July 2022
Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary

Ohio Rise
Medicaid
UnitedHealthcare Connected

United Healthcare Community Plan

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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 > Find Your State.

Easily find information in this manual using the following steps:

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

If available, use the binoculars icon on the top right hand side of the PDF to search for information and topics. We greatly appreciate your participation in our program and the care you offer our members.

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 “provider” refers to any health care provider subject to this manual, including physicians, health care professionals, 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 manual.
- Any reference to “ID card” includes both a physical or digital card.

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Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	800-600-9007
Training	UHCprovider.com/training	
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	
CommunityCare Provider Portal Training	CommunityCare Provider Portal User Guide	
Provider Portal Support	email: ProviderTechSupport@uhc.com	855-819-5909
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 Ohio state goals of increased access, improved health outcomes and reduced costs by offering benefits to the following Medicaid members in every Ohio county.

Ohio Medicaid covers members in the Covered Families and Children (CFC) program. This includes Healthy Start and Healthy Families, Foster Care, or the Aged, Blind, or Disabled (ABD) programs. CFC Medicaid consumers include families, children younger than age 19, and pregnant women. ABD Medicaid consumers include adults age 65 and older and people who are blind or disabled at any age.

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

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

The Ohio Department of Medicaid (ODM) will determine 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 **800-600-9007**.

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.

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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**.

Our approach to health care

Care Model

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

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

- Market-specific care management encompassing medical, behavioral and social care.
- An extended care team including 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.
- 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 behavioral health 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 Medicaid: 800-895-2017 Relay 711 (TTY) or MyCare: 877-542-9236 (TTY 711) . You may also call Provider Services at **800-600-9007**.

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.

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Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has 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.

UnitedHealthcare Community Plan offers the following support services:

- **Language Interpretation Line:** We provide oral interpreter services 24 hours a day, seven days a week to our members free of charge. More than 240 non-English languages and hearing impaired services are available. If a UnitedHealthcare Community Plan member needs interpreter services, they can call the phone number on their ID card. To access a professional interpreter during regular business hours, call **Member Services**.
- **Materials for limited English speaking members:** We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

For more information, go to uhc.com > **Language Assistance.**

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses Interqual (We formerly used MCG Guidelines.) for medical care determinations.

Online resources

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

Electronic Data Interchange (EDI)

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/optimizeEDI**.

Getting started

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

Read our **Clearinghouse Options** page for more information.

Provider Portal- secure care provider website

The Provider Portal provides a secure online portal to support your administrative tasks including eligibility, claims and prior authorization and notifications. To sign in to the portal, go to **UHCprovider.com** and click Sign In on the upper right corner. For more information about all online services, go to **Self Service Tools and Eligibility** or go to the Provider Portal Self Service

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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, the secure care provider website, go to UHCprovider.com and either sign in or create a user ID. You will receive your user ID and password within 48 hours.

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

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

To access the Provider Portal, go to UHCprovider.com, then Sign In.

5 reasons to use UHCprovider.com

1 Provider Portal

Use self-service to verify eligibility and claims, request prior authorization, provide notifications and access Document Library.

Click "Sign In" in the top right corner of UHCprovider.com

2 Prior Authorization and Notification

Request approval for prescriptions, admissions and procedures.

UHCprovider.com/paan

3 EDI

Send batch transactions for multiple members and payers from one place, review claims and submit notifications.

UHCprovider.com/edi

4 Direct Connect

Communicate securely with payers to address errant claims. Email directconnectsupport@optum.com to get started.

5 Policies and Protocols

Review guidelines that apply to UnitedHealthcare Community Plan and how you care for our members.

UHCprovider.com/policies

Find more information about these online services and more at UHCprovider.com – your hub for online transactions, education and member benefit information.

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

- **Eligibility and Benefits** — View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.
- **Claims** — Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims**.
- **Prior Authorization and Notification** — Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/paan**.
- **Specialty Pharmacy Transactions** — Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to **UHCprovider.com/pharmacy** for more information.
- **My Practice Profile** — View and update your provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.
- **Document Library** — Access reports and claim letters for viewing, printing, or download. The Document Library Roster provides member contact information in a PDF, and can only be pulled at the individual practitioner level. For more information, go to **UHCprovider.com/documentlibrary**.
- **Paperless Delivery Options** — The Paperless Delivery Options tool can send daily or weekly email notifications to alert you to new letters when we add them 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, in the Network Bulletin, or online at **UHCprovider.com/EDI** or the Provider Portal at **UHCprovider.com** then click Sign In.

*For more instructions, visit **UHCprovider.com/Training** or **Self Service Tools** for online self- service training and information.

Direct Connect

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

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

All users will access Direct Connect using the 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 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.

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

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How to contact us

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

Topic	Contact	Information
Behavioral Health	Optum providerexpress.com providerexpress.com 866-209-9320 (toll-free)	Eligibility, claims, benefits, authorization and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	UHCprovider.com/benefits 800-600-9007	Confirm a member's benefits and/or prior authorization.
Cardiology Prior Authorization	For prior authorization or a current list of CPT codes that require prior authorization, visit UHCprovider.com/cardiology Medicaid: 866-604-3267 MyCare: 800-366-7304	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Care Management	Medical Care Management Services: 800-508-2581 (Medicaid) Behavioral Health Care Management: 866-261-7692	Call Monday through Friday, 8 a.m. to 5 p.m., Eastern Time. Call 24 hours a day, 7 days a week for help with with referrals, prior authorizations, admissions, discharges and coordination of members' care.
Care Model (Care Management/ Disease Management)	800-508-2581	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
Chiropractor Care	myoptumhealthphysicalhealth.com 800-873-4575	We provide members older than 21 with up to six visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.

