit coverage for health services is determined by the member's specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, or Summary Plan Description, and applicable laws. You may freely communicate with members about their treatment, regardless of benefit coverage limitations.

Clinical practice guidelines for chronic conditions

Because we support evidence-based medicine, we have identified sources that have received national recognition

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both from the government and the health care community. Please review our resulting clinical practice guidelines (CPGs) at UHCprovider.com/njcommunityplan > Policies and Clinical Guidelines > Clinical Guidelines > View Clinical Practice Guidelines. They can serve as a resource to guide your clinical decision-making.

For information on diabetes clinical guidelines, visit UHCprovider.com/njcommunityplan > Policies and Clinical Guidelines > View Clinical Guidelines.

Medical and drug policies and coverage determination guidelines

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

Referral guidelines

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

Include in your referrals the frequency and duration of each service request. We typically approve 2 visits for initial referrals and 3 visits for further referrals. For chronic dialysis, referrals are valid for 6 months.

- Referrals to non-participating specialists require prior authorization. The PCP must request the authorization.
- For chronic dialysis, referrals will be valid for 6 months. Referrals are not required for out-of-area dialysis for ESRD.
- Referrals should indicate all services requested, including frequency and duration of each service.

In addition to clearly noting that the patient is a UnitedHealthcare Community Plan member, include the following information:

- Member name, address, date of birth
- PCP name, UnitedHealthcare Provider ID number, and phone number
- Specialist/ancillary provider name, UnitedHealthcare Provider ID number, address and phone number

Record the referral in the member's medical record.

Specialty referral requirements FAQs

For more detailed information and answers to frequently asked questions (FAQs), reference the Specialty referral requirements FAQ document located on uhcprovider.com/njcommunityplan > Provider Forms and References > UnitedHealthcare Community Plan of New Jersey Specialty Referral Requirements Frequently Asked Questions (FAQ).

Continuation of existing relationships with non-par care providers

We provide access to specialty care, diagnostic, and interventional strategies, as well as long-term management of medical conditions and continuation of non-network care providers when considered to be in the member's best medical interest.

However, try to refer participating specialists and laboratories. Referrals to non-participating specialists require prior authorization. If you need to verify a care provider's network status, call Provider Services. Otherwise, we may approve out-of-network referrals for the following:

- Continuity of care issues
- Necessary services that are not available within network
- Dialysis for end stage renal disease

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

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Behavioral health referrals

PCPs and behavioral health care providers can refer members by calling **Optum Behavioral Health**. Document behavioral health referrals or requests in the patient's medical record.

Standing referral to a specialist

You may create a standing referral when a member requires ongoing, long-term specialty care. Approval depends on the creation of a treatment plan approved by UnitedHealthcare in consultation with the PCP, the specialist, the care manager, and the member (or authorized person).

The standing referral may be limited to a specific number of visits or the period during which visits are authorized.

Special needs referrals

Enrollees with special needs require highly complex, specialized health care services over a prolonged period of time. These members may have physical, mental, substance use, and for developmental disabilities, including such people who are homeless. They may be referred by a physician specialist instead of a PCP.

We provide specialty care, diagnostic and interventional strategies for these members, as well as long-term management of medical conditions. We allow for the continuation of non-participating care providers when it is in the member's best medical interest. We also require qualified specialists who meet our credentialing criteria to coordinate all medically necessary care for members with complex conditions.

Call **Special Needs and Care Management** to refer members with special needs to Care Management for a Comprehensive Health Status Assessment. A plan of care will be developed along with you and the member.

Members or care providers may reach their Personal Care Manager directly by phone during normal business hours. After-hours messages may be left on the automated voice messaging system.

Methods to identify those at risk who should be referred for a comprehensive needs assessment and care management services

Members with special needs are identified in the following ways:

- State enrollment file
- Call center
- Care providers
- Member/guardian
- Utilization reports
- Census reports
- Pharmacy
- Plan Selection Form (PSFs)

Possible risk criteria for enrollees for institutionalization may include the following:

- Advanced age
- Cognitive impairment
- Falls/fractures
- Permanent activities of daily living (ADL)/ Instrumental activities of daily living (IADL) dependency or functional decline
- Lack of caregiver support

You can refer enrollees with special needs and increased risk for institutionalization by contacting our **Special Needs and Care Management Referral** department for a Comprehensive Needs Assessment.

A plan of care will be developed with the care provider, the member, and/or the member's family/guardian.

Responding to crisis situations after hours for members with special needs

All medical emergencies should be handled by contacting 911. Members or care providers may reach their Personal Care Manager directly by phone during normal business hours.

After-hours messages may be left on the automated voice messaging system. **Special Needs and Care Management Referrals** is also available for messages. These messages will be returned in 1 business day.

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Reimbursement

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

- Determine if the member is eligible on the date of service by using the Provider Portal on **UHCprovider.com**, calling our **Provider Services** Department, or the New Jersey Medicaid Eligibility System, **NJ Hotline**.
- Submit documentation needed to support the medical necessity of the requested procedure.
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized.
- Determine if the member has other insurance that should be billed first.

UnitedHealthcare Community Plan will not reimburse:

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

Second opinion benefit

We do not require a second opinion for any specific services or procedures. However, members may get a second opinion from a participating care provider before getting the recommended treatment or surgery. The member must have seen their PCP/PCD, or a participating specialist to whom the PCP/PCD referred them, for initial evaluation or treatment before requesting a second opinion consultation.

Upon the member's request, the PCP/PCD initiates a referral to the second opinion physician.

If our network does not include a participating care provider in the specialty needed, call **Provider Services** to request authorization for a second opinion by an out-of-plan specialist. We will contact the PCP/PCD and specialist within 72 hours with referral information.

The member and their family, after considering the second opinion and alternative treatments, will make the final decision regarding their care.

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

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Care providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward the report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If a network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact us at **888-362-3368**.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations.
- If follow-up care is recommended, the member meets with the PCP before receiving treatment.

Services not covered by UnitedHealthcare Community Plan

The following services are not included in the UnitedHealthcare Community Plan program:

- Any health care not given by a care provider from our network (except emergency treatment)
- Services not medically necessary
- Any care covered by Medicaid but not through managed care:
  - Prescription drugs
  - Long-term care services in a nursing home
  - Nursing facility
  - Intermediate care facilities (ICF) for members with mental handicap
  - Home- and community-based waiver services
  - Residential inpatient hospice (UnitedHealthcare Community Plan covers the facility and anesthesia services when deemed medical necessary. Prior authorization is required.)

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- Mental health and substance abuse care. This service is covered by Optum.
- Phones and TVs used when in the hospital
- Personal comfort items used in the hospital such as a barber
- Contact lenses, unless used to treat eye disease
- Sunglasses and photo-gray lenses
- Ambulances, unless medically necessary
- Infertility services

NJ FamilyCare A, B and C exclusions:

- Cosmetic surgery, except when medically necessary and with prior approval
- Experimental organ transplants and investigational services
- Infertility treatment services
- Rest cures, personal comfort, convenience items and custodial care
- Respite care
- Care involving the facility equipment in which the purchase, rental or construction has not been approved by state laws and regulations
- Care provided by or in institutions owned or operated by the federal government, such as Veterans Administration hospitals
- Care provided in an inpatient psychiatric institution, that is not an acute care hospital, to individuals younger than 65 years and older than 21 years
- Care provided to all persons without charge
- Care and items provided without charge through public programs or voluntary agencies (e.g., New Jersey Department of Health, New Jersey Heart Association, First Aid Rescue Squad)
- Care or items furnished for any sickness or injury occurring while the member is on active duty in the military
- Care provided outside the United States and territories
- Care or items for any condition or injury that occurred on the job for which any benefits are available under workers' compensation law, temporary disability benefits law, occupational disease law, or similar legislation
- Care covered or payable under any health, accident or other insurance policy (including any benefits payable under the New Jersey no-fault automobile insurance laws), any other private or governmental health benefit system, or through any third-party liability. This includes the provision of the Unsatisfied Claim and Judgment Fund.
- Care or items furnished for which the care provider does not normally charge
- Care furnished by an immediate relative or member of the NJ FamilyCare beneficiary's home
- Care billed for which corresponding health care records do not reflect the procedure code requirements
- Services or items reimbursed based on submission of a cost study when there are no acceptable records to validate the costs incurred or beneficiary income available to offset those costs. Without financial records, a care provider may prove costs or available income by means the Division accepts.

NJ FamilyCare D exclusions:

- Non-medically necessary services
- ICF/intellectual disability
- Private duty nursing unless authorized by the contractor
- Personal care assistant services
- Medical day care services
- Chiropractic services
- Orthotic devices
- Residential treatment center psychiatric programs
- Religious non-medical institutions care and services
- EPSDT except for well-child care including immunizations and lead screening and treatments
- Transportation services
- Hearing aid services except for children younger than 16 years
- Blood and blood plasma, except for administration and processing
- Cosmetic surgery
- Custodial care
- Special remedial and educational services
- Experimental and investigational services
- Medical supplies, except diabetic supplies
- Infertility services
- Rehabilitative services for substance use
- Weight reduction programs or dietary supplements, except surgical operations, procedures or treatment of obesity when approved by the contractor
- Acupuncture, except when performed as anesthesia in connection with covered surgery

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- Recreational therapy
- Sleep therapy
- Court-ordered services
- Thermograms and thermography
- Biofeedback
- Radial keratotomy
- Respite care
- Nursing facility services
- Audiology services, except for children younger than 16 years

Services requiring prior authorization

For a list of services that require prior authorization, go to UHCprovider.com/priorauth.

Elective admissions and same-day surgery

The PCP or specialist referring a member for an elective admission or same-day surgery is responsible for contacting us for prior authorization. Submit your request no less than 5 business days before the expected date of service. You may contact us by phone, iExchange or mail.

Include the following to receive authorization:

- Member name and UnitedHealthcare Community Plan ID number
- Referring and referred physician's names and UnitedHealthcare Community Plan Provider ID numbers
- Facility name
- Expected date of admission or service
- Diagnosis codes
- Planned procedures and their codes
- Type of service (e.g., outpatient, inpatient admission, home care, DME)
- Other insurance information for COB

Seek prior authorization within the following time frames

- **Emergency or urgent facility admission:** 1 business day.
- **Inpatient admissions; after ambulatory surgery:** 1 business day.
- **Non-emergency admissions and/or outpatient services (except maternity):** at least 14 business days beforehand; if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time.

Non-participating care providers will always require prior authorization before services can be rendered to a member.

Utilization management guidelines

Call 866-815-5334 to discuss the guidelines and utilization management.

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

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

Key contacts

Topic	Link	Phone Number
EPSDT	state.nj.us	N/A
Vaccines for Children	njiis.nj.gov VFC@doh.state.nj.us	609-826-4862

Looking for something else?

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- In web view, type your keyword in the "what can we help you find?" search bar.

Early, Periodic Screening, Diagnostic and Treatment (EPDST) is a Title XIX-mandated program that covers screening and diagnostic services to determine physical and mental defects in enrollees younger than age 21. It covers health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered, pursuant to Federal Regulations found in Title XIX of the Social Security Act.

All Medicaid-covered members younger than age 21, including those receiving MTLSS, may receive any medically necessary service. This includes:

- Physician and hospital services
- Home care services (including personal care and private duty nursing)
- Medical equipment and supplies
- Rehabilitative services
- Vision care
- Hearing services
- Dental care
- Any other type of remedial care recognized under state law or specified by the Secretary of the Department of Health and Human Services (DHHS)

The need for these services are based on medical necessity. They may not be limited in volume, scope or duration, regardless of established state plan or regulatory limitations.

While approval for these services is determined by medical necessity, the volume, scope and duration of approved services may consider the availability of other medically appropriate, cost-effective alternatives. When a Medicaid-covered beneficiary younger than age 21 requires a medically necessary service that is not listed in the state plan, the beneficiary or their representative should call the number on their health plan Member ID card so this service can be delivered and coordinated.

EPSDT is key to help ensure children and adolescents receive the right preventive, dental, mental health, developmental and specialty services.

For complete details about diagnoses codes as well as full and partial screening, examination, and immunization requirements, go to the EPSDT schedule at medicaid.gov > Medicaid > Benefits > **Early and Periodic Diagnostic and Treatment**. New Jersey schedules and codes are available on **state.nj.us** > **New Jersey Department of Children and Families Policy Manual**.

Bright Futures assessment

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

The *Bright Futures Guidelines* provide guidance for all preventive care screenings and well-child visits. You may incorporate Bright Futures into health programs such as home visiting, child care, school-based health clinics, and many others. Materials developed for families are also available.

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The primary goal of Bright Futures is to support primary care practices (medical homes) in providing well-child and adolescent care. Settings for Bright Futures implementation include private practices, hospital-based or hospital-affiliated clinics, resident continuity clinics, school-based health centers, public health clinics, community health centers, Indian Health Service clinics, and other primary care facilities. A complementary goal is to provide home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the Bright Futures Resources. This objective will help ensure patients receive information and support that is consistent from family and youth perspectives.

Learn more about Bright Futures at **mchb.hrsa.gov/maternal-child-health-topics/child-health/bright-futures.html.**

Children with special health care needs

You must support efforts for well-child care, health promotion, disease prevention, dental care, behavioral health and long-term specialty care for children with special health care needs. This also includes:

- Diagnostic and intervention strategies
- Home therapies
- Ongoing ancillary services
- Long-term management of ongoing medical complications
- Continuation of existing relationships with out-of-network providers, when considered to be in the best medical interest of the member.

Refer children designated as having special needs to Care Management for a Comprehensive Health Status Assessment by calling Special Needs and Care Management Referral at **877-704-8871**.

A plan of care (IHCP) will be developed in conjunction with the provider, the member, and/or the member's family/guardian.

Dental referrals

Refer pediatric members to a primary care dentist (PCD) by age 1 year or soon after the eruption of the first tooth. To find a PCD for referral, visit UHCprovider.com > Our Network > **Find a Provider.** Under Search for Doctors, Clinics or Facilities by Plan Type. Click on Search for a Provider > Medical Directory > Medicaid Plans > New Jersey > (select plan). Under Looking for Dental Providers?, choose a Dental Provider Directory for NJFamilyCare / LTC or Dual Complete Plans.

The NJ Directory of Dentists Seeing Children under 6, NJ Directory of Dentists seeing I/DD Children and I/DD adults and New Jersey Directory of Mobile Dental Services can be found on uhccommunityplan.com/nj > NJ FamilyCare > **Find a Dentist**.

If a member needs specialty care, any PCP or dentist may recommend a network specialty dentist, or the member can self-select a participating network specialist. There shall be no arbitrary number of visits by the PCD to allow a referral. Referrals must be made to qualified specialists who are participating within the provider network. No written referrals are needed for specialty dental care. Dental services referred to any out-of-network providers will need an approved prior authorization.

NJ Smiles

We allow non-dental providers to provide dental risk assessment, anticipatory guidance, fluoride varnish application and dental referral for children through the age of 5 years old. In addition to dental screening, medical staff with training can also provide oral health services using CPT code 99188. Services include anticipatory guidance, caries risk assessment, fluoride varnish application and referral to a dentist.

- Fluoride varnish may be applied by any trained medical staff. The physician must be trained and submit attestation that all staff providing this service are trained and will be supervised.
- Fluoride varnish application will be combined with risk assessment (visit **aap.org** to find the AAP Oral Health Risk Assessment Tool for the Caries Risk Assessment Tool for PCPs), anticipatory guidance and referral to a dentist that treats children younger than age 6 and will be linked to well-child visits for

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children through the age of 5 years old. Visit ada.org to find the ADA Caries Risk Assessment Form for children younger than 6 years old.

- These 3 services will be reimbursed as an all-inclusive service billed using a CPT code and can be provided up to 4 times a year. This frequency does not affect the frequency of this service by the dentist.
- We provide training to all licensed medical staff on the requirement of dental referral by 12 months of age.
- We notify PCPs and PCDs on their referral process and required communications between these provider groups.
- We provide training to all PCDs and licensed medical staff on prescribing fluoride supplements (based on access & use to fluoridated public water) and their responsibility in counseling parents and guardians of young children on oral health and age appropriate oral habits and safety to include what dental emergencies are and use of the ER for dental services.
- The caries risk assessment service is also allowed by the PCD and is billed using a CDT procedure code. The reimbursement will be the same regardless of the determined risk level. The risk assessment must be provided at least once per year in addition to an oral evaluation service by a PCD and is linked to the provider not the member. It may be provided a second time with prior authorization and documentation of medical necessity. Visit ada.org to find the ADA Caries Risk Assessment Form for children younger than 5 years old.

Find dental providers who treat members younger than 6 years old at UHCCommunityPlan.com/nj > NJ FamilyCare > Under "Find Providers for this Coverage Plan" choose "Dentist" > Find Dentist > Click on pdf directory under "**The NJFC Directory of Dentists Treating Children under the Age of 6**."

Development disability services and coordination with regional centers

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

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

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

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EPSDT CPT codes for children 0–21 years

Visit codes

Age and Status	CPT4 Code
Normal Newborn Care	99432
New Patient (Under 1 Year)	99381
New Patient (Ages 1–4 Years)	99382
New Patient (Ages 5–11)	99383
New Patient (Ages 12–17)	99384
New Patient (Ages 18–21)	99385 EP
Established Patient (Under 1 Year)	99391
Established Patient (Ages 1–4 Years)	99392
Established Patient (Ages 5–11 Years)	99393
Established Patient (Ages 12–17 Years)	99394
Established Patient (Ages 18–21 Years)	99395 EP

Immunization and lead screening

Description	CPT4 Code
Lead Screening	83655-91
HPV	90649
Hep A-Adult	90632
Hep-A Ped/Adol	90633
Hep A-Hep B (Adult)	90636
Hib PRP-OMP	90647
Hib PRP-T	90648
Flu (Split Virus)	90655
Flu (Split Virus)	90656
Flu (Split Virus)	90657
Flu (Split Virus)	90658
Flu (Intranasal)	90660
Pneumococcal Conjugate – 7 valent	90669
Pneumococcal Conjugate – 13 valent	90670
Rotavirus – 3 Dose Series	90680
Rotavirus – 2 Dose Series	90681
DTaP	90700
MMR	90707
MMRV	90710
E-IPV	90713
Td	90714
Tdap	90715
Varicella	90716
Tetanus & Diphtheria (Td) for 7 y/o or older	90718
Diphtheria, tetanus, acellular pertussis and Hemophilus influenza B vaccine (DTaP-Hib)	90721
DTaP/HepB/IPV	90723
Pneumococcal (Polysaccharide)	90732
Meningococcal	90734
Hep B - Adol	90743
Hep B	90744
Hep B- Adult	90746
Hep B/Hib PRP-OMP	90748
DTaP/Hib/IPV	90698
DTaP-IPV	90696
Administration Codes*	90465, 90466, 90471, 90472, 90467, 90468, 90473, 90474
ICD-10 Diagnosis Codes**	Z76.1, Z76.2, Z00.129, Z00.121

* Do not submit administrative codes to us for EPSDT visits.

** Primary diagnosis whenever well-child care and immunizations are rendered.

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Full screening

Perform a full screen. Include:

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

  NOTE: Medical staff with training can also provide oral health services and include the CPT code 99188. Services include anticipatory guidance, caries risk assessment, fluoride varnish application and referral to a dentist.

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

Interperiodic screens

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

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

Lead screening/treatment

NJ FamilyCare requires lead toxicity screenings for members at both 12 and 24 months of age. After that, you must screen any child 25 to 72 months of age (younger than age 6) who has not previously been tested. Finally, test any child up to 72 months of age who has been exposed to a known or suspected source of lead, regardless of previous testing on the regular schedule.

Medical record request

Send copies of medical records for any member younger than age 18 who has a lead toxicity screening result with blood lead levels greater than or equal to 5 µg/dl. Include the following information in the medical records:

- Member first and last name
- Member ID
- Date of visit
- Lead screening results

You can send copies of medical records by fax to **855-353-1048** or by secure email to **lead_cm_nj@uhc.com**. If you email medical records, you must use a secure email. If you don't have a secure email, you can email **lead_cm_nj@uhc.com** to request help with creating one.

The state also requires that you complete a verbal risk assessment for lead toxicity at every periodic office visit for children between ages 6 months and 72 months. These questions, which you'll attach to the patient's records, help determine if the child needs more testing for lead exposure. This verbal assessment is required, along with the 2 blood level tests, for members before the age of 24 months.

Find a copy of the Lead Screening guide at UHCprovider.com/NJcommunityplan > Provider Forms and References. Under Reference Guides, click on **Lead Screening Quick Reference Guide**. You can find the **Verbal Risk Assessment for Lead Toxicity** on the same site under Provider Forms. For more information about the New Jersey DOH requirements, go to **nj.gov/childhoodlead**.

This program also applies to members of the same household who are between 6 months and 6 years old. Check out the CDC website at **cdc.gov/nceh/lead** for more information on Childhood Lead Poisoning Prevention.

Newborn screening program

We refer all newborns who test positive on the Department of Health (DOH)'s Newborn Screening Program for further lab tests and treatment of rare conditions. These newborns will be referred to care management for further assessment, intervention and care coordination.

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Vaccines for Children program (VFC)

Each state operates the federally funded Vaccines for Children (VFC) program, which handles the vaccine supply and distribution to providers. The program addresses the disparity between insured children and children with no insurance or children from certain groups. The groups include children enrolled in Medicaid or Medicaid Managed Care, NJ FamilyCare A.

VFC benefits include:

- Cuts out-of-pocket expenses for parents and enrolled care providers.
- Children don't need referrals to public health centers for vaccination, keeping children within their medical home.
- Provides a ready inventory of vaccines for VFC enrollees.

The program supplies vaccines for these groups at no cost to all public and private care providers who agree to administer the vaccine. Vaccines offered through VFC can only be given to children with health insurance when their health insurance does not cover the cost of VFC vaccines and the vaccines are received at a FQHC.

We require all physicians who see children younger than 19 years be enrolled in the VFC program. Because VFC enrollment is independent on your participation with us, it requires separate enrollment.

To enroll, go to **njiis.nj.gov**. For more information about the VFC program call **609-826-4862** or email **VFC@doh.state.nj.us**. Click on the **Vaccines for Children brochure** from nj.gov for more information.

The State of New Jersey's VFC program provides vaccines for Medicaid plan A. See the **Fall 2019** newsletter at **njiis.nj.gov** for CPT codes.