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Topic	Contact	Information
Claims	Use the Link Provider Portal at **UHCprovider.com/claims** 800-600-9007 Mailing address: **UnitedHealthcare Community Plan** P.O. Box 8207 Kingston, NY 12402	Verify a claim status or get information about proper completion or submission of claims.
Claim Overpayments	See the Overpayment section for requirements before sending your request. Sign in to **UHCprovider.com/claims** to access the Provider Portal, then select the UnitedHealthcare Online app 800-600-9007 Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.
Dental Services	DentaQuest 800-341-8478	Call DentaQuest to find a network provider.
Electronic Data Intake Claim Issues	**ac_edi_ops@uhc.com** 800-210-8315	Ask about claims issues or questions.
Electronic Data Intake Log-on Issues	800-842-1109	Information is also available at **UHCprovider.com/edi**.
Eligibility	To access eligibility information, go to **UHCprovider.com**, then Sign In to the Provider Portal or go to **UHCprovider.com/eligibility** Interactive Voice Response 888-586-4766	Confirm member eligibility online or call our toll-free Interactive Voice Response (IVR) system 24 hours a day, 7 days a week.
Enterprise Voice Portal	877-842-3210	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.

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Topic	Contact	Information
Fraud, Waste and Abuse (Payment Integrity)	Payment Integrity Information: UHCprovider.com/OHcommunityplan > **Integrity of Claims, Reports, and Representations to the Government** Reporting: **uhc.com/fraud** **tipform-ui-optum.com** FWA Hotline: 866-242-7727	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Healthy First Steps/ Obstetrics (OB) Referral	800-599-5985	Refer pregnant members to this program.
Laboratory Services	UHCprovider.com > Our Network > **Preferred Lab Network** LabCorp 800-833-3984 Quest Diagnostics **questdiagnostics.com**	LabCorp and Quest Diagnostics are network laboratories.
Medicaid (Ohio Department of Medicaid)	**medicaid.ohio.gov** 800-324-8680	Contact Medicaid directly.
Medical Claim, Reconsideration and Appeal	Sign in to the Provider Portal at **UHCprovider.com** or go to **UHCprovider.com/claims** 800-600-9007 Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 8207 Kingston, NY 12402-5240 Appeals mailing address: **UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	Medicaid: 800-895-2017 Relay 711 (TTY) MyCare: 877-542-9236 (TTY 711)	Assist members with issues or concerns. Medicaid: 7 a.m. – 7 p.m. Central Time, Monday through Friday. MyCare: 8 a.m. – 8 p.m. Eastern Time, Monday through Friday. Voicemail available 24 hours a day, seven days a week.
Mental Health & Substance Use (Behavioral Health)	866-261-7692	Refer members for behavioral health services. (A PCP referral is not required.) *See Behavioral Health row for more information.

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Topic	Contact	Information
Multilingual/ Telecommunication Assistance	Member Services Medicaid: 800-895-2017 Relay 711 (TTY) MyCare: 877-542-9236 (TTY 711)	Medicaid: 7 a.m. – 7 p.m. Central Time, Monday through Friday. MyCare: 8 a.m. – 8 p.m. Eastern Time, Monday through Friday. Voicemail available 24 hours a day, seven days a week.
National Plan and Provider Enumeration System (NPPES)	**nppes.cms.hhs.gov** 800-465-3203	Apply for a National Provider Identifier (NPI).
Network Management Resource Team (NMRT)	877-842-3210	Self-service functionality to update or check credentialing information.
Network Management Team	800-600-9007	This is the provider relations team. Ask about contracting and care provider services.
NurseLine	800-542-8630	Available 24 hours a day, seven days a week.
Obstetrics and Baby Care	Healthy First Steps Pregnancy Notification Form at **UHCprovider.com**, then Sign In for the Provider Portal. 800-599-5985 Healthy First Steps Rewards **UHChealthyfirststeps.com**	For pregnant members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form. Refer members to **UHChealthyfirststeps.com** to sign up for Healthy First Steps Rewards.
Oncology Prior Authorization	UHCprovider.com > Prior Authorization > **Oncology** Optum 888-397-8129 Monday -Friday 7am – 7pm CST	For current list of CPT codes that require prior authorization for oncology
One Healthcare ID Support Center	email: **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.
Pharmacy Services	**professionals.optumrx.com** 877-305-8952 (OptumRx) Technical Help Desk (pharmacies call): 877-305-8952	OptumRx oversees and manages our network pharmacies.

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Topic	Contact	Information
Prior Authorization/ Notification for Pharmacy	**UHCprovider.com** > Prior Authorization and Notification > **Clinical Pharmacy and Specialty Drugs** Medicaid: 800-310-6826 MyCare: 800-711-4555 Provider Pharmacy Prior Authorization Help Desk: 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.
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 Medicaid: 866-604-3267 MyCare: 800-366-7304	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 Visit UHCprovider.com/OHcommunityplan > Prior Authorization and Notification
Provider Services	**UHCprovider.com/OHcommunityplan** 800-600-9007 **UnitedHealthcare Community Plan** 9200 Worthington Road, 3rd Floor Worthington, OH 43082	Available 8 a.m. – 5 p.m. Central Time, Monday through Friday.
Radiology Prior Authorization	**UHCprovider.com/radiology** 866-889-8054	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Referrals	**UHCprovider.com** > **Referrals** or use Referrals on the Provider Portal. Click Sign in at the top right corner of **UHCprovider.com**, then click Referrals. Provider Services 800-600-9007	Submit new referral requests and check the status of referral submissions.

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Topic	Contact	Information
Reimbursement Policy	UHCprovider.com/OHcommunityplan > Policies and Clinical Guidelines	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical Support	website UHCprovider.com/contact-us/technical-assistance 866-209-9320 for Optum support or 866-842-3278, Option 1 for web support email: ProviderTechSupport@uhc.com	Call this number 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.
Transportation	ModivCare 800-269-4190	Call ModivCare or Member Services to schedule transportation or transportation assistance through ModivCare. To arrange non-urgent transportation, please call two business days in advance.
Utilization Management	800-366-7304	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. Request a copy of our UM guidelines or information about the program. For UM policies and protocols, go to UHCprovider.com > Resources > Plans, Policies, Protocols and Guides.
Vaccines for Children (VFC) program	odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Immunization/Vaccines-for-Children-VFC 800-282-0546	Care providers must participate in the VFC Program administered by the Department of Health and Senior Services (DHSS) and must use the free vaccine when administering vaccine to qualified eligible children. Providers must enroll as VFC providers with DHSS to bill for the administration of the vaccine.

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Topic	Contact	Information
Vision Services	March Vision **marchvisioncare.com** 844-756-2724	Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from March Vision.
Website for Ohio Community Plan	**UHCprovider.com/OHcommunityplan**	Access your state-specific Community Plan information on this website.

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Chapter 2: Care Provider Standards and Policies

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	800-600-9007
Enterprise Voice Portal		877-842-3210
Eligibility	UHCprovider.com/eligibility	800-600-9007
Referrals	UHCprovider.com > Referrals	800-600-9007
Provider Directory	UHCprovider.com > Our Network > Find a Provider	800-600-9007

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

Non-discrimination

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

Communication between care providers and members

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

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

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

Provide official notice

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

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.

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6. Closure of practice.

Notify us within 30 calendar days if any of the following changes:

- TIN.
- Address.
- Additions or departures of health care providers from your practice and new service locations.

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 > My Practice Profile > **Care Provider Demographic Information Update Form**.

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. For UnitedHealthcare Connect, the MCP shall send the notice at least 45 calendar days prior to the effective date of the deletion to members who use the subcontractor as a PCP. This may include providing services for a reasonable time at our in-network rate. **Provider Services** may help you and our members with the transition.

Arrange substitute coverage

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

For the most current listing of network care providers and health care professionals, review our care provider and health care professional directory at UHCprovider.com > Our Network > **Find a Provider**.

Administrative terminations for inactivity

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

1. End Agreements with care providers who have not submitted claims for UnitedHealthcare Community Plan members for one year and have voluntarily stopped participation in our network.
2. Inactivate any tax identification numbers (TINs) with no claims submitted for one year. This is not a termination of the 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** > Find Dr. > My Practice Profile Tool > **Care Provider Paper Demographic Information Update Form**.
- To update your care provider information online, go to **UHCprovider.com** > Find Dr. > My Practice Profile Tool > **Go To My Practice Profile Tool**.

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

Updating your practice or facility information

You can update your practice information through the Provider Data Management application on **UHCprovider.com**. Go to **UHCprovider.com** > Our Network > Demographics and Profiles > My Practice Profile > **Care Provider Paper Demographic Information Update Form**. Or submit your change by:

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

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After-hours care

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

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

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 11 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 six years or longer if required by applicable statutes or regulations.

Performance data

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

Comply with protocols

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

You may view protocols at UHCprovider.com.

Compliance to standards of care

UnitedHealthcare Connected participating care providers must comply with all applicable laws and licensing requirements. In addition, furnish covered services in a manner consistent with standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. You must also comply with UnitedHealthcare Connected standards, which include:

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

You must also comply with UnitedHealthcare Connected policies and procedures regarding the following:

- Participation on committees and clinical task forces to improve the quality and cost of care.
- Prior authorization requirements and time frames.
- Participating care provider credentialing requirements.
- Referral policies.
- Care Management Program referrals.
- Appropriate release of inpatient and outpatient utilization and outcomes information.
- Accessibility of member medical record information to fulfill the business and clinical needs of UnitedHealthcare Connected.
- Cooperating with efforts to assure appropriate levels of care.
- Maintaining a collegial and professional relationship with UnitedHealthcare Connected personnel and fellow participating care providers.
- Providing equal access and treatment to all Medicare and Medicaid members.

Compliance process

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

- Out-of-network referrals/utilization without prior authorization by UnitedHealthcare Connected

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- Failure to pre-notify UnitedHealthcare Connected of admissions
- Member complaints/grievances that are determined against the provider
- Underutilization, over utilization, or inappropriate referrals
- Inappropriate billing practices

Non-supportive actions and/or attitude participating care provider noncompliance is tracked, on a calendar year basis. Using an educational approach, the compliance process is composed of four phases, each with a documented educational component. Corrective actions will be taken.

We recommend you advise UnitedHealthcare Connected members about:

- The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including providing enough information to provide an opportunity for members to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.
- The importance of preventive changes at no cost to the member. Such actions shall not be considered non-supportive of UnitedHealthcare Connected.

Office hours

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

Protect confidentiality of member data

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

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

Follow medical record standards

Please reference Chapter 10 for Medical Record Standards.

Inform members of advance directives

The federal Patient Self-Determination Act (PSDA) gives patients the legal right to make choices about their medical care before incapacitating illness or injury through an advance directive. Under the federal act, you must provide written information to members on state laws about advance treatment directives, members' right to accept or refuse treatment, and your own policies regarding advance directives. To comply with this requirement, we inform members of state laws on advance directives through 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

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file an arbitration proceeding as described in your Agreement. Your Agreement describes where arbitration proceedings are held. For more information on the American Arbitration Association guidelines, visit adr.org.

If you have received a notice of contract termination and have a question, call Provider Services at **800-600-9007**.