As such, care providers are reimbursed for the administration of the vaccine for NJ FamilyCare Plan A. Submit claims reimbursement for vaccines and administration for NJ FamilyCare members B, C, & D directly to us. We reimburse all care providers for each administered vaccine. You must submit on a CMS 1500 billing form the vaccine CPT code as well as the administration code to obtain the payment.

If you are enrolled in VFC and disenroll from the program, notify us by emailing **uhccpnj@uhc.com**.

VFC also offers FluLaval as an additional influenza vaccine for children older than 6 months. The FluLaval dosage is 0.5 mL, regardless of the age of the child.

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

- Eligible for Medicaid
- American Indian or Alaska Native, as defined by the Indian Health Services Act
- Uninsured
- Underinsured (These children have health insurance, but the benefit plan does not cover immunizations. Children in this category may not only receive vaccinations from an FQHC or RHC. They cannot receive vaccinations from a private health care provider using a VFC-supplied vaccine.)

As with all vaccine orders:

- Open flu vaccine shipments immediately.
- Check the temperature monitor reading.
- Inspect the vaccine.
- Compare the vaccine received to the packing list.
- Store at appropriate temperatures.

If vaccines have been compromised, if temperature monitors are out-of-range, or if the order received is not accurate, immediately notify the McKesson Specialty Customer Care dedicated vaccine viability line at **877-836-7123**.

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Chapter 6: Managed Long Term Services and Supports (MLTSS)

Looking for something?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

The New Jersey Managed Long Term Services and Supports (MLTSS) program connects members with their health care teams to help them actively manage their conditions. This state program coordinates physical and behavioral health services in a seamless way that helps improve overall health outcomes.

New Jersey's MLTSS program:

- Provides a single point of contact for the member, a care manager.
- Addresses members' values and needs through comprehensive interventions.
- Connects members with their care providers, family, caregivers, and community resources.
- Personalizes each member's care based on economic, psychosocial, cultural, health literacy and environmental factors.
- Helps ensure the highest quality of care that addresses member safety, health care disparities, and the appropriate use of health care services.

MLTSS' fully integrated care coordination helps ensure the member's physical health, behavioral health, and MLTSS/HCBS are provided seamlessly. This effort reduces waste and redundancy in services.

Eligibility and enrollment

Eligibility depends on state approval and the member's in-person assessment using the NJ Choice Tool.

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

Benefits

MLTSS members receive the same benefits as all other UnitedHealthcare Community Plan members. Additionally, they may access the following services when we have deemed them medically necessary:

- Adult family care
- Assisted living services (ALR, CPCH)
- Assisted living program (ALP)
- Traumatic brain injury behavioral management (group and individual)
- Chore services
- Cognitive therapy (group and individual)
- Community residential services (CRS)
- Community transition services
- Home-based supportive care
- Home-delivered meals
- Medical day services
- Medication dispensing device: Setup and monthly monitoring
- Non-medical transportation
- Nursing facility (NF) services (custodial)
- Occupational, physical therapy (group and individual)
- Personal Emergency Response System (PERS): Setup and monitoring
- Private duty nursing (Adult): up to 16 hours of PDN services in any 24-hour period
- Residential modifications
- Respite (daily and hourly)
- Social adult day care
- Specialized medical equipment and supplies
- Speech, language and hearing therapy (group and individual)
- Structured day program
- Vehicle modification

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In addition to mental health and substance use services, we coordinate the following services that MLTSS does not cover:

- Targeted case management
- PACT
- Statewide Clinical Outreach Program for the Elderly (SCOPE)
- Self-help centers
- Supportive housing
- Peer recovery support services
- Behavioral services covered by other sources (TPL)

The MLTSS member's care manager evaluates service needs and develops the member's plan of care. Home and community-based services (HCBS) are determined based on the needs assessment and the assessment of natural supports. The care manager works with the member's care providers to put the plan into action.

Guidelines for private duty nursing

The following requirements apply to private duty nursing (PDN) services:

- PDN is provided for eligible members living in the community only and not in hospital inpatient or nursing facility settings.
- We determine and approve the total PDN hours for reimbursement, based on N.J.A.C. 10:60-5.2(b).
- Members may receive up to 16 hours of PDN services in any 24-hour period.
- We base the total PDN hours approved on alternative sources of PDN care available to the caregiver, such as medical day care or a school program.

Cost-effectiveness of services

MLTSS members will most often receive the most cost-effective placement in a community setting. If the cost of placement is not cost effective, the care manager will initiate an Inter-Disciplinary Team (IDT) meeting to discuss the service options, review and revise the plan of care to safeguard the member's health and safety and, execute a risk management agreement if necessary. When the IDT does not result in a plan of care that is agreeable to both the member and us, we initiate a MLTSS Case Conference Review to create a more suitable plan of care. If the member still does not agree with the plan, they may follow the grievance and appeals process found in the Member Handbook.

Care provider responsibilities

In addition to the general care provider responsibilities listed in "Chapter 2: Care Provider Standards and Policies" of this manual, HCBS providers have the following requirements:

- Provide services based on the plan of care. This includes the amount, frequency, duration, and scope of each service in the member's service schedule.
- If a member is admitted to the hospital, call NJ **PCA, Medical Day Care and MLTSS Services Intake** at **800-262-0305**.
- Notify us within 24 hours when any authorized non-MLTSS service has not been provided to the member.
- If there is a gap in MLTSS services, contact the member immediately. Acknowledge the gap and discuss how to resolve it. Also notify the member's MLTSS care manager.
- Comply with unable to contact requirements.
- Comply with critical incident reporting and management requirements.
- Conduct criminal background checks on all employees who provide direct care to MLTSS enrollees.

Critical incident reporting requirements

Every care provider and subcontractor must follow the Critical Incident Reporting and related requirements. Examples of Critical Incidents (must occur in a NF/special care nursing facility (SCNF), inpatient behavioral health, HCBS setting, community alternative residential setting, adult day care centers or a member's home) are:

- Unexpected death of a member
- Missing person or unable to contact
- Suspected or evidenced physical or mental abuse (including seclusion and restrains, both physical and chemical)

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- Theft with law enforcement involvement
- Law enforcement contact
- Severe injury or fall resulting in the need for medical treatment
- Medical or psychiatric emergency, including suicide attempt
- Medication error
- Inappropriate or unprofessional conduct by a care provider/agency resulting in serious consequences involving the member
- Sexual abuse and/or suspected sexual abuse
- Neglect/mistreatment, including self-neglect, and/or suspected abuse and neglect
- Incident likely to result in media attention
- Exploitation including financial theft, destruction of property
- Failure of member's backup plan
- Elopement/wandering from home or facility
- Eviction/loss of home
- Facility closure, with direct impact to member's health and welfare
- Cancellation of utilities
- Natural disaster, with direct impact to member's health and welfare

Follow the mandatory training and reporting requirements listed in your MLTSS Contract and those applicable to Adult Protective Services, Office of Institutionalized Elderly, Department of Health, the Department of Children and Families and the Division of Disability Services. Also report these incidents to UnitedHealthcare Community Plan within 1 business day of the incident. Then conduct an internal investigation and submit a report to us. Submit the report as soon as possible, based on the severity of the incident. Except under extenuating circumstances, submit no more than 30 calendar days after the date of the incident.

We will review the report and follow up as necessary to help ensure an appropriate investigation was conducted and corrective actions were implemented within applicable time frames.

Home and community-based services requirements

As an HCBS provider, MLTSS care providers must adhere to these requirements:

- Provide services based on the plan of care. This includes the amount, frequency, duration and scope of each service.
- Call **PCA, Medical Day Care and MLTSS Services Intake** if a member is admitted to the hospital.
- Notify us within 24 hours when any authorized non-MLTSS service has not been provided to the member.
- Fulfill the Gap in Care requirements:
  - When you are aware of an upcoming gap in care, contact the member before the scheduled service to advise them their regular caregiver will be unavailable. They may choose to receive the service from another caregiver at another time or from an alternate caregiver from the member's informal support system.
  - When a gap in services is already present, contact the member immediately. Acknowledge the gap and provide an explanation. Also provide a plan to resolve the particular gap and any future gaps. In addition, notify the member's MLTSS Care Manager.
- Comply with Unable to Contact requirements:
  - Reach out to the member again using the contact information on file.
  - If they don't respond, immediately reach out to their emergency contact.
  - If you still can't locate the member, immediately notify the member's MLTSS care manager.

Prior authorization

For MLTSS services (including personal care assistant services and adult/pediatric medical day care services), call **PCA, Medical Day Care and MLTSS Services Intake** any time.

MLTSS claims tips

- Include your National Provider Identifier (NPI) when submitting claims. Non-medical service providers who do not have NPI numbers must include their Medicaid Number (if applicable) and TIN.

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- Call **PCA, Medical Day Care and MLTSS Services Intake** for MLTSS claims/service issues.
- NF and assisted living providers are responsible for collecting patient payment liability from residents. The patient payment liability for cost of care is that portion of the cost of care that NF residents must pay based on their available income as determined and communicated by the County Welfare Agency. Collection of both the room and board and patient payment liability for the cost of care is delegated to the provider. We pay claims net of the applicable patient liability amount.

Provider credentialing/ verification

Participation in the MLTSS provider network requires satisfaction of application and credentialing/verification requirements. To request participation and credentialing, email **NJ_MLTSS_CRED@uhc.com**. You may also call **Provider Services Managed Long Term Services and Supports (MLTSS)** at **888-702-2168** and follow the prompts.

We also require the following:

- Medicaid ID issued by NJ FamilyCare/Medicaid
- Completed application
- Licensure for the services listed in the application
- General/comprehensive liability insurance
- Procedures governing financial responsibility and documentation of sufficient cash flow for 3 months, financial statements, and no filing or history of bankruptcy in the last 7 years
- Documented methods to monitor and review services and to assure quality of care
- Monthly verification that agency and/or employees have not been excluded from Medicare/Medicaid participation
- Evidence of compliance with all applicable laws and regulations, including Workman's Compensation and unemployment insurance and general liability insurance
- For agency and employees, no felonies or listings on abuse and sex offender registries
- Documentation of staff member background checks, qualifications, trainings, and certification
- Membership of board of directors
- Documented service delivery assurances
- Compliance with HIPAA requirements
- Accurate completion of a Disclosure of Ownership and Control Interest Statement and disclosure of ownership information at any time upon request
- Submission of a W-9 Form
- Signed attestation for the accuracy and completion of all required forms
- Submission of adequate proof of liability insurance ($500,000)
- Standards Assessment and Documentation Review

If you are credentialed with us and want to request NJ FamilyCare participation, call the **Provider Services Managed Long Term Services and Supports (MLTSS)** at **888-702-2168**. Follow the prompts:

- Enter Tax ID.
- Request to speak with a Network Management representative for NF contract.
- Submit the signed disclosure forms and Medicaid provider number with signed contract.

To check Credentialing Application Status, call **United Enterprise Voice Portal** at **877-842-3210** and follow the prompts. You can also call **Provider Services Managed Long Term Services and Supports (MLTSS)** at **888-702-2168**. Or send an email to **NJ_MLTSS_CRED@uhc.com**.

We require the following:

- Completed application
- Licensed as appropriate for the service being contracted
- Proof of accreditation or Medicare certification
- Site visit required only if there is not Medicare certification or accreditation by an approved entity
- Meet qualifications as outlined in the credentialing plan under CMS and NCQA
- Monthly verification that agency and/or employees have not been excluded from Medicare/Medicaid participation
- Evidence of compliance with all applicable laws and regulations, including Workman's Compensation and unemployment insurance and general liability insurance
- For agency and employees, no felonies or listings on abuse and sex offender registries
- Documentation of verifying financial capacity to operate
- Documented service delivery assurances

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- Compliance with HIPAA requirement
- Accurate completion of a Disclosure of Ownership and Control Interest Statement and disclosure of Ownership information at any time upon request
- Submission of a substitute W-9 Form
- Signed attestation for the accuracy and completion of all required forms
- Assignment of a valid Medicaid number
- Site visits to help ensure adequate record keeping
- Standards assessment and documentation review

Demographic changes

Notify us of demographic changes 30 days before the change is effective. Email your change requests to **NJ_MLTSS_CRED@uhc.com**.

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Chapter 7: Women's Health, Maternity and Perinatal Management

Looking for something?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

The programs in this chapter relate to New Jersey's efforts to address perinatal risk assessment, early elective delivery, centering, lactation and doula services.

Refer to "Chapter 2: Care Provider Standards and Policies" for your responsibilities as a care provider.

Family planning

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

- Annual gynecological examination
- Annual pap smear
- Contraceptive supplies, devices and medications for specific treatment
- Contraceptive counseling
- Laboratory services

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

Non-covered items include:

- Reversal of voluntary sterilization
- Hysterectomies for sterilization
- In-vitro fertilization, including:
  - GIFT (Gamete intrafallopian transfer)
  - ZIFT (zygote intrafallopian transfer)
  - Embryo transport
- Infertility services, if given to achieve pregnancy
  Note: Diagnosis of infertility is covered. Treatment is not.
  - Morning-after pill. Contact New Jersey Medicaid to verify state coverage.

Parenting/child birth education programs

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

Voluntary sterilization

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the DHS Regulations for more information on sterilization.

Healthy First Steps®

Healthy First Steps® (HFS) strives to:

- Increase early identification of expectant mothers and facilitate case management enrollment.
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care.
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it.
- Multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care.
- Increase the member's understanding of pregnancy and newborn care.
- Encourage pregnancy and lifestyle self-management and informed healthcare decision-making.
- Encourage appropriate pregnancy, postpartum and infant care provider visits.

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- Foster a care provider-member collaboration before and after delivery as well as for non-emergent settings.
- Encourage members to stop smoking with our Quit for Life tobacco program.
- Help identify and build the mother's support system including referrals to community resources and pregnancy support programs.

Program staff act as a liaison between members, care providers, and UnitedHealthcare for care coordination.

Mammogram screenings

New Jersey requires an annual mammography for women aged 40 and older. We support access to mammography through member education and by encouraging members to self-refer for these screenings.

Maternity/pregnancy/ well-child care

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

1. The woman is in her second or third trimester of pregnancy when she became a UnitedHealthcare Community Plan member, and
2. If she has an established relationship with a non-participating obstetrician.

UnitedHealthcare Community Plan must approve all out-of-plan maternity care. A UnitedHealthcare Community Plan member does not need a referral from her PCP for OB/GYN care. Perinatal home care services are available for UnitedHealthcare Community Plan members when medically necessary.

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

Access the digital Notification of Pregnancy form through the Provider Portal at **UHCprovider.com**. You may also call **Healthy First Steps** at 800-599-5985.

Perinatal risk assessment form requirement for pregnancy notification

Prenatal care providers must submit first visit and third trimester assessments for Medicaid Managed Care members through Perinatal Risk Assessments Plus (PRA Plus) on **praspect.org**. Submit the Perinatal Risk Assessment Form electronically to PRA|SPECT within 1 week after the member's first visit and third trimester appointments. If you do not submit data for these members, you won't be reimbursed for prenatal services.

When you let us know you're providing these services, our maternity care management teams help the member achieve better birth outcomes.

For more information on this process requirement by the State of New Jersey DOH, go to **praspect.org** > Documents > Prenatal Care Providers > **PRA Law Fact Sheet**.

Submitting the Perinatal Risk Assessment Form Online

If you are new to PRA|SPECT, go to **praspect.org** and click on "**New Office Registration**." Once you've registered, view the introduction video under "**How to Access PRA|SPECT**."

To view the first visit and third trimester Perinatal Risk Assessment forms, go to praspect.org > Documents > Prenatal Care Providers > **PRA Plus First Visit Form** and **PRA Plus Third Trimester Form**.

If you can't complete the forms online, email PRA|SPECT at **PRA@FHIWorks.org**. Or call **856-665-6000** 9 a.m.–5 p.m. Monday through Friday, Eastern Time. If you have any questions, call **Healthy First Steps**.

Early elective delivery reimbursement

Non-medically indicated early elective deliveries (EEDs) performed at a hospital on a pregnant woman earlier than 39 weeks of gestation will not be reimbursed by NJ FamilyCare (NJFC) Medicaid Program.

Based on the American College of Obstetricians and Gynecologists (ACOG), non-medically indicated EEDs performed before 39 weeks of gestation carry risks for both babies and mothers. A non-medically indicated EED means the artificial start of the birth process through medical interventions or other methods, or the surgical delivery of a baby by cesarean section

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for reasons not consistent with established ACOG standards of clinical care. An EED is not justified solely by maternal request, availability of effective pain management, facility or provider scheduling issues. The ACOG states the following risks of EEDs:

- Higher incidences of neonatal intensive care unit admissions
- Pneumonia
- Longer hospital stays for infants
- Unsuccessful inductions resulting in a cesarean section, which can lead to infections, bleeding and anesthesia complications for mothers

Prior authorization

Scheduled EEDs due to medical necessity require an approved prior authorization or submitted notification. For information on how to submit electronically, visit **UHCprovider.com/paan** or call **Provider Services**.

Claim submissions

Obstetricians, midwives, hospitals and clinics requesting NJ FamilyCare Medicaid reimbursement for a labor and delivery claim must report an ICD-10-CM diagnosis code indicating the week of gestation (ICD-10-CM category code Z3A). Claims submitted without this diagnosis code will be denied. Any claim reporting a week of gestation ICD-10-CM diagnosis code of less than 39 weeks without one of the following diagnosis codes will also be denied: O10, O11, O12, O13, O14, O15, O16, O24, O30, O31, O33, O35, O36, O42, O43, O44, O45, O71 or R03. The following CPT® codes are considered for non-eligibility of claims reimbursement:

- 59409 – Vaginal delivery only
- 59514 – Cesarean delivery only
- 59612 – Vaginal delivery only, after previous cesarean delivery
- 59620 – Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

Patient education

Share educational materials with your patients to help them understand the risks associated with EEDs. Find more information and patient education resources at **nichd.nih.gov** > Health > National Child and Maternal Health Program > Initiatives > **Is It Worth It? Reducing Elective Deliveries Before 39 Weeks**.

Doulas

Doulas cannot replace a trained, licensed medical professional or perform clinical tasks. Doulas serving NJ FamilyCare members should provide culturally competent care that supports the racial, ethnic and cultural diversity of members. In addition to providing direct services, doulas may also assist members with community-based services that may help improve health outcomes.

Doula care is covered when performed by a network provider. Perinatal care providers are encouraged to work with our doula network to provide care to pregnant members.

Doula providers interested in joining the NJ FamilyCare/Medicaid network should visit the State of New Jersey's Doula Care website at state.nj.us/humanservices > Division of Medical Health and Assistance & Health Services > Information for Providers & Stakeholders: Contracts, Legal Notices > **Doula Care Benefit**.

Maternity admissions

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

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

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

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

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

- Date of delivery
- Sex

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- Birth weight
- Gestational age
- Baby name

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

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

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

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

Obstetrical admissions

We consider all full-term maternity admissions to be scheduled admissions. Notify us as soon as a pregnancy is confirmed.

Post maternity care

UnitedHealthcare Community Plan covers post-discharge care to the mother and her newborn. Post-discharge care consists of a minimum of 2 visits, at least 1 in the home, according to accepted maternal and neonatal physical assessments. These visits must be conducted by a registered professional nurse with experience in maternal and child health nursing or a care provider. The first post-discharge visit should occur within 24-48 hours after the member's discharge date. Prior authorization is required for home health care visits for post-partum follow-up. The attending care provider decides the location and post-discharge visit schedule.

Newborn admissions

The hospital must notify **Provider Services** prior to or upon the mother's discharge, if the baby stays in the hospital after the mother is discharged.

Our Health Services Department conducts concurrent review of the newborn's extended stay. The hospital should make available the following information:

- Date of birth
- Birth weight
- Sex
- Any congenital defect
- Name of attending neonatologist

Newborn enrollment

The hospital is responsible to notify the county of all deliveries, including UnitedHealthcare Community Plan members (provided the mother was admitted using her health plan ID card).

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

Hysterectomies

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

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

Find the form on UHCprovider.com/njcommunityplan > Provider Forms and References > **Sterilization Consent Form with Instructions**.

See "Sterilization consent form" section for more information. Exception: New Jersey DHS does not require informed consent if:

1. As the care provider performing the hysterectomy, you certify in writing the member was sterile before

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the procedure. You must also state the cause of the sterility.

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

UnitedHealthcare Community Plan requires, along with your claim, a copy of the signed medical assistance hysterectomy statement. Mail the claim and documentation to claims administration identified on the back of the member's ID card. Reimbursement is made upon completion of documentation requirements and UnitedHealthcare Community Plan review. The member may not be billed if consent forms are not submitted.

Pregnancy termination services

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

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

Sterilization and hysterectomy procedures

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

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

Sterilization informed consent

A member has only given informed consent if the New Jersey Medical Assistance Consent Form for sterilization is properly filled out. Other consent forms do not replace the Medical Assistance Consent Form. Be sure the member fully understands the sterilization procedure and has been told of other family planning options. Informed consent may not be obtained while the member is in labor, seeking an abortion, or under the influence of alcohol or other substances that affect awareness.

Sterilization consent form

Use the consent form for sterilization:

- **Complete all applicable sections of the form.** Complete all applicable sections of the consent form before submitting it with the billing form. The New Jersey Medical Assistance Program cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.
- Your statement section should be completed after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.
- The state's definition of "shortly before" is not more than 30 days before the procedure. Explain the procedure to the member within that time frame. However, do not sign and date the form until after you perform the procedure.

Find the form on UHCprovider.com/njcommunityplan > Provider Forms and References > **Sterilization Consent Form with Instructions**.

Have 3 copies of the consent form:

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

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Neonatal Intensive Care Unit (NICU) case management

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

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

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

Inhaled nitric oxide

Use the NRS guideline for inhaled nitric oxide (iNO) therapy at UHCprovider.com > Resources > Health Plans, Polices, Protocols and Guides > For Community Plans > **Clinical Guidelines**.

Oncology

Prior authorization

For information about our oncology prior authorization program, including radiation and chemotherapy guidelines, requirements and resources, go to UHCprovider.com > Prior Authorization > **Oncology**. Or call Optum at 888-397-8129 Monday-Friday 7 a.m.–7 p.m. CT.

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Chapter 8: Value-Added Services

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	888-362-3368
Healthy First Steps Rewards	uhchealthyfirststeps.com	800-599-5985
Value Added Services	UHCCommunityPlan.com/NJ > View plan details	888-362-3368

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call **Provider Services** at **888-362-3368** unless otherwise noted.