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. Locate our Medicaid website at UHCCommunityPlan.com. Locate the MyCare Member Handbook at UHCCommunityplan.com/oh/medicaid/connected.

Also reference Chapter 13 of this manual for information on provider claim reconsiderations, appeals, and grievances.

Marketing

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

Appointment standards (Ohio Access and Availability Standards)

Comply with the following appointment availability standards:

Primary care (Medicaid)

PCPs should arrange appointments for:

- After-hours care phone number: 24 hours, 7 days a week
- Emergency care: Immediately or referred to an emergency facility
- Urgent care appointment: within 24 hours
- Routine care appointment (no symptoms): within 6 weeks
- Routine appointment (recurring symptoms): no later than the end of the following working day after their initial contact with the PCP site.
- Physical exam: within 6 weeks
- EPSDT appointments: within 6 weeks
- In-office waiting for appointments: not to exceed one hour of the scheduled appointment time

Primary care (MyCare)

- Routine follow-up or preventive care: within 30 days
- Routine/symptomatic: within 7 days
- Non-urgent care: within 1 week
- Urgently needed services: within 24 hours
- Emergency: Immediately

Specialty care (Medicaid)

Specialists should arrange appointments for:

- Routine appointment type: within 30 working days of request/referral

Prenatal care (Medicaid)

Prenatal care providers should arrange OB/GYN appointments for:

- Initial prenatal care appointment: within 2 weeks
- First trimester: within 10 business days of request
- Second trimester: within 5 business days of request
- Third trimester: within 4 business days of request
- High-risk: within 1 week, unless urgent need exists, then within 24 hours

Behavioral health care (Medicaid)

- Routine outpatient care: within 24 hours to member requests
- Initial mental health/substance use disorder appointment: within 10 business days of the request
- Urgent care: within 48 hours
- Non-life-threatening emergencies: within 6 hours
- Life-threatened emergencies: immediately
- Acute inpatient discharge appointment: within 7 days.

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Orthopedic surgery, allergy, dermatology, otolaryntolgy, neurology (Medicaid)

- Urgent care appointments: within 48 hours of referral
- Routine appointments within 6 weeks for new patients, within 4 weeks for established patients

All other care provider types (Medicaid)

- Urgent care appointments: within 24 hours of referral
- Routine appointments: 4 weeks for new patients, 3 weeks for established patient

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

Care provider directory

When you join our network, fill out a UnitedHealthcare Provider Agreement and an ODM Medicaid Addendum. Then be credentialed by UnitedHealthcare Community Plan. Following Credentialing Committee approval, your name or practice name and addresses are listed in our Provider Directory.

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

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

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

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

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

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

For Delegated providers, email your changes to **Pacific_DelProv@uhc.com** or **delprov@uhc.com**.

For Non-delegated providers, visit **UHCprovider.com** for the Provider Demographic Change Submission Form and further instructions.

Online care provider directory

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

Provider attestation

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

Prior authorization request

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

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

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

- VVerify eligibility using the Provider Portal 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.

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- Get prior authorization from the Provider Portal:
  1. To access the Prior Authorization app, go to UHCprovider.com, then Sign In.
  2. Select the **Prior Authorization and Notification app**.
  3. View notification requirements.

Identify and bill other insurance carriers when appropriate.

If you have questions, please call UnitedHealthcare Web Support at **866-842-3278**, option 3, 7 a.m. – 9 p.m. Central Time, Monday through Friday.

Prior authorization for waiver services

If you are providing waiver services to a MyCare Ohio member, contact the member's UnitedHealthcare care manager. The care manager adds these services to the member's Waiver Service Plan (WSP).

The information you submit on the waiver claim (dates of service, procedure code, units etc.) must match the information listed on the member's WSP.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

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

Specialists serving in PCP role

Specialists include internal medicine, pediatrics, or obstetrician/gynecology

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

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

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

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

NPs may enroll with the state as solo providers, but PAs cannot. PAs must be part of a group practice. Specialists may serve as a PCP if a UnitedHealthcare Community Plan medical director approves. Direct requests for a specialist to serve in this role to Member Services.

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

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

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

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support, and benefit from the primary care case management system. The coverage will include availability of 24 hours a day, seven days a week.

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During non-office hours, access by telephone 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 other appropriate health care professionals to develop individualized treatment plans for UnitedHealthcare Community Plan members with special health care needs.

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.
- Provide all well baby/well-child services.
- Coordinate each UnitedHealthcare Community Plan member's overall course of care. This includes behavioral health. PCPs must screen UnitedHealthcare Connected members for behavioral health problems (e.g., chemical dependence) and mental health. File the completed screening tool in the patient's medical record.
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a one MD practice and at least 30 hours per week for a two or more MD practice.
- Be available to members by phone any time.
- Tell members about appropriate use of emergency services.
- Discuss available treatment options with members.

Responsibilities of PCPs and Specialists Serving in PCP Role

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

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

- Act as a member advocate in recommending and arranging care, based on medical necessity.
- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide.
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment.
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Make distinctions between care options that align with the member's cultural background. Provide consistent care across a variety of cultures.
- Provide care to members without regard to race, color, creed, gender, religion, age, national origin, marital status, gender orientation, language, health status, pre-existing conditions, and physical or mental handicap.
- Refer services requiring prior authorization to our **Provider Services**, Clinical, or Pharmacy departments as appropriate.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
- Comply with the Ohio Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.

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- Comply with the UnitedHealthcare Community Plan Healthchek program for children younger than age 21.
- Work with us and local school districts to facilitate access to medically necessary services to school-age children, helping ensure continuity of care and achieve the ODM's goals in this area.

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 an RHC or 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 rural, underserved areas.
- **Federally Qualified Health Center:** An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a care provider, PA, NP and/or social worker.
  - Mental health services.
  - Immunizations (shots).
  - Home nurse visits.
- **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 primary care clinic that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

Specialist care providers responsibilities

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

- Contact the PCP to coordinate the care/services.
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer.

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.

- Verify the eligibility of the member before providing covered specialty care services.
- Provide only those covered specialty care services, unless otherwise authorized.
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care.
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at one UnitedHealthcare Community Plan participating hospital at a minimum.

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- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the Ohio Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, seven days a week.
  Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

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

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

Ancillary care provider responsibilities

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

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

Ancillary care provider checklist

Ancillary care providers include freestanding radiology, freestanding clinical labs, home health, hospice, dialysis, durable medical equipment, infusion care, therapy, ambulatory surgery centers, freestanding sleep centers and other non-care providers. PCPs and specialist care

Ancillary care 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/oh	Medicaid: 800-895-2017 MyCare: 877-542-9236
Member Handbook	UHCCommunityPlan.com/oh > Go to Plan Details, then Member Resources, View Available Resource	
Provider Services	UHCprovider.com	800-600-9007
Prior Authorization	UHCprovider.com/paan	800-600-9007
DSNP	UHCprovider.com > Resources > Health Plans > Choose a Location > Ohio > Dual Complete Special Needs	800-600-9007

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

Go UHCCommunityPlan.com/oh > Medicaid Plans to view plan details for both Medicaid and MyCare.

Assignment to PCP panel roster

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

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

On the report, an asterisk indicates members are new to the practice. An additional column of the roster indicates if a member is due for a Healthchek exam.

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.

Members using UnitedHealthcare Connected for MyCare Ohio must choose a PCP to coordinate their care.

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Choosing a PCP

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

Depending on the member's age, medical condition and location, the choice of PCP may cover a variety of practice areas, such as family practice, general practice, internal medicine, pediatrics and obstetrics. If the member changes the initial PCP assignment, the effective date will be the day the member requested the change.

Members can change their PCPs monthly. If the member requests a PCP change after the first month, the change will be effective on the first day of the next month. A new identification card will be issued and sent to the member's residence indicating the new PCP's name and the date the member can begin seeing the new PCP.

Deductibles/copayments

Medicaid members have no copays for covered services However, MyCare members may have to pay a "patient liability" for nursing facility or waiver services that are covered through their Medicaid benefit. The County Department of Job and Family Services determines if a member's income and certain expenses require you to have a patient liability.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

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

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

Member assignment

Assignment to UnitedHealthcare Community Plan

ODM 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. ODM makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month's end, but at times may occur mid-month.

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

Download a copy of the Member Handbook online at **UHCCommunityPlan.com/OH**. Go to Plan Details, then Member Resources, View Available Resources.

An enrollment verification representative also contacts each new member within one week of enrollment. They verify the member's demographic information and PCP selection. They tell members about their responsibilities and the PCP's role.

Immediate enrollment changes

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

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

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Unborn enrollment changes

Encourage your members to notify the Ohio county offices when they know they are expecting. The offices notify Managed Care Organizations (MCOs) daily of an unborn when Ohio Medicaid learns a woman associated with the MCO is expecting. The MCO or you may use the online change report through the Ohio website to report the baby's birth. With that information, ODM verifies the birth through the mother. The MCO and/or the care provider's information is taken as a lead. To help speed up the process, the mother should notify ODM when the baby is born.

Members may call **ODM**.

UnitedHealthcare Community Plan must first notify ODM of the birth. Prior to enrollment and assignment of a member ID number, bill for services rendered to the newborn using the mother's UnitedHealthcare Community Plan ID number. Eligibility begins on the date of birth and continue through the end of the 12th month. Sometimes newborns are added effective on the date of their birth.

Newborns may get UnitedHealthcare Community Plan-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 an MCO until birth, ask your members to select and contact a PCP for their baby prior to delivery. This will help avoid the delays and confusion that can occur with deferred PCP selections.

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

Member eligibility

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

- Enrollment is effective for new members on the first of the month. Members may check their eligibility at **benefits.ohio.gov**.

Member ID card

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

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

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

Member identification numbers

Each member receives a nine-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. The Ohio Medicaid Number is also on the member ID card.

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Sample health member ID cards

Medicaid

UnitedHealthcare Community Plan
Health Plan (80840) 911-87726-04
Member ID: 002000406 Group Number: WAHLOP
Member:
REISSUE ENGLISH
MMIS: 9999999406A
PCP Name:
DOUGLAS GETWELL
PCP Phone: (509)469-1903
DOB:
05/20/2010
Payer ID: 87726
OPTUMRx
Rx Bin: 610494
Rx Grp: ACUOH
Rx PCN: 4141
0501 OH - Medicaid
Administered by UnitedHealthcare Community Plan of Ohio, Inc.

If you have an emergency, call 911 or go to the nearest emergency room. Printed: 08/23/18

This card does not guarantee coverage. By using this card for services, you agree to the release of medical information, as stated in your Member handbook. If you are not sure whether you need to go to the emergency room, call your Primary Care Provider or the 24/7 NurseLine. To verify benefits or to find a provider, visit the website www.myuhc.com/communityplan or call:

For Members: 800-895-2017 TTY 711
NurseLine: 800-542-8630 TTY 800-855-2880
Mental Health: 866-261-7692

For Providers: UHCprovider.com 800-600-9007
Medical Claims: PO Box 8207, Kingston, NY, 12402-8207
Eligibility: 800-600-9007 Utilization Management: 800-366-7304

Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 877-305-8952

MyCare - Medicaid Only

United Healthcare Community Plan
Health Plan (80840) 911-87726-04
MyCareOhio Connecting Medicare + Medicaid
Member ID: 000000410
Member:
REISSUE ENGLISH
MMIS: 999999941062
Payer ID: 87726
OPTUMRx
Rx Bin: 610494
Rx Grp: ACUOHMMP
Rx PCN: 9999
PCP Name: Refer to Medicare PCP
H2531 PBP# 001 UnitedHealthcare Connected for MyCare Ohio(Medicare-Medicaid Plan)

Printed: 10/13/20

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

Website: MyUHC.com/CommunityPlan
Member Services: 1-877-542-9236 TTY 711
Behavioral Health Crisis: 1-877-542-9236 TTY 711
Care Management: 1-877-542-9236 TTY 711
24 Hour Nurse Advice: 1-800-542-8630 TTY 711

For Providers: 1-800-600-9007
Send claims to: PO Box 8207, Kingston, NY, 12402-8207
Eligibility Verification:1-800-600-9007 Claim Inquiry:1-800-600-9007

Pharmacy Claims:OptumRx, PO Box 650287, Dallas, TX 75265-0287
Pharmacy Help Desk:1-877-889-6510

MyCare - Fully Integrated

United Healthcare Community Plan
Health Plan (80840) 911-87726-04
MyCareOhio Connecting Medicare + Medicaid
Member ID: 000000414
Member:
REISSUE ENGLISH
MMIS: 999999941416
PCP Name:
DOUGLAS GETWELL
PCP Phone: (216)961-2090
Payer ID: 87726
MedicareRx Prescription Drug Coverage
Rx Bin: 610097
Rx Grp: MPDOHCSP
Rx PCN: 9999
H2531 PBP# 001 UnitedHealthcare Connected for MyCare Ohio(Medicare-Medicaid Plan)

Printed: 10/13/20

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Pharmacy Help Desk:1-877-889-6510

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Verifying member enrollment

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

- Provider Portal: access the Link portal through **UHCprovider.com/eligibility**
- Electronic data interchange (EDI): Use the Eligibility & Benefit Inquiry & Response (270/271).
- Phone: Call the United Voice Portal at **877-842-3210**. Or call the Customer Care number on the back of the members' ID card.

PCP-initiated transfers

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

1. To transfer the member, call **Provider Services**, or mail with the specific events documentation. Documentation includes the dates of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider's name

   Mailing address:
   UnitedHealthcare Community Plan
   Attn: Health Services
   5900 Parkwood Place, 5th Floor
   Dublin, OH 43016
2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have five business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

No medical coverage outside the United States

We do not cover any health care services received while out of the country. Medicaid cannot pay for any medical services received outside of the United States.

UnitedHealthcare Dual Complete (DSNP)

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

For general information about DSNP, go to uhc.com > Insurance Plans > Medicaid >**Dual Eligible Special Needs Plans (D-SNP)**.

For information about UnitedHealthcare Dual Complete, please see the Medicare Products chapter of the Administrative Guide for Commercial, Medicare Advantage and DSNP. For state-specific information, go to UHCprovider.com > Resources > Health Plans > **Choose Your Location**.

For Ohio- specific DSNP information, go to **UHCprovider.com/health-plans-by-state/State/medicare-plans/dual-complete-snp-plans.html**.

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Chapter 4: Medical Management

Key contacts

Topic	Link	Phone Number
Referrals	UHCprovider.com > Referrals	800-600-9007
Prior Authorization	UHCprovider.com/paan	Medicaid: 866-604-3267 MyCare: 800-366-7304
Pharmacy	professionals.optumrx.com	Medicaid: 800-310-6826 MyCare: 800-711-4555
Dental	dentaquest.com	DentaQuest 800-341-8478
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.

Before delivering any of these services, obtain informed consent. Informed consent means the treatment was explained to the member. The member must understand their options and say "yes:"

- Members must consent before receiving any treatment.
- Sometimes the consent must be in writing.
- If a member refuses medical treatment, their PCP should discuss other choices with them.
- Members have the right to say yes or no.

Informed consent

Informed consent means the treatment was explained to the member. The member must understand their options and say "yes":

- Members must consent before receiving any treatment.
- Sometimes the consent must be in writing.
- If a member refuses medical treatment, their PCP should discuss other choices with them.
- Members have the right to say yes or no.

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:

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- 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.

Non-emergent medical transportation

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. 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.

UnitedHealthcare Community Plan will provide members with 30 one-way or 15 round trips per year to and from their PCP, WIC, pharmacy, or other participating health care providers, such as vision or dental.

Members may also request help to get to their Medicaid redetermination visits. If a member must travel 30 miles or more from their home to receive covered health care services, UnitedHealthcare Community Plan will provide transportation to and from the provider's office. These services must be medically necessary and not available in the member's service area. Members must also have a scheduled appointment (except in the case of urgent/emergent care). Please contact **Member Services** at least two business days in advance of the member's appointment for assistance.

In addition to the transportation assistance that UnitedHealthcare Community Plan provides, members can still receive assistance with transportation for certain services through the local County Department of Job and Family Services Non-Emergency Transportation (NET) program. Call your County Department of Job and Family Services for questions or assistance with NET services.

For non-urgent appointments, members must call Member Services for transportation at least two business days before their appointment.

Schedule transportation up to 30 days in advance.

Cardiology

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

You must obtain prior authorization for the following cardiology procedures:

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

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

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

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

Request prior authorization online or by phone:

- 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 currently 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.