Adult pain management/ chiropractic services

Evidence-based medicine supports chiropractic care to help lower back pain. In some cases, a visit to the chiropractor can reduce or eliminate the need for pain medication. It can even help combat opioid addiction and overuse.

We provide members older than 21 with up to 6 visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.

Follow these steps to access the fee schedules online:

1. Go to **myoptumhealthphysicalhealth.com**.
2. Enter your provider ID & password.
3. Click "Tools & Resources."
4. Click "Plan Summaries" or "Fee Schedules."

For more information on chiropractic care, go to myoptumhealthphysicalhealth.com or call **800-873-4575**.

Chronic condition management

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

Health4Me

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

NurseLine

NurseLine is available at no cost to UnitedHealthcare Dual Complete® ONE (Medicare) and MLTSS members at any time. Members may call NurseLine to ask if they need to go to the urgent care center, the ER or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **877-440-9407**, TTY 711 to reach a nurse.

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NJ Quitline®

Using a mix of medication support, phone-based coaching, and web-based learning tools, the NJ Quitline program helps NJ FamilyCare members quit tobacco use. NJ FamilyCare members can visit the New Jersey Quitline website at **njquitline.org** or call **866-657-8677** for free help and support.

State-funded programs

The state also has programs, such as Women, Infants, and Children Supplemental Nutrition programs (WIC) to help with nutritional needs for low income families.

To find a location, visit nj.gov/health > Offices & Programs > Family Health > **Women, Infants, and Children (WIC)**.

UHC Doctor Chat— virtual visits

Members will have access to UHC Doctor Chat, an innovative, chat-first platform supported by live video to connect with a doctor from their computer or mobile device for non-emergent care. A board-certified emergency medicine physician will assess the severity of the enrollee's situation, provide treatment (including prescriptions) and recommend additional care. Virtual visits can improve access to care, reduce health disparities and reduce avoidable use of the ED. This program highlights our commitment to bring forward looking for solutions to expand and deliver access to care.

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Chapter 9: Dental

Looking for something?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

The following text is based on the UnitedHealthcare Community Plan Dental Provider Manual for NJ FamilyCare. The benefit grid can be found in "Chapter 3: Care Provider Office Procedures and Member Benefits" under NJ FamilyCare/Medicaid Benefits Grid. For a list of covered dental benefits, please refer to Section 4: Member Benefits / Exclusions & Limitations in the Dental Provider Manual.

For more detailed information regarding dental, or if you are a dental provider, please refer to the Dental Provider Manual. To obtain access to the Dental Provider Manual, go to **uhcproviders.com** and Sign In.

The following guidelines are based on NJ FamilyCare provisions for medically necessary dental services for eligible UnitedHealthcare Community Plan members. UnitedHealthcare Dual Complete® ONE members receive Medicare covered dental benefits through their Medicare enrollment and Medicaid benefits through their NJ FamilyCare A enrollment.

All NJ FamilyCare/Medicaid Members: Plans A, B, C, D, ABP, MLTSS and UnitedHealthcare Dual Complete® ONE (Medicare) members have the same comprehensive dental benefits which include diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgery and other adjunctive general services. Some procedures require prior authorization with documentation of medical necessity. Orthodontic services are age restricted and only approved with documentation of handicapping malocclusion and/or medical necessity.

Dental services are not limited to emergency services. Dental emergency services are a covered benefit which do not require prior authorization. Members that contact you for non-traumatic dental emergencies should be referred to their dentist or to **Member Services** for assistance for locating a dentist. **Member Services** can be reached at **800-941-4647**.

Role of network dental providers

Network general dentists and specialty care dentists are involved in a critical role in the dental delivery system, helping ensure that members receive appropriate access, prevention, continuity of care and treatment services. For this reason, all dentists must be available to our members at any time. They are responsible for assisting in the coordination of dental treatment services. Members have open access to network providers.

Comprehensive dental care services may be provided in the dentist's office, a health care facility or hospital-based practice. The dentist is reimbursed on a fee-for-service basis and agrees to maintain standards set forth in their Participating Provider Agreement. Well-maintained dental records provide documentation of care.

All dental diagnoses should be documented by the treating dentist. Comprehensive oral evaluations shall be conducted during a member's initial non-emergency appointment.

The primary care dentist (PCD) should communicate a diagnosis and proposed treatment to the PCP and work together to achieve optimal dental health for our members.

If the member needs specialty care, the PCD can recommend a network specialty dentist. Or the member can self-select a specialist from our provider directory, by visiting **myuhc.com/communityplan** > Find a Doctor > New Jersey > Select a Medicaid plan in New Jersey > Looking for Dental Providers > Choose a Dental Provider Directory. Or they may call **Member Services** at **800-941-4647**.

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Find dental providers at UHCcommunityplan.com/nj > NJ FamilyCare > **Find a Dentist**. Our directories include dental providers who:

- Are mobile
- Treat members with disabilities
- Treat children younger than age 6

Primary care physicians and dental treatment

Dental screening by the licensed medical staff in this context means, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection.

- A referral to a dentist by 1 year of age or soon after the eruption of the first primary tooth is mandatory. At a minimum, a dental visit twice a year with follow-up during well-child visits helps ensure that all needed dental preventive and treatment services are provided thereafter through the age of 20.
- A referral to a dental specialist or dentist that provides dental treatment to patients with special needs shall be allowed when a PCD requires a consultation for services by that specialty provider.
- The NJ Smiles Program allows non-dental providers to provide dental risk assessment, anticipatory guidance, fluoride varnish application and dental referral for children through the age of 5 years old. Fluoride varnish treatments should be applied twice yearly.

Primary medical providers or licensed medical staff may refer a member to a general dentist or dental specialist. For a list of general dentists and dental specialists, licensed medical staff may visit **myuhc.com/communityplan** > Find a Doctor > New Jersey > Select a Medicaid plan in New Jersey > Looking for Dental Providers > Choose a Dental Provider Directory. Or call **Provider Services** at **888-362-3368**. General dentists and pediatric dentists that treat patients younger than 6 years may also be found in the provider listing at **myuhc.com/communityplan**.

Prior authorization

Submit a dental prior authorization request by calling **UnitedHealthcare Dental** at **800-508-4881** or through the provider web portal at **uhcproviders.com**. You can also mail requests to:

UnitedHealthcare Dental
P.O. Box 2073
Milwaukee, WI 53201

Reference the UnitedHealthcare Community Plan Dental Provider Manual for NJ FamilyCare for more information. For medical/surgical prior authorizations, please see "Chapter 4: Medical Management" of this medical manual.

Specialist referral process

If a member needs specialty care, any PCP or dentist may recommend a network specialty dentist, or the member can self-select a participating network specialist. Referrals must be made to qualified specialists who are participating within the provider network. No written referrals are needed for specialty dental care.

For administrative services or a list of participating network specialists, go to UHCprovider.com > Our Network > **Find a Provider** or call **UnitedHealthcare Dental** at **800-508-4881**.

All dental specialists are either New Jersey board-eligible or board-certified for that specialty and have a valid specialty permit. A dentist with certification in the following specialties must have, or have confirmation of application submission of, valid DEA and CDS certificates:

- Endodontics
- Oral surgery/OMFS
- Periodontics
- Prosthodontics

Administration of medical or dental services

UnitedHealthcare Community Plan understands there are services that can be provided by either a dentist or physician. The plan accepts prior authorization and payment requests from either qualified participating

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physicians or qualified participating oral surgeons and prosthodontists for procedures that may be considered either medical or dental. These include maxillofacial prosthetics and surgical procedures for fractured jaw or removal of cysts.

Submit medical requests through the physician portal, **UHCprovider.com**. Send dental requests through the dental portal **uhcproviders.com** using dental codes.

The following medical services can be performed by either provider type, within the scope of their license:

- Repair of cleft palate
- Cysts removal
- Fractured jaw
- Oral and maxillofacial surgery
- Anesthesia services

Non-dental providers do not perform extractions including impacted teeth. These services (dental codes in the D7000 series) should be treated under the member's dental benefit.

Additional dental services

If oral hygiene instruction needs to be provided to members or their family to help maintain oral health, or if specialized hygiene equipment is needed for members, you must request prior authorization. Use the appropriate miscellaneous procedure code (i.e., D1999) for the authorization request. Include a description of why these services or products are medically necessary for your patient.

The requests will be reviewed by dental consultants licensed in the State of New Jersey who will make determinations based on the information presented and the patient's medical necessity.

Referrals for dental care provided in an operating room

If dental services must be provided in an operating room (OR) setting or ambulatory surgery center due to patient medical necessity, a prior authorization must be obtained. This includes members with special health care needs and children younger than 5 years old. The treating dental provider should submit an authorization to use the OR under CDT Code D9999. Include the name of the facility and an explanation of why an OR is necessary. For step-by-step instructions for the prior authorization process of dental services provided in an OR or ambulatory surgery center, refer to the UnitedHealthcare Community Plan Dental Provider Manual for NJ FamilyCare on **uhcproviders.com**.

American Academy of Pediatrics and American Dental Association oral health risk assessment tools

The American Academy of Pediatrics (AAP) Oral Health Risk Assessment Tool is for the use of licensed medical staff. Developed by the AAP and endorsed by the National Interprofessional Initiative on Oral Health, the Oral Health Risk Assessment (OHRA) Tool is easy to incorporate into any practice. The tool helps medical providers understand the risk factors, protective factors, and clinical findings that demonstrate risk of dental caries in young children.

To download copies of the following dental assessment forms from the American Dental Association (ADA) and the AAP, please visit the following links:

- For PCPs: AAP Oral Health Risk Assessment Tool - **aap.org**
- For PCDs: ADA Caries Risk Assessment Form - **ada.org**
- For PCDs: ADA Caries Risk Assessment Form older than 6 - **ada.org**
- NJ Orthodontic Assessment Tool for Comprehensive Treatment HLD (NJ-Mod3) - **state.nj.us/humanservices/dmahs/home** > Provider Newsletters & Alerts > DMAHS Newsletter Vol. 32, No. 02 which may be found at **njmmis.com** under "Newsletters and Alerts".

For copies of these forms, check the UnitedHealthcare Community Plan Dental Provider Manual for NJ FamilyCare Dental by signing in to **uhcproviders.com**.

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Provision for dental services for members with intellectual and developmental disabilities

We provide access for comprehensive, quality dental services for the special needs member. Services include coordinated care and managing dental services to decrease member caries and periodontal disease. The program goals are to:

- Improve special needs members' access to quality comprehensive dental care through a network of care providers with expertise with developmental disabilities.
- Coordinate access and delivery with licensed medical staff and community-based organizations.
- Create dental management services and expanded benefits for comprehensive dental care within the framework of comprehensive total treatment planning and preventive care delivery.

Referrals for dental care provided in an operating room setting

Special needs members and children under the age of 5 may utilize hospital operating rooms (ORs) or an ambulatory surgical center for dental care when medically necessary. Our objectives are:

- The dental care management coordinator monitors linkages with care managers, community-based organizations and licensed medical staff to emphasize preventive education.
- Our chief dental officer monitors quality UM and program improvement using national and internally developed benchmark standards.
- Provider directories identify dentists that meet the treatment requirements of the special needs member.
- The special needs dental coordinator helps members with special needs in all aspects of dental treatment.

Requirements:

- The provider network includes dentists that offer expertise in the dental management of enrollees with developmental disabilities.
- In addition to the covered services we offer, special needs enrollees have a higher frequency of visits based on the dental risk assessment.
- The standard allows up to 4 preventive visits annually without prior authorization.
- All other quality UM and improvement benchmark standards are in effect.
- Emphasis is placed on partnerships with licensed medical staff, care manager and community organizations.
- Informed consent is required from all members with developmental disabilities or authorized legal representative/guardian before all surgical cases are treated in the OR.
- The member's care manager coordinates authorizations for dental-required hospitalizations with our dental consultant team.
- We review, audit and monitor the special needs program using our UM and quality improvement measures.

NJ FamilyCare dental clinical criteria policies

To view the NJ FamilyCare dental clinical criteria policies, visit UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plan > **Dental Clinical Policies and Coverage Guidelines**.

Orthodontic services standards

View current standards and procedures for orthodontic services in the DMAHS Newsletter Vol. 32, No. 02 at www.njmmis.com under "Newsletters and Alerts:" **DMAHS Newsletter Vol. 32, No. 02**.

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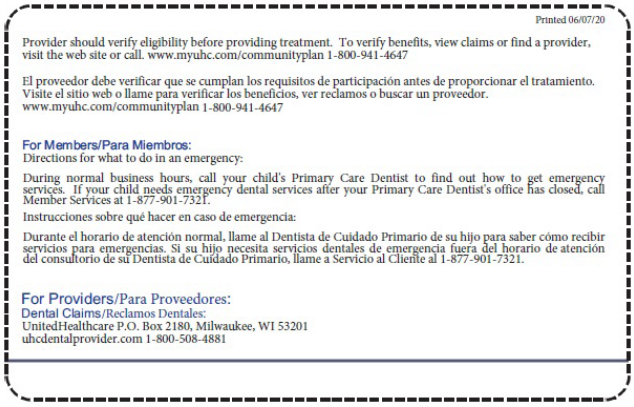
Member dental ID card

The following is a sample of a NJ FamilyCare member dental ID card for members who have a PCD assigned.



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Chapter 10: Mental Health and Substance Use

Key contacts

Topic	Link	Phone Number
Behavioral Health/Provider Express	providerexpress.com	888-362-3368
Provider Services	UHCprovider.com	888-362-3368

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

United Behavioral Health, operating under Optum, provides UnitedHealthcare Community Plan members with mental health and substance use disorder benefits. The national Optum network manual generally applies to all types of business. Some sections may apply differently based on state law.

Find the UnitedHealthcare Community Plan of New Jersey Behavioral Health Manual on providerexpress.com > Our Network > State-specific provider information > New Jersey > Provider Training Materials > New Jersey Medicaid Provider Manual.

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

You must have a National Provider Identification (NPI) number to see Medicaid members and receive payment from UnitedHealthcare Community Plan.

To request an ID number, go to the National Plan & Provider Enumeration System website at nppes.cms.hhs.gov > go to the section titled "Create a new account."

How to join the Optum Behavioral Health network: Credentialing information is available at providerexpress.com > Clinical Resources > Guidelines/Policies & Manuals > Credentialing Plans > Optum.

Behavioral health coverage

NJ FamilyCare MLTSS & DDD, and UnitedHealthcare Dual Complete® ONE (Medicare) members must use participating care providers listed in the provider directory. UnitedHealthcare Dual Complete® ONE (Medicare) members receive mental health and substance use services through us. Dual Complete® ONE members get their Medicare-covered mental health and substance use services through us as well. Submit Medicaid-covered mental health and substance use services to NJ Medicaid FFS unless MLTSS or DDD. The claims are then sent to us.

Covered services

We offer covered behavioral health services for mental, emotional and substance use disorders. We offer care management to help members, clinicians, and PCPs using and offering behavioral health services. We provide information and tools for mental health and substance use diagnoses, symptoms, treatments, prevention and other resources in one place.

liveandworkwell.com includes mental health and well-being information, articles on health conditions, addictions and coping, and provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.

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For member resources, go to providerexpress.com > Clinical Resources > Live and Work Well (LAWW) clinician center > Mind & Body > **Recovery and Resiliency**. This page includes tools to help members addressing mental health and substance use issues. You can also use the Search tool bar to search by word or topic.

Benefits include:

- Autism Spectrum Disorder (ASD)
  - Applied Behavioral Analysis (ABA)
  - Developmental Services
    - i) Developmental Individual Difference Relationship-Based Intervention/Floortime (DIR)
    - ii) Developmental Relationship-Based Intervention (DRBI)
    - iii) Naturalistic Developmental Behavioral Intervention (NDBI)
- Crisis stabilization services (includes treatment crisis intervention).
- Inpatient psychiatric hospital (acute).
- Outpatient assessment and treatment:
  - Partial hospitalization
  - Partial care
  - Intensive outpatient
  - Medication management
  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD long-term residential treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)
  - Child-parent psychotherapy
  - Multi-systemic therapy
  - Functional family therapy
  - Electroconvulsive therapy
  - Telemental health
  - Day treatment/intensive outpatient
- Inpatient medical detoxification
- Rehabilitation services
- Short-term and long-term residential
  - Psychiatric residential rehabilitation/adult mental health rehabilitation)

In addition, we cover SUD services for members enrolled in NJ FamilyCare/Medicaid, MLTSS, Division of Developmentally Disabled (DDD), and UnitedHealthcare Dual Complete® ONE (Medicare) plans. These include:

- Ambulatory withdrawal management
- Medication Assisted Treatment (MAT)
- Targeted case management
- Programs in Assertive Community Treatment (PACT)
- Behavioral health homes (BHH)
- Community support services

NJ FamilyCare members also get acute inpatient hospital coverage. This is not limited to MLTSS/DDD/ UnitedHealthcare Dual Complete® ONE (Medicare).

Eligibility

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

Optum Behavioral Health

Optum Behavioral Health gives you resources when members experience mental health or substance use problems. **Optum Behavioral Health Unit** is staffed by professionals with extensive experience in mental health and chemical dependence services and is available at any time. It helps care providers:

- Handle member emergencies and requests for inpatient behavioral health admissions.
- Assess and refer members to mental health and chemical dependence services.
- Reviews, monitors, and authorizes behavioral health care.

Call **Optum Behavioral Health** at **888-362-3368** to refer a member for behavioral health care. Document behavioral health referrals or requests in the patient's medical record. You may not refer patients to another care provider without notifying **Optum Behavioral Health** and obtaining prior authorization.

An eligible behavioral health member who is DDD, MLTSS, or Dual Complete® ONE (Medicare) can self-

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refer to a participating behavioral health care provider for the first outpatient visit at a participating care provider. Optum Behavioral Health generally approves, at most, 6 initial outpatient visits to allow for full clinical evaluation. The initial treatment assessment must include a full psychosocial history, a mental examination and medical-psychiatric evaluation. The Behavioral Health Unit assesses the member and develops a comprehensive treatment plan within the first 30 days of treatment.

For non-NJ FamilyCare DDD, MLTSS and UnitedHealthcare Dual Complete® ONE (Medicare) members, call the New Jersey Division of Medical Assistance and Health Services (DMAHS) at **800-701-0710**.

Behavioral health emergencies

If you believe the member is having a psychiatric emergency, call 911. Or direct the member to the designated county screening center or nearest ER. If you are unsure about the member's mental status, call Optum Behavioral Health.

If you are unsure about the member's mental status, call Provider Services at **888-362-3368**.

Behavioral health guidelines and standards

We use the following diagnostic assessment tools and placement criteria guidelines, consistent with current standards of care:

- DSM-IV (Diagnostic and Statistical Manual of Mental Disorders), 4th edition
- ASAM PPC-2 (American Society of Addiction Medicine)

UnitedHealthcare Community Plan uses Interqual guidelines for appropriateness of care and discharge reviews for mental health services and ASAM patient placement criteria and LOCI for substance use disorder (SUD) services.

Please comply with Timeliness Standards for Appointment Scheduling found in "Chapter 2: Care Provider Standards and Policies".

Behavioral health resources for PCPs

Behavioral health toolkit

PCPs must screen members for behavioral health conditions. As such, we created a behavioral health toolkit to help identify Integrated Care Program (ICP) members who may need behavioral health services. The toolkit provides helpful resource links containing important information about common behavioral health conditions and their treatment. It also assists the PCP in obtaining consultation and/or referral services treating behavioral health conditions.

Clinical practice guidelines (CPGs)

Access CPGs related to bipolar disorder, schizophrenia, depression, substance abuse disorders, at psych.org.

Screening tool

Screen members for depression at phqscreeners.com. If a member screens positive for a behavioral health condition, or you suspect the presence of a behavioral health condition needing further assessment, refer the member to a network behavioral health care provider.

Other resources

- Substance Abuse and Mental Health Services Administration (SAMHSA): samhsa.gov
- National Alliance on Mental Illness (NAMI): nami.org

Authorizations

Members may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care. Help ensure prior authorizations are in place before rendering non-emergent services. To obtain prior authorization, call Provider Services at **888-362-3368.**

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Enter your TIN, select option 3 (intake), enter member ID/DOB and select the option for Mental Health.

Continuation of outpatient behavioral health Services for NJ FamilyCare DDD, MLTSS and UnitedHealthcare Dual Complete® ONE (Medicare) Members

Call Optum Behavioral Health to submit requests for continued treatment. The Optum Behavioral Health evaluates the treatment plan for quality assurance. Optum Behavioral Health forwards the treatment plan review to the member's PCP to assure coordination of care. We authorize outpatient treatment for a 3-6 month period depending on treatment intensity.

Collaboration with other care providers

Coordination of care

When a member is receiving services from more than 1 professional, you must coordinate to deliver comprehensive, safe and effective care. This is especially true when the member:

- Is prescribed medication,
- Has coexisting medical/psychiatric symptoms, or
- Has been hospitalized for a medical or psychiatric condition.

Please talk to your patients about the benefits of sharing essential clinical information.

Referrals

Behavioral health care providers may not refer patients to another provider without notifying Optum Behavioral Health and obtaining prior authorization.

Care providers referring members for behavioral health services need to provide a copy of the medical consultation and diagnostic results to the mental health (MH)/substance abuse (SA) care provider. You must notify an enrollee's mental health/substance use provider of the findings of the physical examination and laboratory/radiological tests within 24 hours of receipt for urgent cases and 5 business days in non-urgent cases. Notification should be made by phone with follow-up in writing when feasible for services we manage and those managed by Medicaid FFS.

Documentation is required when notifying a member's MH/SA provider of the findings of their physical examination and laboratory/radiological tests within 24 hours of receipt for urgent cases and within 5 business days in non-urgent cases. Notification should be made by phone with follow-up in writing.

Referrals for members with special needs

To find a behavioral health specialist to refer a member with special needs, visit UHCprovider.com > Our Network > Find a Provider. Under Search for Doctors, Clinics or Facilities by Plan Type, click on Search for a Provider > Medical Directory > Medicaid Plans > New Jersey > (select plan) > Under Looking for Mental Health? choose a Mental Health Directory for NJ FamilyCare/LTC or UnitedHealthcare Dual Complete® ONE. Or call Provider Services at **888-362-3368**.

Portal access

Website: UHCprovider.com

Access the Provider Portal, the gateway to UnitedHealthcare Community Plan's online transactions, on this site. Use the transactions to verify eligibility, review electronic claim submission, view claim status, and submit notifications/prior authorizations.