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Care management

UnitedHealthcare Connected helps manage the care of members with acute or chronic conditions. UnitedHealthcare Connected care management programs include:

- **Special Needs Populations** – These members have serious and chronic physical, developmental or behavioral conditions requiring health and related services of a type or amount beyond what most members need. We consider members to have special needs when the medical condition both:
  - Lasts or may last one year or longer.
- Requires ongoing care a PCP generally does not provide.
  The following populations meet the criteria for the special needs designation. This includes members who:
  - Get services through the Ohio Bureau for Children with Medical Handicaps, Ohio and county Boards of Developmental Disabilities, county Protective Children's Services organizations.
  - Get services through the Ohio Department of Health Services/Division of Behavioral Health-contracted Regional Behavioral Health Authorities.
  - Are diagnosed with HIV/AIDS.
  - Are diagnosed with end-stage renal disease receiving dialysis or waiver services.
- **Organ Transplantation** – A Transplant Nurse Care Coordinator coordinates authorization requests for organ transplants. They work with the Medicaid Office of Medical Management, contracted providers and UnitedHealthcare Connected departments to coordinate service delivery included in the transplantation process.
- **Emergency Department (ED)** – Our Care Coordination Program helps members with multiple ED visits get appropriate medical and specialty care.
- **HIV+/AIDS** – This program is offered alongside the Medicaid guidelines for managing HIV/AIDS members' treatment regimens. The Medicaid guidelines require that any member receiving antiretroviral therapy be assigned to a UnitedHealthcare Connected HIV/AIDS Nurse Care Coordinator. Contact the department whenever a member is diagnosed with HIV or AIDS or if an HIV/AIDS- diagnosed member is noncompliant. The HIV/AIDS Nurse Care Coordinator helps coordinate care for these members.
- **Chronic Pain and Substance Use Disorder** – The Specialty Care Coordination Department handles your requests for assistance with members with chronic pain and related drug-seeking behavior and/or ED abuse.

Call a UnitedHealthcare Personal Care Specialist at **888-303-6163** to refer candidates for care management.

Care provider responsibility with termination of services-notification of Medicare non-coverage

Skilled nursing facility (SNF), home health agency (HHA), and comprehensive outpatient rehabilitation facility (CORF) notification requirements

As a participating UnitedHealthcare SNF, HHA, or CORF provider, you give members the Notice of Medicare Non-Coverage (NOMNC). This notice tells members when their service coverage ends and what they should do if they want to appeal the decision or need more information.

CMS has developed a single, standardized NOMNC designed to make notice delivery easy. It has three variable fields (patient name, ID/Medicare number and last day of coverage) for you to fill in.

When to deliver the NOMNC

Based on when services should end, the SNF, HHA, or CORF delivers the NOMNC no later than two days before the end of coverage. If services are expected to end in fewer than two days, deliver the NOMNC upon admission. If there is more than a two-day span between services (e.g., home health setting), issue the NOMNC on the next to last time you furnish services. We encourage SNF, HHA, and CORF providers to work with us so these notices can be delivered as soon as the service termination date is known.

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How to deliver the NOMNC

SNF, HHA, and CORF providers must carry out "valid delivery" of the NOMNC. This means the member (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by phone if personal delivery is not immediately available. In this case, notify the authorized representative of the notice contents. Document the call and mail the notice to the representative.

Expedited review process

If the member decides to appeal the end of coverage, they must contact the Quality Improvement Organization (QIO) by no later than noon the day before services are to end (as indicated in the NOMNC).

The QIO for Ohio is Livanta. A member may call Livanta at **888-524-9900**.

The QIO tells us and you of the request for a review. We provide the QIO and member with a detailed explanation of why coverage is ending. Based on the expedited time frames, the QIO decision should take place by close of business of the day coverage is to end.

Exclusions from NOMNC delivery requirements

You do not have to deliver the NOMNC if coverage is ending for any of the following reasons:

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

We issue members a Detailed Explanation of Non-Coverage (DENC) explaining why services are no longer medically necessary. We notify the QIO no later than close of business (typically 4:30 p.m.) the day of the QIO's notification that the member requested an appeal, or the day before coverage ends, whichever is later.

Find the form on CMS.gov > Medicare > Beneficiary Notices Initiative (BNI) > **MA Expedited Determination Notices**.

Care coordination/ health education

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

The program goals are to:

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

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

Programs are based upon the findings from our Health Education, Cultural and Linguistic Group Needs

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Assessment (GNA) and will identify the health education, cultural and linguistic needs.

Chiropractic care

You must obtain prior authorization for children younger than age 21. We do not require prior authorization for chiropractic care for members 21 years and older. Adult members may access care in 15 visits per year. MyCare Ohio Chiropractic services covers diagnostic X-rays and corrective spine adjustments.

Dental services

A Dental Provider Manual is available for detailed coverage information.

UnitedHealthcare Community Plan works with DentaQuest to cover the facility and anesthesia for medically necessary outpatient dental services for adults ages 21 and older. If older than 21, we do not provide coverage without the presence of trauma or cases where treatment is needed for serious medical conditions. It does not cover orthodontia for any member.

Facility services require a prior authorization.

For more details, visit DentaQuest's website at **dentaquest.com**.

To find a dental provider, go to UHCprovider.com > Our Network > **Find a Provider** > Dental Providers by state, network and location.

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** > Resources > Plans, Policies, Protocols and Guides > For Community Plans > **Medical & Drug Policies and Coverage Determination Guidelines for Community Plan**.

Obtain authorization for DME rentals or any purchase with a billable charge greater than $500. A list of items requiring prior authorization is located at **UHCprovider.com/priorauth**. Call Provider Services to request prior authorization. You may also use the secure provider portal at **UHCprovider.com**.

Incontinence supplies

Edgepark Medical Supply provides all incontinence supplies for UnitedHealthcare Community Plan. Call Edgepark at **844-564-1008** for more information.