View the Prior Authorization list, find forms and access the care provider manual. Or call Provider Services to verify eligibility and benefit information.

Website: providerexpress.com

Update your practice information, review guidelines and policies, and view the national Optum Network Manual. Or call Optum Behavioral Health.

Claims

Submit claims using the 1500 Claim Form (v 02/12) or UB-04 form, whichever is appropriate. Use applicable coding, including ICD diagnosis code(s), CPT, Revenue and HCPCS coding. Include all necessary data to process a complete claim. Find out more about filing claims in "Chapter 14: Billing and Submission".

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Monitoring audits

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

Addressing the opioid epidemic

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

Brief summary of framework

- Prevention:
  - Prevent OUDs before they occur through pharmacy management, provider practices, and education.
- Treatment:
  - Access and reduce barriers to evidence-based and integrated treatment.
- Recovery:
  - Support case management and referral to person-centered recovery resources.
- Harm Reduction:
  - Access to Naloxone and facilitating safe use, storage, and disposal of opioids.
- Strategic community relationships and approaches:
  - Tailor solutions to local needs.
- Enhanced solutions for pregnant mom and child:
  - Prevent neonatal abstinence syndrome and supporting moms in recovery.
- Enhanced data infrastructure and analytics:
  - Identify needs early and measure progress.

Increasing education & awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based CPGs. We keep OUD related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to CPGs, free SUD/OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also need behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, “The Role of the Health Care Team in Solving the Opioid Epidemic,” and “The Fight Against the Prescription Opioid Abuse Epidemic.” While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

Access these resources at **UHCprovider.com/njcommunityplan > Pharmacy Resources and Physician-Administered Drugs**. Click Opioid Program and Resources to find a list of tools and education.

Prescribing opioids

Go to our **Drug Lists and Pharmacy page** to learn more about which opioids require prior authorization and if there are prescription limits.

Expanding medication assisted treatment (MAT) access & capacity

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

To find a behavioral health MAT provider in New Jersey:

1. Visit UHCprovider.com > Our Network > **Find a Provider**.
2. Under Search for Doctors, Clinics or Facilities by Plan Type, click on Search for a Provider > Medical Directory > Medicaid Plans > New Jersey > (select plan).
3. Under Looking for Mental Health? choose a Mental Health Directory for NJ FamilyCare/LTC or UnitedHealthcare Dual Complete ONE.

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4. Under Refine Results, go to Treatment Options and click then check the box stating Medication Assisted Treatment.

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

To find medical MAT providers, see the **MAT section** in the Medical Management chapter.

Office-based addictions treatment attestation

Office-Based Addictions Treatment (OBAT) is the use of medications in combination with navigator services to coordinate counseling and behavioral therapies to treat SUD and OUD. These care providers are registered with the DEA to prescribe OUD treatment. Increasing PCPs' participation in SUD treatment, particularly MAT, offers an opportunity to improve access and to expand integration of care within NJ FamilyCare. The OBAT program supports care providers by:

- Increasing rates.
- Removing prior authorization requirements.
- Allowing PCPs to bill the managed care plan for this SUD service when the beneficiary is covered by managed care.
- Offering clinical guidance and support.

For more information about the OBAT program, refer to the State of New Jersey DHS Division of Medical Assistance & Health Services Newsletter Volume 29 No. 06 dated March 2019 at **njmmis.com** > Recent Newsletters > Volume 29 No. 06 - Subject: Office Based Addictions Treatment (OBAT) and Elimination of Prior Authorization for MAT for All MAT Providers, as of Jan. 1, 2019.

For a copy of the OBAT form, go to **UHCprovider.com/njcommunityplan** > **Provider Forms and References**. Under Provider Forms, click on **Medication-Assisted Treatment (MAT) and Office Based Addictions Treatment (OBAT) Questionnaire**.

Prescription abuse

If you suspect a member is misusing or abusing the prescription benefit by obtaining prescriptions from multiple care providers or requesting controlled substances for questionable indications, call the **UnitedHealthcare Fraud and Abuse Hotline** at **877-401-9430**. Also report stolen prescription pads and suspected forged prescriptions to us.

We will investigate the issues and take the appropriate action. This may include reporting the member to the state, enrolling the member in the pharmacy lock-in program and informing the pharmacy network of the activity. The pharmacy lock-in program restricts a member to a single pharmacy for obtaining prescriptions.

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Chapter 11: Member Rights and Responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	NJ FamilyCare/Medicaid: UHCCommunityplan.com/nj > NJ FamilyCare UnitedHealthcare Dual Complete® ONE: UHCCommunityplan.com/nj > UnitedHealthcare Dual Complete® ONE (HMO D-SNP)	800-941-4647 800-514-4911
Member Details	NJ FamilyCare/Medicaid Member Handbook: UHCCommunityplan.com/nj > NJ FamilyCare > Member Handbook Summary of Benefits for UnitedHealthcare Dual Complete® ONE: UHCCommunityPlan.com/nj > UnitedHealthcare Dual Complete® ONE (HMO D-SNP) > Downloadable resources > Summary of Benefits	800-941-4647 800-514-4911

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

Privacy regulations

HIPAA privacy regulations offer full federal protection to protect member health care information. These regulations control the internal and external uses and disclosures of such data. They also create member rights.

Access to protected health information

Members may access their medical records or billing information either through you or us. If their information is electronic, they may ask that you or we send a copy in an electronic format. They may also ask that a copy of their information be provided to a third party.

Amendment of PHI

Our members have the right to ask that you or we change information they believe to be inaccurate or incomplete. The member request must be in writing and explain why they want the change. You or we must act on the request within 60 days, or may extend another 30 days with written notice. If denying the request, provide certain information to the member explaining the denial reason and actions the member must take.

Accounting of disclosures

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

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

Right to request restrictions

Members have the right to ask you to restrict the use and disclosures of their PHI for treatment, payment and health care operations. For example, members may request to restrict disclosures to family members or to others who are involved in their care or payment. You may deny this request. If you approve restriction, document the request and restriction details. You will be required to abide by the restriction.

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Right to request confidential communications

Members have the right to request communications from you or us be sent to a separate location or other means. You must accommodate reasonable requests, especially if the member states disclosure could endanger them. Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Member rights and responsibilities

Our Member Handbook for NJFamilyCare and the Summary of Benefits for Dual Complete® ONE have sections on member rights and responsibilities. In them, we ask that members treat you with respect and courtesy.

Please refer to the table at the beginning of this chapter for the link to the Member Handbook for NJ FamilyCare. In this guide, the following member rights and responsibilities are published:

Member rights

Members have the right to:

- Be treated with respect, dignity and privacy by UnitedHealthcare and its providers.
- Be told about any illness they may have.
- Be told of any care or treatment that their PCP feels should be done before anything is done, even if UnitedHealthcare does not cover it. This includes the right to get accurate, easy-to-understand information to help them make good choices about their treatment.
- Refuse treatment as far as the law allows and to know what the outcome may be.
- Expect their doctors to keep their records and anything they say private. No information will be released to anyone without their consent, unless required by law.
- Request a current directory of providers in the UnitedHealthcare network to choose their own PCP.
- Get needed medical services within a reasonable length of time.
- If the member has a baby, they have the right to stay in the hospital for at least 48 hours after the delivery if it is a normal vaginal delivery. If they have a Cesarean section, they may stay in the hospital at least 96 hours after their baby is born.
- File a grievance or an appeal to UnitedHealthcare and get a reply in a timely manner.
- Receive information about UnitedHealthcare, its services, its practitioners and providers, member rights and responsibilities, and to be informed of UnitedHealthcare rules and any changes that are made.
- Make suggestions regarding UnitedHealthcare policies and procedures, including their rights and responsibilities.
- Talk about their medical records with their PCP and get a complete copy of those records.
- Be informed of all FFS benefits they are eligible for and of all medical services available to them by UnitedHealthcare.
- Have an authorized representative of their choice to make medical determinations for them.
- Ask for a second opinion about any medical care that their PCP advises them to have.
- Know how UnitedHealthcare decides whether a service is covered and/or is medically necessary.
- A translator if they need one when they talk to us or one of our providers.
- Participate in all decisions about their health care and the development of any plan of care designed for them.
- Speak to providers in private and have medical records kept private.
- Be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse or neglect.
- Be free from hazardous procedures.
- Be free from balance billing.
- Have services provided that promote a meaningful quality of life and independence for them including living in their own home or another community setting as long as it is medically and socially feasible, and the right to the preservation and assistance of their natural support system.
- Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, gender identity, marital status, or disability.

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- Obtain information about our provider that includes the provider's education, residency completed, board certification and recertification. To get this information, members may call Member Services at 800-941-4647, TTY 711.

MLTSS members also have the right to:

- Request and receive information on choice of services available.
- Have access to and choice of qualified service providers.
- Be informed of their rights prior to receiving chosen and approved services.
- Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status, or disability.
- Have access to appropriate services that support their health and welfare.
- Assume risk after being fully informed and able to understand the risks and consequences of the decisions made.
- Make decisions concerning their care needs.
- Participate in the development of changes to their plan of care.
- Request changes in services at any time, including add, increase, decrease or discontinue.
- Request and receive from their care manager a list of names and duties of any persons assigned to provide services under their plan of care.
- Receive support and direction from their care manager to resolve concerns about their care needs and/or grievances about services or providers.
- Be informed of and receive in writing facility specific resident rights upon admission to an institutional or residential setting.
- Be informed of all the covered/required services the member is entitled to, required by and/or offered by the institutional or residential setting, and any charges not covered by the managed care plan while in the facility.
- Not to be transferred or discharged out of a facility except for medical necessity; to protect their physical welfare and safety or the welfare and safety of other residents; or because of failure, after reasonable and appropriate notice of non-payment to the facility from available income as reported on the statement of available income for FFS payment.
- Have their health plan protect and promote their ability to exercise all rights.
- Have all rights and responsibilities forwarded to their authorized representative or court appointed legal guardian.

NJ FamilyCare: New Jersey HMO consumer bill of rights

In addition to the rights members have as part of UnitedHealthcare Community Plan, they have other rights as a member of a health plan in New Jersey.

The New Jersey Association of Health Plans is a non-profit association representing leading commercial and Medicaid health care plans in the state. For a list of their Consumer Bill of Rights, visit njahp.org > Consumer Information > **Consumer Bill of Rights**.

Member responsibilities

Members should:

- Supply information the organization or practitioners need to provide care.
- Understand their benefits so they can get the most value from them.
- Show you their Medicaid member ID card.
- Prevent others from using their ID card.
- Understand their health problems and give you true and complete information.
- Ask questions about treatment.
- Work with you to set treatment goals.
- Follow the agreed-upon treatment plan.
- Get to know you before they are sick.
- Keep appointments or tell you when they cannot keep them.
- Treat your staff and our staff with respect and courtesy.
- Get any approvals needed before receiving treatment.
- Use the ER only during a serious threat to life or health.
- Notify us of any change in address or family status.
- Make sure you are in-network.
- Follow your advice and understand what may happen if they do not follow it.
- Give you and us information that could help improve their health.

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UnitedHealthcare Dual Complete® ONE member rights and responsibilities

Dual Complete® ONE members have similar rights and responsibilities. Please refer to the table at the beginning of this chapter for the link to the Summary of Benefits for UnitedHealthcare Dual Complete® ONE. Following are some of these members' rights and responsibilities published in this guide:

- A right to respect, fairness, and dignity. This includes the right to:
  - Get covered services without concern about race, ethnicity, national origin, color, religion, creed, sex (including sex stereotypes and gender identity), age health status, disability (mental, physical, or sensory), sexual orientation, genetic information, ability to pay, or ability to speak English. No health care provider should engage in any practice, with respect to any member that constitutes unlawful discrimination under any state or federal law or regulation.
  - Ask for and get information in other formats (for example, large print, braille, audio) free of charge.
  - Be free from any form of physical restraint or seclusion.
  - Not be billed by network providers for covered services.
  - Have their questions and concerns answered completely and courteously.
  - Apply their rights freely without any negative effect on the way UnitedHealthcare Dual Complete® ONE or their provider treats them.
- Get information about their health care. This includes information on treatment and their treatment options, regardless of cost or benefit coverage. This information should be in a format and language that they can understand. These rights include getting information on:
  - UnitedHealthcare Dual Complete® ONE
  - The services we cover
  - How to get services
  - How much services will cost the member
  - Names of health care providers and care managers
  - Rights and responsibilities
- Make decisions about their care, including refusing treatment. This includes the right to:
  - Choose a PCP. Members can change their PCP at any time during the year. They can call Member Services for Dual Complete® ONE at 800-514-4911 if they want to change their PCP.
  - See a women's health care provider without a referral.
  - Get their covered services and drugs quickly.
  - Know about all treatment options, no matter what they cost or whether they are covered.
  - Refuse treatment as far as the law allows, even if their health care provider advises against it.
  - Ask for a second opinion about any health care that their PCP or care team advises them to have. UnitedHealthcare Dual Complete® ONE will pay for the cost of their second opinion visit.
  - Make their health care wishes known in an advance directive.
- Timely access to care that does not have any communication or physical access barriers. This includes the right to:
  - Get timely medical care.
  - Get in and out of a health care provider's office. This means barrier-free access for people with disabilities, based on the American with Disabilities Act.
  - Have interpreters to help with communication with their doctors, other providers and their health plan.
  - Have their Evidence of Coverage and any printed materials from UnitedHealthcare Dual Complete® ONE translated into their primary language, or to have these materials read out loud to them if they have trouble seeing or reading. Oral interpretation services will be made available upon request and free of charge.
  - Be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience or retaliation.
- Seek emergency and urgent care when they need it. This means they have the right to:
  - Get emergency and urgent care services, 24 hours a day, 7 days a week, without prior approval.
  - See an out-of-network urgent or emergency care provider, when necessary.

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- Confidentiality and privacy. This includes the right to:
  - Ask for and get a copy of their medical records in a way that they can understand and to ask for their records to be changed or corrected.
  - Have their personal health information kept private. No personal health information will be released to anyone without their consent, unless required by law.
  - Have privacy during treatment.
- Make complaints about their covered services or care. This includes the right to:
  - Access an easy process to voice their concerns, and to expect follow-up by UnitedHealthcare Dual Complete® ONE.
  - File a complaint or grievance against us or our providers. They also have the right to appeal certain decisions made by us or our providers.
  - Ask for a state appeal (state fair hearing).
  - Get a detailed reason why services were denied.

UnitedHealthcare Dual Complete® ONE member responsibilities include:

- Treating others with respect, fairness, and dignity. Members should:
  - Treat their health care providers with dignity and respect.
  - Keep appointments, be on time, and call in advance if they're going to be late or have to cancel.
- Give information about them and their health. They should:
  - Tell their health care provider their health complaints clearly and provide as much information as possible.
  - Tell their health care provider about themselves and their health history.
  - Tell their health care provider that they are a UnitedHealthcare Dual Complete® ONE member.
  - Talk to their PCP, care manager or other appropriate person about seeking the services of a specialist before they go to a hospital (except in cases of emergency).
  - Tell their PCP, care manager, or other appropriate person within 24 hours of any emergency or out-of-network treatment.
  - Notify UnitedHealthcare Dual Complete® ONE Customer Service if there are any changes in their personal information, such as their address or phone number.
- Make decisions about their care, including refusing treatment. They should:
  - Learn about their health problems and any recommended treatment, and consider the treatment before it's performed.
  - Partner with their care team and work out treatment plans and goals together.
  - Follow the instructions and plans for care that the member and their health care provider has agreed to, and remember that refusing treatment recommended by their health care provider might harm their health.
- Obtain their services from UnitedHealthcare Dual Complete® ONE. The member should:
  - Get all their health care from UnitedHealthcare Dual Complete® ONE, except in cases of emergency, urgent care, out-of-area dialysis services, or family planning services, unless UnitedHealthcare Dual Complete® ONE provides a prior authorization for out-of-network care.
  - Not allow anyone else to use their UnitedHealthcare Dual Complete® ONE Member ID Card to obtain healthcare services.
  - Notify UnitedHealthcare Dual Complete® ONE when they believe that someone has purposely misused UnitedHealthcare Dual Complete ® ONE benefits or services.

For a complete details of the Dual Complete® ONE member Rights & Responsibilities, visit **UHCCommunityPlan.com/nj** > UnitedHealthcare Dual Complete® ONE (HMO D-SNP) > Downloadable Resources > Evidence of Coverage.

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

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

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Chapter 12: Medical Records

Looking for something?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.

Medical record charting standards

All participating medical, dental, behavioral and MLTSS practitioners are required to keep complete and orderly medical records in paper or electronic format, which fosters efficient and quality member care.

You are subject to our periodic quality medical record review. The review could include any of the following items to determine compliance.

Topic	Contact
Confidentiality of Record	Office policies and procedures exist for: • Privacy of the member’s medical record. • Initial and periodic training of office staff about medical record privacy. • Release of information. • Record retention. • Availability of medical record if housed in a different office location. • Process for notifying UnitedHealthcare Community Plan upon becoming aware of a patient safety issue or concern. • Coordination of care between medical and behavioral care providers.
Record Organization and Documentation	• Have a policy that provides medical records upon request. Urgent situations require you to provide records within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing Medical records. • Release only to entities as designated consistent with federal requirements. • Keep in a secure area accessible only to authorized personnel.

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Topic	Contact
Procedural Elements	**Medical records are readable*** • Sign and date all entries. • Member name/identification number is on each page of the record. • Document language or cultural needs. • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member's first language is something other than English. • Procedure for monitoring and handling missed appointments is in place. • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions. • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions.*
History	An initial history (for members seen 3 or more times) and physical is performed. It should include: • **Medical and surgical history.*** • A family history that includes relevant medical history of parents and/or siblings. • A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance abuse use/history beginning at age 11. • Current and history of immunizations of children, adolescents and adults. • Screenings of/for: - Recommended preventive health screenings/tests - Depression - High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit - Medicare members for functional status assessment and pain - Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

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Topic	Contact
Problem Evaluation and Management	Documentation for each visit includes: • Appropriate vital signs (Measurement of height, weight, and BMI annually) - **Chief complaint*** - **Physical assessment*** - **Diagnosis*** - **Treatment plan*** • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines. • Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnostic and Treatment (EPSDT). • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets. • Treatment plans are consistent with evidence-based care and with findings/ diagnosis: - Time frame for follow-up visit as appropriate - Appropriate use of referrals/consults, studies, tests • X-rays, labs and consultation reports are included in the medical record with evidence of care provider review. • There is evidence of care provider follow-up of abnormal results. • Unresolved issues from a previous visit are followed up on the subsequent visit. • There is evidence of coordination with a behavioral health care provider. • Education, including lifestyle counseling, is documented. • Member input and/or understanding of treatment plan and options is documented. • Copies of hospital discharge summaries, home health care reports, emergency room care and practitioner are documented.
Pediatric Primary Care	Pediatric charting must include: • Flow chart for immunizations. • Growth and development chart. • Documentation of compliance with EPSDT guidelines (for NJ FamilyCare members younger than age 21 years).

***Critical element**

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Member copies

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

Medical record review

On an ad hoc basis, we conduct a review of our members' medical records. We expect you to achieve a passing score of 85% or better. To achieve this score, the medical records you maintain should contain an initial health assessment, including a baseline comprehensive medical history. This assessment should be completed in less than 2 visits, with ongoing physical assessments occurring on following visits. It should also include:

- Problem list with:
  - Biographical data with family history.
  - Past and present medical and surgical intervention.
  - Significant medical conditions with date of onset and resolution.
  - Documentation of education/counseling regarding HIV pre- and post-test, including results.
- Entries dated and the author identified.
- Legible entries.
- Medication allergies and adverse reactions (or note if none are known).
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen 3 or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record.
- Tobacco habits, alcohol use and substance abuse (11 years and older).
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one.
- History of physical examination (including subjective and objective findings).
- Unresolved problems from previous visit(s) addressed in subsequent visits; diagnosis and treatment plans consistent with finding.
- Lab and other studies as appropriate.
- Member education, counseling and/or coordination of care with other care providers.
- Notes regarding the date of return visit or other follow-up.
- Consultations, lab, imaging and special studies initialed by PCP to indicate review.
- Consultation and abnormal studies including follow-up plans.

Member hospitalization records should include, as appropriate:

- History and physical.
- Consultation notes.
- Operative notes.
- Discharge summary.
- Other appropriate clinical information.
- Documentation of appropriate preventive screening and services.
- Documentation of behavioral health assessment (CAGE-AID, TWEAK AND PHQ-9).

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Medical record documentation standards audit tool sample

Provider Name: Provider ID#:

Review Name: Review Date:

Member Name:

Member ID#:

AUDIT CRITERIA	Yes	No	N/A
Procedural Elements			
1. The medical record is legible.			
2. All entries are signed and dated.			
3. Patient name/identification number is located on each page of the record.			
4. Medical records contain patient demographic information.			
5. Medical record identifies primary language spoken and any cultural or religious preferences if applicable.			
6. Adults 18 and older, emancipated minors, and minors with children have an executed advance directive documented in a prominent part of the medical record. IF NONE, then adults 18 and older, emancipated minors, and minors with children are given information about advance directives and documented.			
7. A problem list includes significant illnesses and active medical conditions.			
8. A medication list includes prescribed and over-the-counter medications and is reviewed annually.			
9. The presence or absence of allergies or adverse reactions is clearly displayed.			
History			
1. Medical and surgical history is present.			
2. For children/adolescents (birth to 18 years) documentation of prenatal care, birth and operations of childhood (if applicable)			
3. The family history includes pertinent history of parents and/or siblings.			
4. The social history minimally includes pertinent information such as occupation, living situation, etc.			
5. If applicable, is there a completed consent form for hysterectomy and sterilization?			
Preventive Services			
1. Evidence that patients age 65 and older are screened for functional status and pain.			
2. Annual comprehensive physical (or more often for newborns).			
3. Documentation of mental & physical development for children and/or cognitive functioning for adults.			
4. Evidence of depression/mental health screening (12 years or older).			
5. Evidence of Verbal Lead Risk Assessment at periodic visits from 6 months until the age of 72 months (6 years old) (If applicable).			
6. Documentation of screening for smoking with clinical response to positive screen (11 years and older) (if applicable).			
7. Documentation of alcohol and substance abuse with clinical response to positive screen (11 years and older) (if applicable).			

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AUDIT CRITERIA	Yes	No	N/A
Procedural Elements			
8. Documentation of family planning for patients age 19 and older and emancipated minors ages 18 and younger (if applicable).			
9. Evidence of tracking and referral of age and gender appropriate preventive health services.			
10. Use of flow sheets or tools to promote adherence to Clinical Practice Guidelines/ Preventive Screenings.			
11. Dental referral/education/visit for adults or any child greater than 1 year or after first tooth eruption.			
12. Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) for children under age 21: (if applicable) *Comprehensive health and development history, unclothed exam, nutrition assessment, immunizations, lab testing including lead screening, vision/hearing screening, dental inspection.			
Problem Evaluation and Management			
1. Adult BMI value done annually (ages 18-74).			
2. Child/adolescent BMI percentile done annually (ages 3-17).			
3. If there is BMI documentation, is there documentation of counseling for nutrition & physical activity (ages 13-17)?			
4. If there is BMI documentation, is there documentation regarding physical activity? (ages 3-17)?			
5. Appropriate vital signs done at each visit.			
6. Chief complaint listed at each visit.			
7. Physical assessment done at each visit.			
8. Diagnosis listed at each visit.			
9. Treatment plan for each visit.			
Treatment Plans - Are consistent with evidence-based care and with findings/diagnosis:			
1. Appropriate use of referrals, consults, studies and tests (N/A if services not warranted).			
2. X-rays, labs, consultation reports are documented in the medical record and reviewed by provider (if applicable).			
3. Timeframe for follow-up visit as appropriate.			
4. Follow-up of all abnormal diagnostic tests, procedures, x-rays, consultation reports (if applicable).			
5. Unresolved issues from the first visit are followed up on the subsequent visit (if applicable).			
6. There is evidence of coordination of care with behavior health as applicable (if applicable).			
7. Education, including counseling is documented.			
8. Copies of hospital discharge summaries, home health care reports, emergency room care, physical or therapies as ordered by the practitioner are documented (if applicable).			

Care providers whose medical records are surveyed are required to pass with an 85% score. All surveyed providers are notified of their scores. Any provider who scores less than 85% will receive the details of their medical records review results and have the opportunity to discuss the results with the Quality Division.

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Chapter 13: Quality Management (QM) Program and Compliance Information

Key contacts

Topic	Link	Phone Number
Credentialing	Medical: Network Management Resource Team at Networkhelp@uhc.com	877-842-3210
Fraud, Waste and Abuse (Payment Integrity)	uhc.com/fraud	800-455-4521

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

What is the Quality Improvement Program?

UnitedHealthcare Community Plan's comprehensive Quality Improvement program falls under the leadership of the CEO and the chief medical officer. A copy of our Quality Improvement program is available upon request.

The program consists of:

- Identifying the scope of care and services given.
- Developing clinical guidelines and service standards.
- Monitoring and assessing the quality and appropriateness of services given to our members based on the guidelines.
- Promoting wellness and preventive health, as well as chronic condition self-management.
- Maintaining a network of providers that meets adequacy standards.
- Striving for improvement of member health care and services.
- Monitoring and enhancing patient safety.
- Tracking member and provider satisfaction and taking actions as appropriate.

As a participating care provider, you may offer input through representation on our Provider Advisory Committee (PAC) and by communicating with your provider services representative/provider advocate.

Cooperation with quality-improvement activities

You must comply with all quality-improvement activities. These include:

- Providing requested timely medical records.
- Cooperating with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.
- Participating in quality audits, such as site visits and medical record standards reviews, and taking part in the annual HEDIS® record review.
- Providing requested medical records at no cost to the member (or as indicated in your Agreement with us). You may provide records during site visits or by email or secure email.
- Adhering to practitioner appointment access and availability requirements.

We require your cooperation and compliance to:

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

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Quality concerns and corrective actions

All confirmed quality issues are subject to corrective action, including provider sanctions. The QM staff review activities for potential quality concerns on an ongoing basis and refer potential quality concerns to our medical director. When the QM staff finds a quality concern, it notifies the appropriate care provider and requests a response, along with any supporting documentation, within a specified period. A second opinion by a specialist may be requested, if deemed appropriate. Upon receipt, a medical director assigns a severity level:

- 0: No quality issue identified; no adverse member outcome
- 1: Quality issue identified; appears to have not contributed any harm or damage to the member
- 2: Quality issue identified; appears to have contributed to non-permanent harm or damage to the member
- 3: Quality issue identified; appears to have contributed to permanent harm or damage to the member (not recoverable), including death

A confirmed issue is presented to our PAC for peer review. The PAC makes a final determination on the severity level. The medical director notifies the provider through certified mail. The letter includes a description of the quality concern and detailed action plan.

Sanctions for quality concerns

In addition to the corrective action plan, we may impose provider sanctions, depending upon the severity level and frequency of the issue. Not implementing the corrective action plan within 60 days may result in a 30-day closure of the care provider's panel to new members or issuance of a notice of termination.

A medical director may require the care provider to obtain additional education, including:

- CME courses relating to the problem.
- Medical literature reading.
- Charting conferences.
- Self-examination courses.

The care provider is given a specified period to complete the appropriate educational plan. Failure to do so may result in the issuance of a notice of termination or notifying the appropriate federal, state, and licensing authorities.

Termination and appeal process

We may end a care provider's network participation for not complying with certain contractual obligations or QM requirements. Termination may be immediate or allow for an appeals process.

We may not suspend or terminate a care provider solely because they:

- Acted as an advocate for a member seeking appropriate, medically necessary care.
- Filed an appeal.
- Expressed disagreement with our decision to deny or limit benefits to a member.
- Engaged in medical communications with a patient about medically necessary treatment options.

Termination for failure to comply with quality management requirements

The QM committee may suspend or terminate any health care provider's network participation for several reasons. They include:

- Not complying with their corrective action plan.
- Refusing to make medical records available for examination.
- Not submitting recredentialing information.
- Not complying with the QM program.

In these cases, a medical director will send a certified letter explaining the termination and detailing the care provider's rights to comply, respond or ask for a hearing.

Care provider satisfaction

Every year, UnitedHealthcare Community Plan conducts care provider satisfaction assessments as part of our quality improvement efforts. We assess and promote your satisfaction through annual care provider satisfaction surveys.

Our main concern with the survey is objectivity. That's why UnitedHealthcare Community Plan engages

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independent market research firm Center for the Study of Services (CSS) to analyze and report findings.

Survey results are reported to our PAC. It compares the results year over year as well as to other UnitedHealthcare Community Plan plans across the country. The survey results include key strengths and improvement areas. Additionally, we carry out improvement plans as needed.

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you based on applicable New Jersey statutes and the NCQA. We require the following items to begin the credentialing process:

- A completed credentialing application, including Attestation Statement.
- Current medical license.
- Current DEA certificate.
- Current professional liability insurance.

We verify information from primary sources about licensure, education and training. We also verify board certification and malpractice claims history.

Credentialing and recredentialing process

Our credentialing and recredentialing process determines whether you are a good fit for our care provider network. You must go through the credentialing and recredentialing process before you treat our members.

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

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

Excluded from this process are practitioners who:

- Practice only in an inpatient setting,
- Hospitalists employed only by the facility, and/or
- NPs and PAs who practice under a credentialed UnitedHealthcare Community Plan care provider.

Health facilities

Facility providers such as hospitals, home health agencies, SNFs and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements. Facilities must meet the following requirements or verification:

- State and federal licensing and regulatory requirements and an NPI number.
- Have a current unrestricted license to operate.
- Have been reviewed and approved by an accrediting body.
- Have malpractice coverage/liability insurance that meets contract minimums.
- Agree to a site visit if not accredited by the Joint Commission (JC) or other recognized accrediting agency.
- Have no Medicare/Medicaid sanctions.

UnitedHealthcare Community Plan does not make credentialing and recredentialing decisions based on race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes.

The National Credentialing Center (NCC) completes these reviews. Find applications on the Council for Affordable Quality Healthcare (CAQH) website.

Go to **UHCprovider.com/join** to submit a participation request.

Submit the following supporting documents to CAQH after completing the application:

- Curriculum vitae
- Medical license
- DEA certificate
- Malpractice insurance coverage
- IRS W-9 Form

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Peer review

Credentialing process

A peer review committee reviews all credentialing applications and makes a final decision. The decisions may not be appealed if they relate to mandatory criteria at the time of credentialing. We will notify you of the decision in writing within 60 calendar days of the review.

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every 3 years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website. Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have 3 chances to answer the request before your participation privileges are terminated.

Performance review

As part of the recredentialing process, UnitedHealthcare Community Plan looks in its Quality Management database for information about your performance. This includes member complaints and quality of care issues.

Applicant rights and notification

You have the right to review information you submitted to support your credentialing/recredentialing application. This excludes personal or professional references or review protected information. You have the right to correct erroneous information you find. Submit updated information directly to your CAQH credentialing application. If the NCC finds erroneous information, a representative will contact you by phone or in writing. You must submit corrections within 30 days of notification by phone, or in writing to the number or address the NCC representative provided.

You also have the right to receive the status of your credentialing application, please email us at networkhelp@uhc.com. Include your full name, NPI, TIN and brief description of the request. A UnitedHealthcare representative will be in touch with you within 2 business days from when we receive your request.

Confidentiality

All credentialing information collected during the review process is kept confidential. It is only shared with your approval or as required by law with those involved in the credentialing process.

Resolving disputes

Contract concerns

If you have a concern about your Agreement with us, email northeastprteam@uhc.com.

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

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

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

If a member has authorized you in writing to appeal a clinical or coverage determination on their behalf, that appeal follows the member appeals process as outlined in the Member Handbook, Evidence of Coverage and "Chapter 15: Claims, Reconsiderations and Appeals" of this manual.

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HIPAA compliance – your responsibilities

Health Insurance Portability and Accountability Act

The HIPAA Act of 1996 aims to improve the efficiency and effectiveness of the U.S. health care system. While the Act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have had the greatest impact on how the health care industry works. UnitedHealthcare Community Plan is a "covered entity" under these regulations. So are all health care providers who conduct business electronically.

Transactions and code sets

If you conduct business electronically, submit claims using the standard formats adopted under HIPAA. Otherwise, submit claims using a Clearinghouse.

Unique identifier

HIPAA also requires unique identifiers for employers, health care providers, health plans and individuals for use in standard transactions.

National Provider Identifier

The NPI is your standard unique identifier. It is a 10-digit number with no embedded intelligence that covered entities must accept and use in standard transactions. While HIPAA only requires you to use the NPI in electronic transactions, many state agencies require it on FFS claims and encounter submissions. For this reason, UnitedHealthcare Community Plan requires the NPI on paper transactions.

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES). Share it with all affected trading partners, such as care providers to whom you refer patients, billing companies and UnitedHealthcare Community Plan.

Privacy of individually identifiable health information

The privacy regulations limit how health plans, pharmacies, hospitals and other covered entities can use members' medical information. The regulations protect medical records and other identifiable health information. This includes electronic, paper or spoken data.

They enhance consumers' rights by giving them access to their health information and controlling its inappropriate use. They also improve health care delivery by extending the privacy efforts of states and health systems to a national level.

Security

Covered entities must meet basic security measures:

- Help ensure the confidentiality, integrity and availability of all electronic protected health information (PHI) the covered entity creates,
- Protect against any reasonably anticipated threats, uses or disclosures of information not permitted or required under the Privacy Regulations, and
- Help ensure compliance with the security regulations by the covered entity's staff.

UnitedHealthcare Community Plan expects you to comply with all HIPAA regulations.

Find additional information on HIPAA regulations at cms.hhs.gov.

Ethics and integrity

UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with you, members, suppliers and government officials and agencies. Making sound decisions as we interact with you, other health care providers, regulators and others is necessary for our continued success and that of our business associates. It's also the right thing to do.

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Compliance program

As a segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Community Plan Compliance program incorporates the required 7 elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

- Oversight of the Ethics and Integrity program.
- Development and implementation of ethical standards and business conduct policies.
- Creating awareness of the standards and policies by educating employees.
- Assessing compliance by monitoring and auditing.
- Responding to allegations of violations.
- Enforcing policies and disciplining confirmed misconduct or serious neglect of duty.
- Reporting mechanisms for workers to alert management and/or the Ethics and Integrity program staff to violations of law, regulations, policies and procedures, or contractual obligations.

UnitedHealthcare Community Plan has compliance officers for each health plan. In addition, each health plan has a compliance committee consisting of senior managers from key organizational areas. The committee provides program direction and oversight.

Reporting and auditing

Report any unethical, unlawful or inappropriate activity by a UnitedHealthcare Community Plan employee to a UnitedHealthcare Community Plan senior manager or directly to the Compliance Office.

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

An important part of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews to help ensure compliance with law, regulations and policies/contracts. When informed of potentially inappropriate or fraudulent practices within the plan or by you, UnitedHealthcare Community Plan conducts an investigation. You must cooperate with the company and government authorities. This means giving access to pertinent records (as required by your applicable Provider Agreement and this manual) as well as access to office staff. If we establish activity in violation of law or regulation, we will advise appropriate governmental authorities.

If you become the subject of a government inquiry or investigation, or a government agency requests documents relating to your operations (other than a routine request for documentation), you must provide UnitedHealthcare Community Plan with the details. You must also reveal what triggered the inquiry.

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan works with the State of New Jersey to perform "individual and corporate extrapolation audits." This may affect all programs supported by dual funds (state and federal funding) as well as state-funded programs, as requested by the New Jersey DHS.

Delegating and subcontracting

If you delegate or subcontract any function, the delegate or subcontractor must include all requirements of your applicable Provider Agreement and this manual.

Fraud, waste and abuse

Call the toll-free **Fraud, Waste and Abuse Hotline** to report questionable incidents involving plan members or care providers. Or go to **uhc.com/fraud**.

There is no single definition of *fraud* in the health care industry. Generally speaking, fraud as a legal concept involves an intentional misrepresentation of a material fact made to induce detrimental reliance by another. A misrepresentation can entail an affirmative false statement or the omission of a material fact. Moreover, fraud can be both intentional (knowing), reckless, or negligent. Intentional or knowing fraud can include both misrepresentations made to deceive and induce reliance, and those made with the knowledge that they

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are substantially likely to induce reliance. Federal and state statutes and regulations variously define fraud (e.g.,42 C.F.R. § 455.2 defines fraud as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person."). For the purposes of this Program, PSMG construes health care fraud liberally in its broadest sense.

Waste and abuse in the context of health care claims are generally broader concepts than fraud. They include over- utilization of services and care provider and member practices inconsistent with sound fiscal, business, or medical practices that cause unnecessary costs or fail to meet professionally recognized health care standards.

Some typical general categorical examples of care provider health care fraud, waste and abuse include:

- Billing for services/goods never provided.
- Billing for services/goods not medically necessary.
- Billing for services/goods not covered (e.g., experimental services) and/or for services to ineligible members.
- Duplicative billing for the same services/goods.
- Billing without adequate supporting documentation.
- Billing for more costly/complex services/goods than those actually provided ("upcoding").
- Billing separately services/goods required to be billed collectively ("unbundling").
- Improper modifications of billing code.
- Billings by fictitious, sanctioned, and/or unqualified provider.
- Excessive fees charged for services/goods.
- Poor quality services that are tantamount to no services provided.
- Care provider/member identity theft.
- Care provider waiver of patient copayments.
- Misrepresentations in cost reports.
- Unlawful referrals of patients to related care providers.

Some examples of member/beneficiary health care fraud, waste and abuse include:

- Selling/loaning member identification information.
- Intentional receipt of unnecessary/excessive services/ goods.
- Unlawful sales of prescriptions and/or prescription medications.
- Misrepresentations to establish program/plan eligibility (e.g., non-disclosure of income/assets).

UnitedHealthcare Community Plan's anti-fraud, waste and abuse program

Our program focuses on prevention, detection and investigation of any false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies according to state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its Anti-Fraud, Waste and Abuse Program. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

An important aspect of the Compliance Program is reviewing our operation's high-risk areas. Then we implement reviews and audits to help ensure compliance with law, regulations and contracts. You are contractually obligated to cooperate with the company and government authorities.

Find out how we follow federal and state regulations around false claims at UHCprovider.com/NJcommunityplan > **Integrity of Claims, Reports, and Representations to the Government** or call **844-359-7736**.

Federal and state fraud, waste and abuse laws

The Deficit Reduction Act (DRA) of 2005 plays a role in preventing/detecting fraud, waste and abuse under Medicaid. Find information about the DRA at CMS.

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gov > Regulations & Guidance > Legislation > **Deficit Reduction Act**. You can also access **Deficit Reduction Act: Important Facts for State Government Officials** for more details. For a reference to the policy developed by the Department of Human Services (DHS) Division of Developmental Disabilities (DDS), visit **Federal Deficit Reduction Act of 2005, Section 6032 Policy on Fraud, Waste and Abuse**.

The DRA has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least $5 million in annual Medicaid payments must have written policies for entity employees and contractors. They must provide detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

This policy details our commitment to compliance with the federal and state false claims acts. It provides a detailed description of these acts and of organizational mechanisms that detect and prevent fraud, waste and abuse. It also details how whistleblowing employees are protected. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

You are required to comply with all federal and state fraud, waste and abuse laws.

Federal False Claims Act

Find information about the Federal False Claims Act, 31 U.S.C. § 3729 – 3733 by visiting the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) > Compliance > Compliance Resource Portal > Resources for Physicians > A Roadmap for New Physicians > **A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse**. This includes whistleblower protections and Fraud, Waste and Abuse sections such as the Anti-Kickback Statue and the Exclusion statute.

To see the policy developed by the Department of Human Services (DHS) Division of Developmental Disabilities (DDS) referencing the False Claims Act, visit **Federal Deficit Reduction Act of 2005, Section 6032 Policy on Fraud, Waste and Abuse**.

Federal Program Fraud Civil Remedies Act

Read about the Federal Program Fraud Civil Remedies Act, 31 31 U.S.C. § 3801 – 3812 at hhs.gov > About HHS > HHS Family of Agencies > HHS Agencies & Offices > Department Appeals Board (DAB) > Different Appeals at DAB > Appeals to Board > Guidelines > **Under the Program Fraud Civil Remedies Act of 1986**. For a reference to the policy developed by the DHS Division of Developmental Disabilities (DDS) referencing the Federal Program Fraud Civil Remedies Act, visit **Federal Deficit Reduction Act of 2005, Section 6032 Policy on Fraud, Waste and Abuse**.

New Jersey Health Care Claims Fraud Act

Learn about the New Jersey Health Care Claims Fraud Act, N.J.S. 2C:21 4.2 and 4.3 at on nj.gov > **Definitions relative to healthcare claims fraud and Health care claims fraud, degree of crime; prosecution guidelines**. Additionally, a reference to the New Jersey Code of Criminal Justice Section 2C:51-5 - Forfeiture, suspension of license, certificate; exceptions states that "a practitioner convicted of health care claims fraud or a substantially similar crime under the laws of another state or the United States shall forfeit his license and be forever barred from the practice of the profession unless the court finds that such license forfeiture would be a serious injustice which overrides the need to deter such conduct by others and in such case the court shall determine an appropriate period of license suspension which shall be for a period of not less than 1 year."

New Jersey Conscientious Employee Protection Act

The New Jersey Conscientious Employee Protection Act , N.J.S. 34:19 1 et seq., protects employees against retaliation from their employer. For more information, reference the **Conscientious Employee Protection Act "Whistleblower Act"** found on nj.gov.

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New Jersey False Claims Act

Find information about the New Jersey False Claims Act, N.J.S.A. 2A:32C-1 through 2A:32C-17 and N.J.S.A. 30:4D-17(e) on nj.gov > **New Jersey Department of Health, Office of Primary Care & Rural Health Fraud, Waste, and Abuse Policy**.

New Jersey Insurance Fraud Prevention Act

The New Jersey Insurance Fraud Prevention Act, N.J.S.A 17:33A 1 et seq. takes a multifaceted approach to confronting the problem of insurance fraud in New Jersey. For more information, read about the **New Jersey Insurance Fraud Prevention Act** on nj.gov.

To view UnitedHealthcare Community Plan of New Jersey's False Claims Act Compliance Policy and our Deficit Reduction Act/False Claims, visit **UHCprovider.com/njcommunityplan**.

Reporting fraud, waste, and abuse

Providers, their employees, applicable contractors and agents have the responsibility and a right to report suspected fraud, waste and abuse. After making your report, we work to detect, correct and prevent fraud, waste and abuse in the health care system.

You and your employees can make your report in several ways by contacting us directly:

- Online: **uhc.com/fraud**
- Phone: 844-359-7736

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

- Care provider's name, address and phone number
- Care provider's NPI or Tax ID
- Care provider type (physician, physical therapist, pharmacist, etc.)
- Names and phone numbers of others who can aid in the investigation
- Dates of events
- Details about the suspected fraud or abuse

For CMS information about how you can prevent, detect and report fraud, waste and abuse, visit cms.gov > Outreach & Education > Learn > Get Training > Medicare Learning Network® (MLN) > Publications & Multimedia > Publications > Medicare Fraud & Abuse: Prevent, Detect, Report > Downloads > **Medicare Fraud & Abuse: Prevent, Detect, Report**.

Report suspected fraud, waste, and abuse to the following state agencies:

- New Jersey State Hotlines
- NJ Medicaid Fraud Division Hotline: 888-937-2835
- NJ Insurance Fraud Prosecutor Hotline: 877-55-FRAUD or **njinsurancefraud2.org/#report**.

Medical record requests

We may request copies of medical records from you in connection with our UM/care management, quality assurance and improvement processes, claims payment and other administrative obligations. This includes reviewing your compliance with the terms and provisions of your agreement with us, and with appropriate billing practice.

If we request medical records, provide them free of charge unless your participation agreement provides otherwise. Submit records based on the method established by the requester. These records must be maintained and protected for confidentiality for 6 years or longer if required by applicable statutes or regulations. In the event that provider fails to comply, actions including interruption of payment and contract termination may be taken by UnitedHealthcare Community Plan.

Exclusion checks

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month. For more information or access to the publicly accessible, excluded party online databases, please see the following links:

- State of New Jersey debarment list (mandatory): **nj.gov/comptroller/divisions/medicaid/disqualified/**
- Federal exclusions database (mandatory): **exclusions.oig.hhs.gov/**
- N.J. Treasurer's exclusions database (mandatory):

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state.nj.us/treasury/revenue/debarment/debarsearch.shtml

- N.J. Division of Consumer Affairs licensure databases (mandatory): njconsumeraffairs.gov/Pages/verification.aspx
- N.J. Department of Health licensure database (mandatory): state.nj.us/health/guide/find-select-provider/
- Certified nurse aide and personal care assistant registry (mandatory, if applicable): njna.psiexams.com/search.jsp
- Federal exclusions and licensure database (optional and fee-based): npdb.hrsa.gov/hcorg/pds.jsp. Please note that only certain provider types may access this database. See npdb.hrsa.gov/hcorg/register.jsp for more information.
- Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE)
- General Services Administration (GSA) System for Award Management > Data Access

What you need to do for exclusion checks

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of care and services (QOC) concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all primary care provider office sites to help ensure facility quality.

UnitedHealthcare Community Plan requires you and your facilities meet the following site standards:

- Clean and orderly overall appearance.
- Available handicapped parking.
- Handicapped accessible facility.
- Available adequate waiting room space.
- Adequate exam room(s) for providing member care.
- Privacy in exam room(s).
- Clearly marked exits.
- Accessible fire extinguishers.
- Post file inspection record in the last year.

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least 10 years from the close of the New Jersey program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

If any litigation, claim, negotiation, audit or other action involving the records has been started before the 10-year period ends, you agree to keep the records until 1 year after the resolution of all issues that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your Provider Agreement.

To help ensure members receive quality services, you must also comply with requests for on-site reviews conducted by the state. During these reviews, the state will address your capability to meet New Jersey program standards.

You must cooperate with the state or any of its authorized representatives, the New Jersey DHS, CMS, the Office of Inspector General, or any other agency prior-approved by the state, at any time during your Provider Agreement.

These entities may, at all reasonable times, enter your premises. You agree to allow access to and the right to audit, monitor and examine any relevant books, documents, papers and records to otherwise evaluate (including periodic information systems testing) your performance and charges.

We perform reviews and audits without delaying your work. If you refuse to allow access, this constitutes a breach of your Provider Agreement.

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Criteria for site visits

The following table outlines the criteria used to require a site visit. When the threshold is met, we conduct a site visit according to UnitedHealthcare Community Plan policy.

QOC Issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	1 complaint
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	2 complaints in 6 months
Other	All other complaints concerning the office facilities	3 complaints in 6 months

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Chapter 14: Billing and Submission

Key contacts

Topic	Link	Phone Number
Claims	UHCprovider.com/claims	866-633-4449
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	800-465-3203
EDI	UHCprovider.com/EDI	866-633-4449

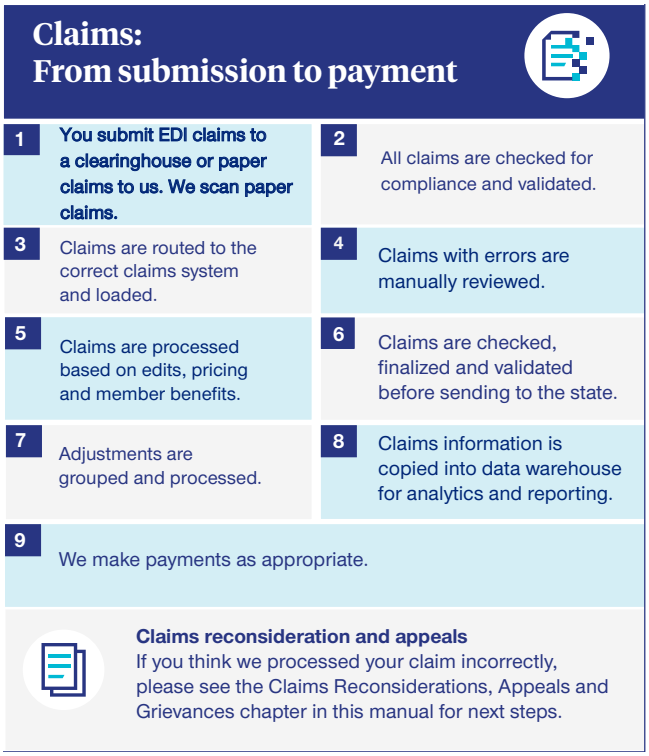
Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

Our claims process

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

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



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National Provider Identifier

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

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

Your clean claims must include your NPI and federal TIN.

General billing guidelines

We only consider reimbursing claims if you met billing and coverage requirements. Submitting a referral does not guarantee we will pay you. Payment depends on the member's coverage on the date(s) of service, medical necessity, plan rules about limitations and exclusions, and UnitedHealthcare Community Plan policies. We don't reimburse excessive, inappropriate or non-covered charges. To comply with applicable standards, policies and law, we may adjust previous payments for services and audit claims. We may seek reimbursement for overpayments or offset future payments as allowed by law.

Fee schedule

If your Agreement is based on the New Jersey Medicaid FFS Fee Schedule, check njmmis.com > Rate and Code Information for Medicaid-set rates your contract may base rates on.

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

Dual Complete® ONE (Medicare) billing

UnitedHealthcare Community Plan has an automated system for processing claims for members enrolled in both the Medicaid and Medicare under UnitedHealthcare Dual Complete® ONE (Medicare).

Using the member's **UnitedHealthcare Medicare ID** from the ID card, you'll only need to submit **1 claim**. Your claims will automatically be processed first against the Medicare benefits and then against the Medicaid benefits.

Use the **UnitedHealthcare Medicare ID** on the member's Dual Complete® ONE (Medicare) card as the member ID number when submitting claims for reimbursement.

You'll receive 2 provider remittance advices (PRAs), 1 for Medicare and 1 for Medicaid. There's no need to resubmit a secondary claim to UnitedHealthcare Community Plan.

UnitedHealthcare Dual Complete® ONE (Medicare) members should not be balance billed for any covered benefit.

Modifier codes

Use the appropriate modifier codes on your claim form. The modifier must be used based on the date of service.

Member ID card for billing

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

Acceptable claim forms

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

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

Use the UB-04 form for hospital inpatient and outpatient services, dialysis services, skilled nursing homes, inpatient services, long-term care facilities, hospice services and other care providers.

Paper claims

If you can't submit medical, professional or facility claims electronically, or are submitting a claim requiring invoice documentation, send paper claims to:

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UnitedHealthcare Community Plan
P.O. Box 5250
Kingston, NY 12402-5250

Clean claims and submission requirements

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

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

We may require additional information for some services, situations or state requirements.

Submit any services completed by NPs or PAs who are part of a collaborative agreement. Use their tax ID and NPI, and we will process the claims just like other physicians'.

Care provider coding

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

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

Electronic claims submission and billing

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

- All claims are set up as "commercial" through the clearinghouse.
- Our payer ID is 86047.
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit.
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for CMS 1500 and UB-04 forms.

For more information, contact EDI Claims.

EDI companion documents

UnitedHealthcare Community Plan's companion documents are intended to share information within Implementation Guides (IG) adopted by HIPAA. The companion documents identify the data content requested when it is electronically transmitted. UnitedHealthcare Community Plan uses companion documents to:

- Clarify data content that meets the needs of the health plan's business purposes when the IG allows multiple choices.
- Provide values the health plan will return in outbound transactions.
- Outline which situational elements the health plan requires.

The companion document provides general information and specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements.

The companion documents are located at UHCprovider.com/EDI > EDI Companion Guides.

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Clearinghouse and status reports

Software vendor reports only show the claim left your office and was either accepted or rejected. They don't confirm the claim status. Acknowledgment reports confirm the information you sent has been received. Review your reports, clearinghouse acknowledgment reports and the status reports to reduce processing delays and timely filing penalties.

For clearinghouse options, use our Electronic Data Exchange (EDI) at UHCprovider.com/EDI > **EDI Clearinghouse Options**.

e-Business support

Call **Provider Services** for help with Electronic Remittance Advices (ERAs) and Electronic Funds Transfers (EFTs). To use ERAs, you must enroll through a clearinghouse.

For all of our claims and payment options, such as business support and EDI claims, go to "Chapter 1: Introduction" under Online Services.

To find more information about EDI online, go to **UHCprovider.com/EDI**.

Electronic payment solution: OptumPay™

UnitedHealthcare has launched the replacement of paper checks with electronic payments and will no longer be sending paper checks for payment. You will have the option of signing up for Automated Clearing House (ACH)/direct deposit, our preferred method of payment, or to receive a Virtual Card payment (Virtual Card). The only alternative to a Virtual Card is direct deposit. Both of these options allow you to get paid quickly and securely.

Why choose ACH/direct deposit?

- Direct deposit puts payment directly into your bank account
- Easy and fast way to get paid
- Improved financial control; no paper checks or remittance information to lose or misplace
- Ability to track information on online portal

What does this mean to you?

- If your practice/healthcare organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a Virtual Card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**.
- If your practice/healthcare organization is already enrolled and receiving your claim payments through AHC/direct deposit from Optum Pay™ or receiving Virtual Cards there is no action you need to take.
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Library.
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

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

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Completing the CMS 1500 Claim form

Companion documents for 837 transactions are on UHCprovider.com/EDI.

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

Completing the UB-04 form

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

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

Form reminders

- Note the attending provider's name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims.
- Send the referring provider's NPI and name on outpatient claims when this care provider is not the attending provider.
- Include the attending provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims.
- Behavioral health care providers can bill using multiple site-specific NPIs.
- Claims sent to the wrong lock box will be denied.
- Do not send claims to UnitedHealthcare of New Jersey offices.
- Do not send claims to any New Jersey P.O. Box.

To be paid promptly for the services you provide, please follow these procedures:

- Submit claims within 180 days from date of service/date of discharge.
- Send any additional requested information needed to process the claim within 90 days.
- Submit corrected claims within 365 days from the date of service.
- If we are considered a secondary payer, submit COB claims within 60 days from the date of the primary insurer's EOB or 180 days from the dates of service, whichever is later.

Subrogation and coordination of benefit

Our benefits contracts are subject to subrogation and COB rules:

Subrogation: We may recover benefits paid for a member's treatment when a third party causes the injury or illness.

For NJ FamilyCare/Medicaid members, maintain and make available to us records reflecting collection of benefits by the care provider and amounts paid directly to NJ FamilyCare/Medicaid members by other payers.

Notify us when a member is present with an illness or injury that is related to an automobile accident or employment. Notification can be made on a standard claim form.

COB: We coordinate benefits based on the member's benefit contract and applicable regulations.
The most common COB issue arises with persons who have traditional Medicare FFS and are enrolled in NJ FamilyCare/Medicaid. In New Jersey, an individual who is dually eligible for Medicare and Medicaid may be enrolled in one of the following combinations:

- UnitedHealthcare Dual Complete® ONE Special Needs Plan (Medicare) and NJ FamilyCare
- Traditional Medicare and NJ FamilyCare
- Medicare Advantage plan and NJ FamilyCare

For members who have both Medicare and Medicaid, Medicare is always primary. Either bill traditional Medicare, the member's Medicare Advantage plan, or UnitedHealthcare Dual Complete® ONE (Medicare), depending on the member's coverage.

If the member is enrolled in UnitedHealthcare Dual Complete® ONE (Medicare), submit the Medicare claim to us. We will coordinate the benefits through automatic claim adjudication.

If the member is enrolled in either traditional Medicare or a Medicare Advantage plan, and Medicaid is secondary, first submit the claim to the appropriate plan. Then submit to us the secondary claim on paper with the Medicare EOB. The only exception is for a working Medicare beneficiary who has health coverage through their employer, in which case the commercial insurance is primary. However, these members are rarely enrolled in the UnitedHealthcare Dual Complete® ONE plan.

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If COB is involved, attach evidence of payment from the first payer (traditional Medicare, Medicare Advantage or Commercial insurance) when billing us as the second payer. Submit COB of claims within 60 days from the date of primary insurer's EOB or 180 days from the dates of service, whichever is later.

In New Jersey, some individuals in the ABD category, including DDD clients, may be enrolled in UnitedHealthcare Community Plan and have commercial health insurance coverage as a dependent through a parent or guardian's health plan. In these cases, the commercial plan is primary and must be billed first.

Unless we have given prior authorization, we are not liable for payment if the other payer refuses payment due to a determination that the services provided were not medically necessary. If we give prior authorization for services for members and another payer denies the authorized services, we pay based on the terms of the contractual agreement with the care provider.

Tort policy

You must tell us when a member has an illness or injury related to an automobile accident or employment. You can notify us on a standard claim form.

You must also notify us if you become aware of any litigation on behalf of the member resulting from the member's injuries. Call **Provider Services**.

Hospital and clinic method of billing professional services

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

Global days

Global days include the billable period involving pre-operative visits, the procedure itself, and post-operative visits in which the care provider performs all necessary services. The visits must be performed by the same care provider or another care provider reporting the same TIN in either an inpatient hospital, outpatient hospital, ambulatory surgical center (ASC) or physician's office.

For reimbursement, we follow CMS guidelines and the National Physician Fee Schedule (NPFS) Relative Value File to determine global days values. To learn more about billing for global days and their values, read our global days policy on UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > Reimbursement Policies for Community Plan > **Global Days Policy, Professional - Reimbursement Policy - UnitedHealthcare Community Plan**.

Correct Coding Initiative

UnitedHealthcare Community Plan performs coding edit procedures based on the Correct Coding Initiative (CCI) and other nationally recognized sources.

Comprehensive and component codes

Comprehensive and component code combination edits apply when a code pair(s) appears to be related. These edits can be further broken down to explain the bundling rationale. Some of the most common causes for denials in this category are:

- **Separate procedures:** Only report these codes when performed independently.
- **Most extensive procedures:** You can perform some procedures with different complexities. Only report the most extensive service.
- **With/without services:** Don't report combinations where one code includes and the other excludes certain services.
- **Medical practice standards:** Services part of a larger procedure are bundled.
- **Laboratory panels:** Don't report individual components of panels or multichannel tests separately.

Clinical laboratory improvements amendments

Submit your laboratory claims with the Clinical Laboratory Improvements Amendments (CLIA) number. In box 23 of the CMS 1500 claim form, enter the 10-digit

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CLIA certification number for laboratory services billed by an entity performing CLIA-covered procedures.

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. For more information about the CLIA number, contact the CMS CLIA Central Office at **410-786-3531** or go to cms.gov > Regulations & Guidance > **Clinical Laboratory Improvement Amendments (CLIA)**.

Billing multiple units

When billing multiple units:

- If the same procedure is repeated on the same date of service, enter the procedure code once with the appropriate number of units.
- The total bill charge is the unit charge multiplied by the number of units.

Billing guidelines for hysterectomies

Specific Medicaid requirements must be met for hysterectomies and documented on the Hysterectomy Receipt of Information Form (FD-189). Include a completed FD-189 form for any hysterectomy procedure claim (hospital, operating physician, anesthesiologist, clinic, etc.). Electronic billing for hysterectomy claims is not permitted.

Find the form at UHCprovider.com/njcommunityplan > Provider Forms and References > under Provider Forms, choose **Sterilization Consent Form with Instructions**.

Billing guidelines for pregnancy visit

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

Medicaid does not consider ultrasounds medically necessary if they are done only to determine the fetal sex or provide parents with a photograph of the fetus. We allow the first 3 obstetrical ultrasounds per pregnancy. The fourth and subsequent obstetrical ultrasound procedures will only be allowed for identified high-risk members. High-risk member claims must include the corresponding diagnosis code.

Billing guidelines for obstetrical services

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

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

Billing guidelines for newborn outpatient visits

Newborn outpatient visits may occur in the 60 days before a NJ FamilyCare/Medicaid number is assigned to the newborn. In these cases, report the following information on the electronic claim or the CMS 1500 form for services eligible for reimbursement:

- The mother's identification number in Section 1a
- The newborn's name in Section 2
- The newborn's date of birth in Section 3
- The mother's name in Section 4

Billing guidelines for transplants

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

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Submitting an NPI, TIN and taxonomy

We accept NPI on the UB-04 and CMS 1500 (08-05) paper and HIPAA 837 professional and institutional claim submissions. All electronic and paper claims must include both the TIN, NPI and billing provider NUCC taxonomy code on institutional claims.

We will notify you of any changes to our NPI policy. These communications will express when we reserve the right to no longer accept HIPAA transactions that do not contain a valid NPI in the fields specified by our HIPAA-adopted implementation guides.

The following identifies the location for NPI, TIN and taxonomy on paper and electronic claims.

HIPAA 837P (professional) claim transaction (for enumerated providers)

- Billing Provider Identifier Location Primary Identifier NPI Loop 2010AA, NM109 / NM108=XX
- Secondary Identifier TIN Loop 2010AA, REF02 (REF01=EI or SY)
- Pay-To Provider
  - Primary Identifier NPI Loop 2010AB, NM109 (NM108=XX)
  - Secondary identifier TIN Loop 2010AB, REF02 (REF01=EI or SY)
- Referring Physician Primary Identifier NPI Loop 2310A, NM109 (NM108=XX
- Rendering Physician Primary Identifier NPI Loop 2310B, NM109 (NM108=XX

HIPAA 837I (institutional) claim transaction (for enumerated providers)

- Billing Provider Identifier Location Primary Identifier NPI Loop 2010AA, NM109 (NM108=XX)
- Secondary Identifier TIN Loop 2010AA, REF02 (REF01=EI or SY)
- Taxonomy NUCC Code Loop 2000A, PRV03 (PRV01=BI)
- Pay-To Provider
  - Primary Identifier NPI Loop 2010AB, NM109 (NM108=XX)
  - Secondary identifier TIN Loop 2010AB, REF02 (REF01=EI or SY)
- Taxonomy NUCC Code Loop 2000A, PRV03 (PRV01=PT)
- Attending Physician Primary Identifier NPI Loop 2310A, NM109 (NM108=XX)
- Taxonomy NUCC Code Loop 2310A, PRV03

Refer to the Implementation Guides at **wpc-edi.com** for additional 837I/P rules about these identifiers. Taxonomy is mutually exclusive.

We will reject 837I and 837P electronic claims that contain a P.O. Box address in the 2010AA Billing Provider Loop. You should make any necessary adjustments in your system to avoid an increase in claim rejections.

If you need to submit a P.O. Box or lockbox address, use the 2010AB Pay-to Address Loop instead. This change is due to the ASC X12 Health Care Claim: Professional (837) implementation guide (005010X222A1) and the Institutional (837) implementation guide (005010X223A2), which specify that the 2010A Billing Provider Loop must contain a street address.

If you have any questions about this information, please contact our EDI Support Team at 800-842-1109.

Ambulance claims (emergency)

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

New Jersey state regulations state that all ambulance service claims for UnitedHealthcare Community Plan members must include appropriate origin and destination modifiers for reimbursement. Claims missing an origin/destination will be denied.

For more information on reimbursement, view our reimbursement policy online at UHCprovider.com/NJcommunityplan > Policies and Clinical Guidelines > View Current Reimbursement Policies > **Ambulance Policy, Professional - Reimbursement Policy - UnitedHealthcare Community Plan**.

National Drug Code

Claims must include:

- National Drug Code (NDC) and unit of measurement for the drug billed.
- HCPCS/CPT code and units of service for the drug billed.
- Actual metric decimal quantity administered.

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Submit the NDC on all claims with procedure codes for care provider-administered drugs in outpatient clinical settings. The claims must show the NDC that appears on the product. Enter the identifier N4, the 11-digit NDC code, unit/basis of measurement qualified, and metric decimal quantity administered. Include HCPCS/CPT codes.

Medical necessity

UnitedHealthcare Community Plan only pays for medically necessary services. See "Chapter 4: Medical Management" for more information about medical necessity.

Place of Service codes

Go to CMS.gov > Medicare > Place of Service Codes > Place of Service Code Set for Place of Service codes.

Asking about a claim

You can ask about claims through Provider Services and our provider portal. To access the portal, go to UHCprovider.com and sign in. Follow the instructions to get a user ID, if needed. You will receive your user ID and password within 48 hours.

Provider Services

Provider Services helps resolve claims issues. Have the following information ready before you call:

- Member's ID number
- Date of service
- Procedure code
- Amount billed
- Your ID number
- Claim number

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

UnitedHealthcare Community Plan Provider Portal

You can view your online transactions by signing in to the Provider Portal on UHCprovider.com with your One Healthcare ID. This portal offers you online support any time. If you are not registered, you may do so on the website.

Claim correction

What is it?

You may need to update information on a claim you've already submitted. A corrected claim replaces a previously processed or denied claim submitted in error.

When to use:

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

How to use:

Use the claims reconsideration application on the Provider Portal. To access the portal, go to UHCprovider.com and sign in with your One Healthcare ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response. Mail to:

UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

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

Resubmitting a claim

What is it?

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

When to use it:

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

Common reasons for rejected claims

Some of the common causes of claim rejections happen due to:

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- Errors in member demographic data – name, age, date of birth, sex or address.
- Errors in care provider data.
- Wrong member insurance ID.
- No referring care provider ID or NPI number.

How to use:

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

UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

Warning! If your claim was denied and you resubmit it, you will receive a duplicate claim rejection. A denied claim has been through claim processing and we determined it cannot be paid. You may appeal a denied claim by submitting the corrected claim information or appealing the decision. See Claim Correction and Reconsideration sections of this chapter for more information.

Claim adjustments

If you believe you were underpaid, submit an adjustment request at **UHCprovider.com** or call **Provider Services** at **866-362-3368**.

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

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

If you prefer we recoup the funds from your next payment, call **Provider Services**.

If you prefer to mail a refund, send an Overpayment Return Check or the Overpayment Refund/Notification form.

Also send a letter with the check. Include the following:

- Name and contact information for the person authorized to sign checks or approve financial decisions.
- Member ID number.
- Date of service.
- Original claim number (if known).
- Date of payment.
- Amount paid.
- Amount of overpayment.
- Overpayment reason.
- Check number.

Where to send:

Mail refunds with an Overpayment Return Check or the Overpayment Refund/Notification form to:

UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0800

The form can be found **here**.

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

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

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

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Sample overpayment report

*The information provided is sample data only for illustrative purposes. Please populate and return with the data relevant to your claims that have been overpaid.						
Member ID	**Date of Service**	**Original Claim #**	**Date of Payment**	**Paid Amount**	**Amount of Overpayment**	**Reason for Overpayment**
11111	01/01/14	14A000000001	01/31/14	115.03	115.03	Double payment of claim
2222222	02/02/14	14A000000002	03/15/14	279.34	27.19	Contract states $50, claim paid 77.29
3333333	03/03/14	14A000000003	04/01/14	131.41	99.81	You paid 4 units, we billed only 1
44444444	04/04/14	14A000000004	05/02/14	412.26	412.26	Member has other insurance
55555555	05/05/14	14A000000005	06/15/14	332.63	332.63	Member terminated

Resolving claim issues

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

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

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

For paper claims

Submit a screen shot from your accounting software that shows when you submitted the claim. The screen shot must show the correct:

- Member name.
- Date of service.
- Claim date submission (within the timely filing period).

Timely filing

Timely filing issues may occur if members give the wrong insurance information when you treat them. This results in receiving:

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

All of the above must include documentation the claim is for the correct member and the correct date of service. A submission report alone is not considered proof of timely filing for electronic claims. They must be accompanied by an acceptance report.

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

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

If a claim is rejected, and corrections are not received within 90 days from date of service or close of business

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from the primary carrier, the claim is considered late billed. It will be denied timely filing.

Timely filing limits can vary based on state requirements and contracts. If you don't know your timely filing limit, refer to your Provider Agreement.

Balance billing

Do not balance bill members. Sending bills or balance bills to members for covered services is a violation of your provider Agreement and violates New Jersey law and regulation. Instruct office staff to ask for appropriate documentation of a patient's insurance coverage and accurately maintain this information in all billing systems.

Document any agreement with the member if they have agreed to the responsibility of out-of-pocket payment for any non-covered, or non-medically necessary service that did not require or was not approved by prior authorization.

Third-party resources

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible members. Therefore, you must bill and obtain an EOB from any other insurance or health care coverage resource before billing UnitedHealthcare Community Plan, as required by contract. Refer to your Agreement for third-party claim submission deadlines. Once you bill the other carrier and receive an EOB, the claim may then be submitted to UnitedHealthcare Community Plan. Please attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or denial reason.

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Chapter 15: Claims, Reconsiderations and Appeals

Looking for something?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider agreement. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

For claims, billing and payment questions, go to **UHCprovider.com > Claims and Payments**.

We no longer use fax numbers for this purpose. Please use either the online tool or phone number.

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

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

APPEAL STEP/STAGE	DEFINITION	SUBMISSION ADDRESS	ONLINE FORM FOR MAIL	CONTACT PHONE NUMBER	ONLINE SUBMISSION	FILING TIME FRAME	UNITEDHEALTHCARE COMMUNITY PLAN RESPONSE TIME FRAME
Medical and Behavioral Care Provider Claim Reconsideration	A request for a one-time case review of an administrative denial you don't agree with. If you submit the Health Care Provider Application to Appeal a Claims Determination (HCPAA) form, it will be handled as a Formal Appeal.	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 5250 Kingston, NY 12402-5250	UHCprovider.com/claims	888-362-3368	Use the Claims Management application on the Provider Portal. Go to UHCprovider.com, then Sign In or go to UHCprovider.com/claims.	NJFamilyCare/ Medicaid: UnitedHealth Group Error (e.g., request due to contract updates, provider participating/ non-participating status, etc.) - Accepted within 18 months from the DOS or within 95 calendar days from the paid date of the last timely submission (whichever is later). Non-UnitedHealth Group Error - Accepted within 95-calendar days from the PRA, EOB, or letter date. UnitedHealthcare Dual Complete® ONE: Inpatient requests that result in an increased DRG payment: within 60 calendar days from the DOS. Dispute of a Medical Review Denial: 15 months from the last paid date. All other claims: 365 days from the original PRA.	30 calendar days

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APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS							
APPEAL STEP/STAGE	**DEFINITION**	**SUBMISSION ADDRESS**	**ONLINE FORM FOR MAIL**	**CONTACT PHONE NUMBER**	**ONLINE SUBMISSION**	**FILING TIME FRAME**	**UNITEDHEALTHCARE COMMUNITY PLAN RESPONSE TIME FRAME**
Medical and Behavioral Care Provider Claim Formal Appeal	An appeal request for review of an administrative denial you don't agree with. Submit it on the HCPAA form. Requests from network providers who do not include the HCPAA form will be routed for Reconsideration if eligible.	NJ FamilyCare/ Medicaid: UnitedHealthcare Community Plan Grievances and Appeals Attention: Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364 UnitedHealthcare Dual Complete® ONE : UnitedHealthcare Community Plan Grievances and Appeals Attention: Appeals P.O. Box 6103 Cypress, CA 90630-9998	UHC provider.com/ njcommunityplan > Provider Forms and References > DOBI Health Care Provider Application to Appeal a Claims Determination	888-362-3368	Use the Claims Management application on the Provider Portal. Go to UHCprovider.com, then Sign In or go to UHCprovider.com/claims.	NJ FamilyCare/ Medicaid: Must receive within 90 days from the determination date UnitedHealthcare Dual Complete® ONE: Par providers should follow their contract. Non-par providers must be received within 60 days.	NJ FamilyCare/Medicaid: 30 business days UnitedHealthcare Dual Complete® ONE: Par providers should follow their contract. Non-par providers - 60 calendar days

Utilization Management Appeal Process: Service denial/limitation/reduction/termination based on medical necessity

You and the member should receive a notification letter of any decision to deny, reduce or terminate a service or benefit. If you or the member disagrees with our decision, you (or the member) can challenge our decision by requesting a Utilization Management Appeal submitted with the member's written permission. See the following summary for the time frames to request an appeal.

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UTILIZATION MANAGEMENT APPEAL STANDARD DEFINITIONS AND PROCESS REQUIREMENTS						
APPEAL STEP/ STAGE	**DEFINITION**	**HOW TO SUBMIT**	**CONTACT PHONE NUMBER**	**FILING TIME FRAME**	**FILING TIME FRAME TO REQUEST CONTINUATION OF BENEFITS FOR EXISTING SERVICES**	**DETERMINATION TIME FRAME**
Internal Utilization Management Appeal	The **Internal Appeal** is the first level of appeal, administered by the health plan. This level of appeal is a formal, internal review by health care professionals selected by the plan who have expertise appropriate to the case in question, and who were not involved in the original determination. This option is for FamilyCare Plan Type A / ABP, B, C, D.	NJFamilyCare/Medicaid: UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364 Or Fax: 801-994-1082 – Standard pre-service and post service appeals 801-994-1261 – expedited pre-service and concurrent appeals Or Online: UHCprovider.com > Prior Auth and Notification Learn More > Forms > UnitedHealthcare Community Plan (Medicaid) Pre-Service Appeals & Grievances UnitedHealthcare Dual Complete® ONE: UnitedHealthcare Attn: Appeals and Grievance Department P.O. Box 6103 Cypress, CA 90630-9998	888-362-3368	60 days from the date of the denial letter	**The Later of**: On or before the last day of the current authorization; or Within 10 calendar days of the date on the initial denial notification letter.	Urgent appeals: within 72 hours Standard appeals: within 30 days
External/ IURO Appeal	The External/IURO appeal is an external appeal conducted by an **I**ndependent **U**tilization **R**eview **O**rganization (IURO). This option is for FamilyCare Plan Type A / ABP, B, C, D.	Maximus Federal – NJ IHCAP 3750 Monroe Avenue, Suite 705 Pittsford, NY 14534 Fax: 585-425-5296 Online: njihcap.maximus.com	888-866-6205	60 calendar days from date on Internal Appeal notification letter	**The Later of**: On or before the last day of the current authorization; ***or*** Within 10 calendar days of the date on the Internal Appeal notification letter.	45 calendar days or less from IURO's decision to review the case
Medicaid Fair Hearing	You can appeal to the IURO before you request a Medicaid Fair Hearing and wait for the IURO's decision, or you can appeal to the IURO at the same time that you request a Medicaid Fair Hearing. This option is for FamilyCare Plan Types A /ABP ***only***.	State of New Jersey Division of Medical Assistance and Health Services Fair Hearing Unit P.O. Box 712 Trenton, NJ 08625-0712 Or Fax: 609-588-2435.	n/a	120 calendar days from date on Internal Appeal notification letter	**The Later of**: On or before the last day of the current authorization, ***or*** Within 10 calendar days of the date on the Internal Appeal notification letter, ***or*** Within 10 calendar days of the date on the External/IURO appeal decision notification letter	A final decision will be reached within 90 calendar days of the Fair Hearing request.

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The prior definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements.

UnitedHealthcare Community Plan and its contracted providers may agree to more stringent requirements within provider agreements than described in the standard process.

Dental appeals and grievances

For information regarding appeals and grievances related to Dental, please refer to the Dental Provider Manual, which can be found on UHCprovider.com. Section: 4.2 Member Appeals & Inquiries covers the dental appeals and grievances information.

To obtain access to the Dental Provider Manual, go to UHCproviders.com.

Denials

UM denials

Denials can be UM denials or administrative denials. UM denials are refusals to pay a claim or to authorize a service or supply because we determined the service or supply is either:

- Not medically necessary,
- Experimental or investigational,
- Cosmetic,
- Dental rather than medical, or
- Intended to treat an excluded pre-existing condition.

A UM denial may also occur if we deny a covered person's request to get services from an out-of-network provider and a network care provider is not available. This type of request is known as an in-plan exception.

Administrative denials

An administrative denial is a refusal to pay a claim or authorize a service based on contract provisions or other grounds not involving medical judgment. Examples include denials because the person was not covered on the date of service or the service is excluded from coverage (e.g., adult hearing aids).

Claim reconsideration

What is it?

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

When to use:

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

How to use:

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

Valid proof of timely filing documentation (reconsideration)

What is it?

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

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

A submission report is not proof of timely filing for electronic claims. It must be accompanied by an acceptance report. Timely filing denials are often upheld due to incomplete or wrong documentation submitted

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with a reconsideration request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use:

Submit a reconsideration request electronically, by phone or mail with the following information:

- **Electronic claims:** Include the EDI acceptance report stating we received your claim.
- **Mail reconsiderations:** Submit a screen shot from your accounting software that shows the date you submitted the claim. The screen shot must show:
  - Correct member name.
  - Correct date of service.
  - Claim submission date.

Additional Information:

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

Appeals

What is it?

An appeal is a request for review of an administrative denial you don't agree with.

When to use:

If you do not agree with an administrative denial or outcome of a reconsideration request.

How to use/file:

Submit the New Jersey Department of Banking and Insurance approved form, called the Health Care Provider Application to Appeal a Claims Determination (HCPAA). Find this form at UHCprovider.com/njcommunityplan > Provider Forms and References > **DOBI Health Care Provider Application to Appeal a Claims Determination**. Requests from network care providers who do not include the HCPAA form will be routed for reconsideration if eligible.

Also submit any related documents. These may include a cover letter, medical records and additional information. Send your information electronically or by mail. In your appeal, please include any supporting information not included with your reconsideration request.

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved.
- Call **Provider Services** if you can't verify a claim is on file.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. In your reconsideration request, please ask for a medical necessity review. Include all relevant medical records.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Member appeals and grievances

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

Member appeals

What is it?

An appeal is a formal way to share dissatisfaction with an adverse medical necessity determination.

A member, or the provider on the member's behalf, submitted with their written consent:

- Lowers, suspends or ends a previously authorized service.
- Refuses, in whole or part, payment for services.
- Fails to provide services in a timely manner, as defined by the state or CMS.
- Doesn't act within the time frame CMS or the state requires.

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When to use:

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

Where to send:

You or the member may call or mail the information within 60 calendar days from the date of the adverse benefit determination.

How to use:

Whenever we deny a service for medical necessity, we must provide the member with UnitedHealthcare Community Plan appeal rights. The member has the right to:

- Receive a copy of the rule used to make the decision.
- Present evidence, and allegations of fact or law, in person and in writing.
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal.
- Ask for an expedited appeal if waiting for this health service could harm the member's health.
- Ask for continuation of services during the appeal. The member must either request an internal appeal on or before the final day of the previously approved authorization, or request an internal appeal within 10 calendar days of the date of the denial notice, whichever is later. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the provider, you cannot ask for a continuation. Only the member may do so.

We resolve a standard appeal 30 calendar days from the day we receive it.

We resolve an expedited appeal 72 hours from when we receive it.

We may extend the response up to 14 calendar days if the following conditions apply:

- Member requests we take longer.
- We request additional information and explain how the delay is in the member's interest.

If you submit a non-expedited appeal on behalf of a Medicaid member, we require written consent from the member. We require Medicare Form 1696, Appointment of Representative, for all appeals submitted on behalf of a UnitedHealthcare Dual Complete® ONE member.

For more about NJ FamilyCare/Medicaid member rights, including Member Grievances and State Fair Hearings, refer to the Medicaid Member Handbook on UHCCommunityPlan.com/nj > NJ FamilyCare > Member Handbook. For UnitedHealthcare Dual Complete® ONE member rights, refer to the Summary of Benefits and Evidence of Coverage on UHCCommunityPlan.com/nj > UnitedHealthcare Dual Complete® ONE (HMO D-SNP) > Downloadable Resources.

Filing an appeal or grievance on behalf of a member

Member Services helps members submit appeals and grievances. Representatives help complete forms and assist with other steps in the appeal or grievance process. This may include providing interpreter services that have adequate TTY/ TTD capability.

Discrimination for appeals and grievances

You may not discriminate against a member for filing a grievance. Also, we will not take any action with respect to an enrollee or a health care provider that penalizes or discourages the member or you from undertaking an appeal, dispute resolution or judicial review of an adverse determination. We will not take any punitive action against you for requesting an expedited resolution or supporting a member's appeal.

Neither our UM committee nor any utilization review agent will take any action with respect to an enrollee or a health care provider to penalize or discourage the enrollee or the enrollee's health care provider from undertaking an appeal, dispute resolution or judicial review of an adverse determination. Additionally, neither our UM committee nor any utilization review agent shall take any punitive action against a provider who requests an expedited resolution or supports a member's appeal.

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Chapter 16: Care Provider Communications and Outreach

Key contacts

Topic	Link	Phone Number
Provider Education	UHCprovider.com > Resources > Resource Library	888-362-3368
News and Bulletins	UHCprovider.com > Resources > News	888-362-3368
Provider Manuals	UHCprovider.com/guides	888-362-3368

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

Connect with us on social media:

Communication with care providers

UnitedHealthcare is on a multi-year effort to enhance our digital delivery channels and transition paper transactions to electronic, whenever possible. Our goal is to make it easier for you to work with us and reduce the time it takes for you to perform claim and clinical activities. We may provide electronic notice of policy, protocol and payment policy changes; news and other important updates.

Accordingly, there are a number of ways clinicians, practice managers, administrative staff, facilities and hospitals can stay up to date on items of interest from UnitedHealthcare:

- UHCprovider.com: This public website is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.
- UHCprovider.com/NJcommunityplan: The UnitedHealthcare Community Plan of New Jersey page has state-specific resources, guidance and rules.
- **Policies and protocols**: UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans library includes UnitedHealthcare Community Plan policies and protocols.
- **New Jersey health plans**: UHCprovider.com/NJ is the fastest way to review all of the health plans UnitedHealthcare offers in New Jersey. To review plan information for another state, use the drop-down menu at UHCprovider.com > Resources > Health Plans. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **UnitedHealthcare Provider Portal**: This secure portal is accessible from UHCprovider.com. It allows you to access patient information such as eligibility and benefit information and digital ID cards.
  You can learn more about the portal in "Chapter 1: Introduction" of this manual or by visiting UHCprovider.com/portal. You can also access UHCprovider.com/training > Digital Solutions for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News:** Bookmark UHCprovider.com > Resources > News. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans. You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your practice and

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care for patients. This includes the communication formerly known as the Network Bulletin.

Receive personalized Network News emails twice a month by subscribing at cloud.provideremail.uhc.com/subscribe. You'll get the latest news, policy and reimbursement updates we've posted on our news webpage. These email briefs include monthly notification of policy and protocol updates, including medical and reimbursement policy changes. They also include announcements of new programs and changes in administrative procedures. You can tailor your subscription to help ensure you only receive updates relevant to your state, specialty and point of care.

Care provider education and training

To help ensure you are reimbursed accurately and patients have access to the care they need, we have developed a full range of training resources, including interactive self-paced courses and quick reference guides along with registration for instructor-led sessions. Topics include the digital solutions available on the UnitedHealthcare Provider Portal, plan and product overviews, clinical tools and state-specific training.

View the training resources at UHCprovider.com/training. Content is updated frequently and organized by categories to make it easy to find what you need.

Email communication – required contact information

We must have a valid email address on file to send you required notifications and important information.

Submit your email address in one of the following ways:

1. Sign up for a One Healthcare ID, which also gives you access to the UnitedHealthcare Provider Portal
2. Subscribe to Network News email briefs to receive regular email updates. Need to update your information? It takes just a few minutes to manage your email address and content preferences.

Already have a One Healthcare ID? To review or update your email, simply sign in to the portal. Go to "Profile & Settings," then "Account Information" to manage your email.

Care provider manual

UnitedHealthcare Community Plan publishes this manual online. If you do not have internet access, request a hard copy of this manual by contacting Provider Services.

Quick reference guide

You can also find a downloadable copy of the quick reference guide at UHCprovider.com/njcommunityplan > Provider Forms and References. Under Reference Guides, click on NJ FamilyCare/Medicaid UnitedHealthcare Community Plan Quick Reference Guides 2022.

Care provider best practices

We believe that patients who have positive experiences in care provider offices are more likely to follow medical advice and treatment plans. Consider sharing these best practices found at UHCprovider.com/njcommunityplan > Training and Education > CAHPS with your office staff and your patients to help ensure members get the most from their visits with you.

- 2022 Patient Experience Guidebook
- Have a health care visit coming up? 5 tips to help you make the most of it
- Self-paced Patient Experience Course.
- Tips to help elevate the patient office visit experience

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Glossary

ABD
The Aged, Blind, and Disabled population of the NJ FamilyCare/Medicaid Program.

Abuse (by care provider)
Care provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost, or in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost, as defined by 42 C.F.R. 455.2.

Abuse (of member)
Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S 46-451.

Acute Inpatient Care
Care provided to members sufficiently ill or disabled requiring:

- Constant availability of medical supervision by attending care provider or other medical staff
- Constant availability of licensed nursing personnel
- Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

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

Adverse Benefit Determination
(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service.

(4) The failure to provide services in a timely manner, as defined by the state.

(5) The failure of someone or a company to act within the time frames provided in the contract and within the standard resolution of grievances and appeals.

(6) For a resident of a rural area, the denial of a member's request to exercise their right, to obtain services outside the network.

(7) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Ambulatory Care
Health care services that do not involve spending the night in the hospital. Also called "outpatient care". Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility
A state facility that is licensed, equipped and operated to provide surgeries and obstetrical deliveries. Members can leave the facility the same day surgery or delivery occurs.

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

Appeal

- A request for review of an action.
- A request for review of an administrative denial you don't agree with.

Authorization
Approval obtained by care providers from UnitedHealthcare Community Plan for a service before the service is rendered. Used interchangeably with "preauthorization" or "prior authorization."

Authorized Person or Authorized Representative
A person authorized to make medical determinations for an enrollee, including enrollment and disenrollment decisions and choice of a PCP. For individuals eligible through the Division of Child Protection and Permanency (DCP&P), Department of Children and Families (DCF), the authorized person is authorized to make medical determinations, including enrollment, disenrollment and choice of a PCP, on behalf of or in conjunction with individuals eligible through DCP&P/DCF. These persons may include a foster home parent, an authorized health care professional employee of a group home,

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an authorized health care professional employee of a residential center or facility, a DCP&P/DCF employee, a pre-adoptive or adoptive parent receiving subsidy from DCP&P/ DCF, a natural or biological parent, or a legal caretaker.

For individuals eligible through the Division of Developmental Disabilities (DDD), the authorized person may be one of the following:

- The enrollee, if they are an adult and can make medical decisions
- The enrollee's parent or guardian, if the enrollee is a minor, or the individual or agency having legal guardianship if the enrollee is an adult who lacks the capacity to make medical decisions
- The Bureau of Guardianship Services (BGS)
- A person or agency duly designated by a power of attorney for medical decisions made on behalf of an enrollee.

For MLTSS members, an authorized representative is a person or entity empowered by law, judicial order or power of attorney, or otherwise authorized by the MLTSS member to make decisions on behalf of the member.

Beneficiary
Any person eligible to receive services in the New Jersey Medicaid/NJ FamilyCare program.

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

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

Caregiver (paid or unpaid)
A person who assists with care for a member who is ill, has a disability and/or has functional limitations and requires assistance with activities of daily living or instrumental activities of daily living. Unpaid caregivers or informal family caregivers include but are not limited to relatives, friends, and others who volunteer to help. Paid or formal caregivers are those who provide services in exchange for payment for services rendered.

Care Management
A set of enrollee-centered, goal-oriented, culturally relevant, and logical steps to assure that an enrollee receives needed services in a supportive, effective, efficient, timely, and cost-effective manner. Care management emphasizes prevention, continuity of care, and coordination of care, which advocates for, and links enrollees to, services as necessary across providers and settings. At a minimum, Care Management functions must include, but are not limited to:

(1) Early identification of enrollees who have or may have special needs,

(2) Assessment of an enrollee's risk factors,

(3) Development of a plan of care,

(4) Referrals and assistance to ensure timely access to providers,

(5) Coordination of care actively linking the enrollee to providers, medical services, residential, social, and other support services where needed,

(6) Monitoring,

(7) Continuity of care, and

(8) Follow-up and documentation.

Care management is driven by quality-based outcomes such as: improved/maintained functional status, improved/maintained clinical status, enhanced quality of life, enrollee satisfaction, adherence to the care plan, improved enrollee safety, cost savings, and enrollee autonomy.

Care Provider
Any physician, hospital, facility, health care professional or other provider of enrollee services licensed or otherwise authorized to provide services in the state or jurisdiction in which they are furnished.

Case Management
A component of care management. A set of activities tailored to meet a member's situational health-related needs. Situational health needs can be defined as time-limited episodes of instability. As in care management, case management activities also emphasize prevention, continuity of care, and coordination of care. Case management activities are driven by quality-based outcomes such as improved/maintained functional status; enhanced quality of life; increased member satisfaction; adherence to the care plan; improved member safety; and to the extent possible, increased member self-direction.

Case Manager
The individual responsible for coordinating the overall service plan for a member in conjunction with the member, the member's representative and the member's primary care provider (PCP). Case managers facilitate access to services, both clinical and nonclinical, by

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connecting the member to resources that support them in playing an active role in the self-direction of their health care needs.

Centers for Medicare & Medicaid Services (CMS)
A federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and SCHIP programs, formerly the Health Care Financing Administration (HCFA) within the U.S. Department of Health and Human Services.

Children with Special Health Care Needs
Children who have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions who also require health and related services of a type and amount beyond that required by children generally. This includes all children who are MLTSS members.

CHIP
Children's Health Insurance Program.

Chronic Illness
A disease or condition of long duration (repeated inpatient hospitalizations, out of work or school at least 3 months within a 12-month period, or the necessity for continuous health care on an ongoing basis), sometimes involving very slow progression and long continuance. Onset is often gradual and the process may include periods of acute exacerbation alternating with periods of remission.

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

CMS
Centers for Medicare and Medicaid Services, the federal regulatory agency for these programs.

Cognitive Rehabilitation Therapy
A systematic, functionally oriented service of therapeutic cognitive activities based on an assessment and an understanding of the behavior of a person served. Services are directed to achieve functional improvement by:

1. Reinforcing, strengthening, or reestablishing previously learned patterns of behavior; or

2. Establishing new patterns of cognitive activity or mechanisms to compensate for impaired neurological systems.

Complaint
See "Grievance."

Comprehensive Orthodontic Treatment
The use of fixed orthodontic appliances (bands/brackets and arch wires) to improve the craniofacial dysfunction and/or dentofacial deformity of the patient. Active orthodontic treatment begins with banding of teeth or when tooth extractions are initiated as the result of and in conjunction with an authorized orthodontic treatment plan.

Condition
A disease, illness, injury, disorder, or biological or psychological condition or status for which treatment is indicated.

Consultation
A referral between different provider types or referral from a PCP or PCD to a specialist or in the case of dentistry, to a dentist that provides dental services to special needs patients. A member cannot be denied access to the consultation or when needed to medically necessary services provided by that specialty provider.

Continuity of Care
The plan of care for a particular enrollee that should assure progress without unreasonable interruption.

Contracted Health Professionals
PCPs, specialists, medical facilities, allied health professionals and ancillary service providers under contract with UnitedHealthcare Community Plan. These care providers deliver specific covered services to members. They represent those individuals and entities used through the UnitedHealthcare Community Plan prior authorization and referral policies and procedures.

Coordination of Benefits (COB)
A process of figuring out which of 2 or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

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

Credentialing
The verification of applicable licenses, certifications and experience. This process assures care provider status is extended only to professional, competent care providers who continually meet UnitedHealthcare Community Plan qualifications, standards and requirements. The determination as to the qualifications and ascribed privileges of a specific provider to render specific health care services.

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Critical Incident
An occurrence involving the care, supervision, or actions involving a member that is adverse in nature or has the potential to have an adverse impact on the health, safety, and welfare of the member or others. Critical incidents also include situations occurring with staff or individuals or affecting the operations of a facility/institution/school.

Cultural Competency
A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance of and respect for cultural differences and similarities within, among and between groups and the sensitivity to how these differences influence relationships with enrollees. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse enrollee needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

Current Procedural Terminology (CPT) Codes
A code assigned to a task or service a health care provider does for a member. Every medical task or service has its own CPT code. These codes are used by the insurer to know how much they need to pay the physician. CPT codes are created and published by the American Medical Association.

Delivery System
The mechanism by which health care is delivered to a member. Examples include hospitals, provider offices and home health care.

Dental Home
The ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care. It includes referral to dental specialists when appropriate.

Dental Records
The complete, comprehensive records of dental services, to include date of service/visit, chief complaint, treatment needed, treatment planned and treatment provided during each patient visit. The dental record shall include charting of the existing dentition, hard and soft tissue findings, completed assessment tools and diagnostic images to include radiographs and digital views as well as photographs where medically necessary. Dental records shall also be kept in compliance with all DMAHS and NJ State Board of Dentistry regulations. The dental record is to be accessible at the office/clinic location of Member's participating dentist and also in the records of a residential facility for those members residing in a facility. Providers who render dental services in other settings such as in an operating room shall also include a record that documents provided treatment in the member's dental record located in the office/clinic.

Developmental Disability
A severe, chronic disability of a person that is attributable to a mental or physical impairment or combination of mental and physical impairments; manifested before the person reached 22 years; is likely to continue indefinitely; results in substantial functional limitations in 3 or more of the following areas of major life activity:

- Self-care
- Receptive and expressive language
- Learning
- Mobility
- Self-direction
- Capacity for independent living and economic self-sufficiency.

The person would need a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes severe disabilities attributable to an intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the criteria are met.

Diagnostic Services
Any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under state law, to enable them to identify the existence, nature, or extent of illness, injury, or other health deviation in a patient.

Disability
A physical or mental impairment that substantially limits 1 or more of the major life activities for more than 3 months a year.

Disability in Adults
For adults applying under New Jersey Care Special Medicaid Programs and Title II (Social Security Disability Insurance Program) and for adults applying under Title

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XVI (the Supplemental Security Income [SSI] program), disability the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

Disability in Children
A child younger than 18 years is considered disabled if they have a medically determinable physical or mental impairment that results in marked and severe functional limitations that limit the child's ability to function independently, appropriately, and effectively in an age-appropriate manner. It can be expected to result in death or which can be expected to last for 12 months or longer.

Disallow Amount (Amt)
Medical charges for which the network provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member. Examples are:

- The difference between billed charges and in-network rates.
- Charges for bundled or unbundled services as detected by Correct Coding Initiative edits.

Discharge Planning
Screening eligible candidates for continuing care following treatment in an acute care facility. It involves care planning, scheduling, arranging and steps that move a member from one level of care to another.

Disenrollment
The removal of an enrollee from participation in the Contractor's plan, but not from the Medicaid program.

Dispute
Provider claim reconsideration: Step 1 when a provider disagrees with the payment of a service, supply, or procedure.

Provider appeal: Step 2 when a provider disagrees with the payment of a service, supply, or procedure.

Division of Developmental Disabilities (DDD)
A Division within the New Jersey Department of Human Services that provides evaluation, functional and guardianship services to eligible persons. Services include residential services, family support, contracted day programs, work opportunities, social supervision, guardianship, and referral services.

Division of Disability Services (DDS)
A Division within the Department of Human Services that promotes the maximum independence and participation of people with disabilities in community life. The DDS administers 7 Medicaid waiver programs, the work incentives Medicaid buy-in program, the New Jersey personal assistance services program (PASP) and the New Jersey cash and counseling demonstration program.

Division or DMAHS
The New Jersey Division of Medical Assistance and Health Services within the Department of Human Services which administers the contract on behalf of the Department.

DOBI
The New Jersey Department of Banking and Insurance in the executive branch of New Jersey State government.

DOH
The New Jersey Department of Health in the executive branch of New Jersey State government.

Dual Eligible
Individual covered by both Medicaid and Medicare.

Durable Medical Equipment (DME)
Equipment, such as assistive technology, which:
(a) can withstand repeated use;

(b) is used to service a health or functional purpose;

(c) is ordered by a qualified practitioner to address an illness, injury or disability; and

(d) is appropriate for use in the home or workplace/school.

DME may include oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Periodic Screening Diagnostic and Treatment Program (EPSDT)
A mandated program that covers screening and diagnostic services to determine physical and mental defects in enrollees younger than 21 years, health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered, pursuant to Federal Regulations found in Title XIX of the Social Security Act, Section 1905 (R). Covered services include a complete health history and developmental assessment; an unclothed physical exam; immunizations; laboratory tests; health education; and screenings for vision, dental, substance abuse, mental health and hearing. They also include any medically necessary services found during the preventive exam.

Electronic Data Interchange (EDI)
The electronic exchange of information between 2 or more organizations.

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Electronic Funds Transfer (EFT)
The electronic exchange of funds between 2 or more organizations.

Electronic Medical Record (EMR)
An electronic version of a member's health record and the care they have received.

Electronic Visit Verification (EVV) System
An electronic system that meets the minimum functionality requirements prescribed by DMAHS, which provider staff must use to check in at the beginning and check out at the end of each period of service delivery to monitor member receipt of specified personal care services as defined by section 1905. [42 U.S.C. 1396d] Any such system shall comply with the 21st Century Cures Act.

Eligibility Determination
Deciding whether an applicant meets the requirements for federal or state eligibility.

Emergency Care
The provision of medically necessary services required for immediate attention to review or stabilize a medical emergency.

Emergency Dental Condition
An orofacial condition manifesting itself by acute symptoms of sufficient severity which impair oral functions including:

- Severe pain or infection of dental origin resulting in facial swelling and possible airway obstruction
- Uncontrolled bleeding due to tissue laceration
- Oral trauma to include fracture of the jaw or other facial bones and/or dislocation of the mandible

These serious conditions as well as other acute symptoms that occur outside the normal office hours of a dental clinic or office require immediate medical attention to avoid placing the health of the individual in jeopardy.

Emergency Medical Condition
A medical condition manifesting itself by acute symptoms of sufficient severity, (including severe pain) such that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where there is inadequate time to effect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Services
Covered inpatient and outpatient services furnished by any qualified provider that are necessary to evaluate or stabilize an emergency medical condition.

Encounter
The basic unit of service used in accumulating utilization data and/or a face-to-face contact between a member and a health care provider resulting in a service to the member. You are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan electronically reports these encounters to state Medicaid. The state audits encounter submission accuracy and timeliness on a regular basis.

Enrollee
An individual who is eligible for Medicaid/NJ FamilyCare, living in the defined enrollment area, who elects or has had elected on their behalf by an authorized person, in writing, to participate in our plan and who meets Medicaid/NJ FamilyCare eligibility requirements for plan enrollment agreed to by the Department and us. Enrollees include individuals in the AFDC/TANF, AFDC/TANF-Related Pregnant Women and Children, SSI-Aged, Blind and Disabled, DCP&P/DCF, NJ FamilyCare, and Division of Developmental Disabilities/Community Care Waiver (DDD/CCW) populations.

Enrollee with Special Needs
Members with complex/chronic medical conditions requiring specialized health care services and persons with physical, mental/substance use disorder, and/or developmental disabilities, including persons who are eligible for the MLTSS program. See also "Children with Special Health Care Needs".

Enrollment
The process by which an individual eligible for Medicaid voluntarily or mandatorily applies to use our plan in lieu of standard Medicaid benefits, and such application is approved by DMAHS.

Evidence-Based Care
An approach that helps care providers use the most current, scientifically accurate research to make decisions about members' care.

Expedited Appeal
An expedited review process for appeals determines that

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taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

Federally Qualified Health Center (FQHC)
An entity that provides outpatient health programs pursuant to 42 U.S.C. § 201 et seq.

Fee For Service (FFS)
A method for reimbursement based on payment for specific services rendered to an enrollee.

FHC
Family Health Center

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

Grievance
An expression of dissatisfaction about any matter, a complaint, or a protest by an enrollee or provider as to the conduct by the Contractor or any agent of the Contractor, or an act or failure to act by the Contractor or any agent of the Contractor, or any other matter in which an enrollee or provider feels aggrieved by the Contractor, that is communicated to the Contractor either verbally or in writing. Grievances are to be resolved as required by the exigencies of the situation, but no later than 30 days after receipt.

Health Care Professional
A physician or other health care professional if coverage for the professional's services is provided under our contract for the services. It includes podiatrists, optometrists, chiropractors, psychologists, dentists, physician assistants, physical or occupational therapists and therapist assistants, speech-language pathologists, audiologists, registered or licensed practical nurses (including nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives), licensed certified social workers, registered respiratory therapists, and certified respiratory therapy technicians.

Health Care Services
All preventive and therapeutic medical, dental, surgical (including any medical or psychiatric clearances required prior to proceeding with a medical or surgical procedure), ancillary (medical and non-medical) and supplemental benefits provided to enrollees to diagnose, treat, and maintain the optimal well-being of enrollees provided by physicians, other health care professionals, institutional, and ancillary service providers.

Healthcare Effectiveness Data and Information Set (HEDIS®)
A rating system developed by NCQA that helps health insurance companies, employers, and consumers learn about the value of their health plan(s) and how it compares to other plans.

HIPAA
Health Insurance Portability and Accountability Act. A federal law that provides data privacy protection and security provisions for safeguarding health information.

Home and Community-Based Services (HCBS)
Services that are provided as an alternative to long-term institutional services in a nursing facility or Intermediate Care Facility for the Intellectually Disabled (ICF/ID). HCBS are provided to individuals who reside in the community or in certain community alternative residential settings.

Home Health Care (Home Health Services)
Health care services and supplies provided in the home, under physician's orders. Services may be provided by nurses, therapists, social workers or other licensed health care providers. Home health care usually does not include help with non-medical tasks, such as cooking, cleaning or driving.

In-Network Provider
A care provider who has a written Agreement with UnitedHealthcare Community Plan to provide services to members under the terms of their Agreement.

Managed Care
A comprehensive approach to the provision of health care which combines clinical preventive, restorative, and emergency services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other medically necessary health care services in a Cost Neutral manner.

Managed Long Term Services and Supports (MLTSS)
A program that applies solely to individuals who meet MLTSS eligibility requirements and encompasses the NJ FamilyCare A benefit package, NJ FamilyCare ABP (excluding the ABP BH/SUD benefit) as specified in Article 4.1.1.C, HCBS and institutionalization for long term care in a nursing facility or special care nursing facility.

Medicaid
A federal health insurance program for low-income

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families and children, eligible pregnant women, people with disabilities, and other adults. The federal government pays for part of Medicaid and sets guidelines for the program. States pay for part of Medicaid and have choices in how they design their program. Medicaid varies by state and may have a different name in your state.

Medical Emergency
An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention you could reasonably expect one of the following to result:

- Their health would be put in danger; or
- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body.

Medically Necessary
Medically necessary health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Medicare
The program authorized by Title XVIII of the Social Security Act to provide payment for health services to federally defined populations.

Member
An individual who is eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement.

MLTSS Eligibility
Applies to individuals who have been assessed for LTSS and have met both the financial and clinical eligibility requirements established by the state for MLTSS.

Mental Health/Substance Use Disorder (MH/SUD) Services
Mental health services include, but are not limited to comprehensive intake evaluation; off-site crisis intervention; family therapy; family conference; psychological testing; case management; programs of assertive community treatment, inpatient treatment and medication management. Substance Use Disorder Services include inpatient medical detoxification; outpatient (non-medical) detoxification, partial care; intensive outpatient (IOP); opioid treatment services; and short-term rehabilitation.

Mobile Dental Practice
A dental provider traveling to various locations and using portable equipment to provide dental services.

Mobile Dental Van
A dental provider using a vehicle specifically equipped with stationary dental equipment used to provide dental services.

NCQA
The National Committee for Quality Assurance

N.J.A.C.
New Jersey Administrative Code.

NJ FamilyCare Program
State-covered programs that provide comprehensive managed care coverage. Eligibility groups include:

- NJ FamilyCare A:
  - Uninsured children younger than age 19 with family incomes up to and including 142% of the federal poverty level
  - Pregnant women up to 200% of the federal poverty level
  - Beneficiaries eligible for MLTSS services.
  - This group may access certain other services which are paid FFS by the state and not covered.
- NJ FamilyCare B: uninsured children younger than 19 years with family incomes above 142% and up to and including 150% of the federal poverty level. This group may access certain other services which are FFS and not covered under this contract.
- NJ FamilyCare C: uninsured children younger than 19 years with family incomes above 150% and up to and including 200% of the federal poverty level. Eligibles must take part in cost-sharing in the form of a personal contribution to care for most services. Exception – Both Eskimos and Native American Indians younger than 19 years old, identified by Race Code 3, shall not participate in cost sharing and shall not be required to pay a personal contribution to care. This group also has access to certain other services which are paid FFS and not covered under this contract.
- NJ FamilyCare D:
  - Uninsured children younger than age 19 with family incomes between 201% and up to and including 350% of the federal poverty level.
  - Eligibles with incomes above 150% of the federal poverty level must participate in cost sharing in the form of monthly premiums and/or copayments for most services with the exception of both

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Eskimos and Native American Indians younger than 19 years. These groups are identified by Program Status Codes (PSCs) or Race Code on the eligibility system. For clarity, the Program Status Codes or Race Code, in the case of Eskimos and Native American Indians under the age of 19 years, related to NJ FamilyCare D non-cost sharing groups are also listed. Some of the Program Status Codes can include certain restricted alien adults.

- NJ FamilyCare ABP: parents between ages 19-64 with income up to and including 133% FPL, and childless adults between 19-64 with income up to and including 133% FPL. These members may also access certain other services which are paid FFS by the state and not covered by the contract.

Non-Covered Medicaid Services
All services that are not covered by the New Jersey Medicaid State Plan.

Non-Participating Care Provider
A provider of service that does not have a contract.

Non-Traditional Provider
An entity that qualifies as a provider of services pursuant to the approved New Jersey MLTSS criteria to address the authorized non-medical needs documented in an MLTSS member's plan of care.

Nursing Facility Transitions
An interdisciplinary team approach that assists individuals with transitions from nursing facilities to the community and helps the state to strengthen and improve community based systems of long-term care for low-income seniors and individuals with disabilities.

NPI
National Provider Identifier. Required by CMS for all care providers who bill, prescribe or refer for health care services and is used on all electronic transactions. It is a single unique provider identifier assigned to a care provider for life that replaces all other health care provider identifiers. It does NOT replace your DEA number.

Out-Of-Area Care
Care received by a UnitedHealthcare Community Plan member when they are outside of their geographic territory.

Outcomes
The results of the health care process, involving either the enrollee or care provider, and may be measured at any specified point in time. Outcomes can be medical, dental, behavioral, economic, or societal in nature.

Outpatient Care
Treatment provided to an enrollee who is not admitted to an inpatient hospital or health care facility.

Participating Care Provider
A care provider who has entered into a provider contract or other arrangement in accordance with N.J.A.C. 11:24 et seq. with the Contractor to provide services.

Patient
An individual receiving needed professional services directed by a licensed practitioner of the healing arts toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

Patient Payment Liability
That portion of the cost of care that nursing facility, assisted living services residents, AFC residents, and CRS residents must pay based on their available income as determined and communicated by the County Welfare Agency.

Peer Review
A mechanism in quality assurance and utilization review where care delivered by a physician, dentist, or nurse is reviewed by a panel of practitioners of the same specialty to determine levels of appropriateness, effectiveness, quality, and efficiency.

Physician Group
A partnership, association, corporation, individual practice association, or other group that distributes income from the practice among members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

Post-stabilization Care Services
Covered services related to an emergency medical condition provided after an enrollee is stabilized to maintain the stabilized condition, or to improve or resolve the enrollee's condition.

Preventive Health Care
Health care emphasizing priorities for prevention, early detection and early treatment of conditions. It generally includes routine/physical examination and immunization.

Primary Care
All health care services and laboratory services furnished by or through a general practitioner, family physician, internal medicine physician, or pediatrician, and may be furnished by a nurse practitioner to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

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Primary Care Dentist (PCD)
A licensed dentist who is the health care provider responsible for supervising, coordinating and providing initial and primary dental care to patients; initiating referrals for specialty care; and maintaining the continuity of patient care.

Primary Care Provider (PCP)
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the plan who provides, coordinates or helps members access a range of health care services.

Prior Authorization (Notification)
The process where health care providers seek approval prior to rendering health care services, drugs or DME as required by UnitedHealthcare Community Plan policy.

Provider Contract (Provider Agreement)
Any written contract between us and a provider that requires them to perform specific parts of our obligations for the provision of services under this contract.

Provider Group
A partnership, association, corporation, or other group of care providers.

Quality Management (QM)
A methodology that professional health personnel use to achieve desired medical standards and practices. The formal program includes activities to help improve and maintain quality service and care and involve multiple organizational components and committees.

Reassignment
The process by which an enrollee's entitlement to receive services from a particular PCP/PCD is terminated and switched to another PCP/PCD.

Residential Treatment Center (RTC)
A live-in health care facility providing therapy for substance use Disorder, mental illness, or other behavioral problems.

Routine Care
Treatment of a condition which would have no adverse effects if not treated within 24 hours or could be treated in a less acute setting (e.g., physician's office) or by the patient.

Rural Health Clinic
A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics may receive enhanced payments for services provided to enrolled members.

Scope of Services
Specific health care services for which a care provider has been credentialed, by the plan, to provide to enrollees.

Screening Services
Any encounter with a health professional practicing within the scope of their profession as well as the use of standardized tests given under medical direction in the examination of a designated population to detect the existence of 1 or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by New Jersey DHS.

Specialist
A care provider licensed in the state of New Jersey and has completed a residency or fellowship focusing on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a care provider who has special training in a specific area of health care.

Special Care Nursing Facility (SCNF)
A distinct SCNF unit within a Medicaid-certified conventional nursing facility which has been approved by the state to provide care to Medicaid/NJ FamilyCare beneficiaries who have been determined to require intensive nursing facility services beyond the scope of a conventional nursing facility as defined in N.J.A.C. 8:85-2. A SCNF or related unit must have at least 24 beds.

State Fair Hearing
An administrative hearing requested if the member does not agree with a Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

TANF
Temporary Assistance to Needy Families. A state program that gives cash assistance to low-income families with children.

TDD
Telecommunication Device for the Deaf

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Terminal Illness
A condition in which it is recognized that there will be no recovery, the patient is nearing the "terminus" of life and restorative treatment is no longer effective.

Third Party
Any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance payable under the New Jersey Medical Assistance and Health Services Act N.J.S.A. 30:4D-1 et seq.

Third-Party Liability (TPL)
A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan pays claims for covered benefits and pursues refunds from the third party when liability is determined.

Timely Filing
When UnitedHealthcare Community Plan puts a time limit on submitting claims.

Title XIX
Section of Social Security Act describing the Medicaid program coverage for eligible persons.

UnitedHealthcare Community Plan
An affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

Urgent Care
Treatment of a condition that is potentially harmful to a patient's health and for which their physician determined it is medically necessary for the patient to receive medical treatment within 24 hours to prevent deterioration.

Utilization
The rate patterns of service usage or types of service occurring within a specified time.

Utilization Management (UM)
Involves coordinating how much care members get. It also determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.

Utilization Review
Procedures used to monitor or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings. Includes ambulatory review, prospective review, concurrent review, second opinions, Care Management, discharge planning, or retrospective review.

WIC
A special supplemental food program for Women, Infants, and Children.

Withhold
A percentage of payments or set dollar amounts we deduct from a practitioner's service fee, capitation, or salary payment, and that may or may not be returned to the physician, depending on specific predetermined factors.

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