Respiratory supplies

Medical Service Company (MSC) provides respiratory supplies such as oxygen/continuous positive airway pressure (CPAP) machines, concentrators, nebulizers and other related supplies for Medicaid members age 7 and older. Call 888-50MyUHC for more information.

Medical advances

When UnitedHealthcare Community Plan receives requests to cover newly developed medical equipment or procedures, our national Technology Assessment Committee reviews them. This committee includes physicians and other health care professionals. The Committee uses national guidelines and scientific evidence from medical literature to help decide whether UnitedHealthcare Community Plan should approve the use of the equipment or procedures.

Emergency/urgent care services

Emergency services do not require prior authorization.

While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about

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

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 to the ER, they may call 911. No referral is needed. Members have been told to call their PCP as soon as possible after receiving emergency care. They pay no out-of-pocket cost for ER or emergency ambulance services.

Before they are treated, UnitedHealthcare Community Plan members who visit an ER 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 one hour for pre-approval for more care to make sure the member remains stable. If the hospital needs to appeal the decision or if does not receive a decision within one hour and/or they need to speak with a peer (medical director), call 800-599-5985. The treating care provider may continue with care until the health plan's medical care provider is reached, or when one of these guidelines is met:

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

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

Urgent care (non-emergent)

Urgent care services are covered.

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

Emergency care resulting in admissions

An emergency medical condition is defined as 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 health and medicine, 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 and her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or,
- Serious dysfunction to any bodily organ or part.

Prior authorization is not required for emergency services.

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

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

UnitedHealthcare Community Plan makes utilization management 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 Utilization Management 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**. Call Utilization Management at **800-366-7304** for authorization for hospital admissions. Call **866-261-7692** for approval for inpatient admissions for behavioral health. For policies and protocols, go to UHCprovider.com > Resources > 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.

Post-stabilization services

UnitedHealthcare Community Plan covers post-stabilization services as defined in federal Medicaid managed care regulation at 42 CFR 438.114(e) and 42 CFR 422.113(c) and OAC rule 5160-26-03(G) without requiring prior authorization. This is the case if any of the following situations exist:

- The post-stabilization services were pre-approved by UnitedHealthcare Community Plan.
- The post-stabilization services were not pre-approved by UnitedHealthcare Community Plan because UnitedHealthcare Community Plan did not respond to your request for the services within 1 hour of the request.
- The post-stabilization services were not pre-approved by UnitedHealthcare Community Plan because UnitedHealthcare Community Plan could not be reached to request pre-approval.
- The post-stabilization services are not pre-approved by a UnitedHealthcare Community Plan Utilization Management representative and a UnitedHealthcare Community Plan medical director was not available for consultation; the treating provider may continue with the proposed plan of care until a plan medical director can be reached.
- The attending or treating care provider shall determine when the member is stable for transfer or discharge. UnitedHealthcare Community Plan shall defer to the treating care provider regarding the point of stabilization.

Hospital transfers

In the event of a transfer admission to or from the hospital, the sending and receiving hospital or the attending provider must contact the Utilization Management department. No party should assume the other has obtained prior authorization.

Outpatient surgical services

Prior authorization may be required for the procedure or surgery. The ordering Provider must make the request for such prior authorization.

The requesting care provider should make every attempt to request the above prior authorization at least 72 hours prior to admission unless contract guidelines stipulate otherwise.

In the event that a member's condition requires an immediate admission, prior authorization must be obtained for the admission. The ordering Provider or the facility may make the request for such prior authorization. Please be sure that all claims include your appropriate Provider ID numbers and appropriate authorization information for each place of service.

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Discharge planning

Discharge planning begins at the time a member is admitted to the hospital and continues through the concurrent review process. The Utilization Management nurse will use approved medical criteria as discharge indicators. In addition to the member's clinical status, the psychosocial situation and home environment are also taken into consideration when evaluating the member's discharge status. Post-hospitalization services may include, but are not limited to, home health visits, DME, rehabilitation and pharmacy services. The Utilization Management nurse will refer pre-identified patients to a dedicated discharge team. This discharge team will assume responsibility for the finalization of the discharge plan and will serve as a resource to the attending provider, hospital team and the member. The discharge team will perform the following discharge planning tasks:

- Confirm benefit levels.
- Assist with the identification of participating care providers.
- Facilitate the certification process of post-hospitalization services.
- Refer members to Care Management for continuity of care.
- Identify high-risk patients for post-discharge follow-up contact to confirm the discharge plan was executed.
- Assist provider with identification and resolution of unanticipated issues identified immediately post-discharge.

The Utilization Management discharge team's focus is to assist the hospital staff and attending provider with the coordination of the member's discharge plan.

In addition, during the discharge planning process, the discharge team will identify those members who may be considered high-risk and will outreach to the member post-discharge to verify the discharge plan was executed as the treating provider intended.

Inpatient rehabilitation unit/long term acute care facility

UnitedHealthcare Community Plan care providers may use an Inpatient Rehabilitation Unit only when prior authorized by the Utilization Management department.

The ordering care provider of the facility may make the request for such prior authorization.

The requesting care provider should make every attempt to make the above prior authorization request at least 72 hours prior to admission, unless contract guidelines stipulate otherwise.

Facility admission notification requirements

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

- Planned/elective admissions for acute care
- Unplanned admissions for acute care
- SNF admissions
- Admissions following outpatient surgery
- Admissions following observation

Family planning

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

- Annual gynecological examination
- Annual pap smear
- Contraceptive supplies, devices and medications for specific treatment
- 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:
  - ZIFT (zygote intrafallopian transfer)
  - GIFT (gamete intrafallopian transfer)

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  - Embryo transport
- Infertility services, if given to achieve pregnancy
  Note: Diagnosis of infertility is covered. Treatment is not.
  - Morning-after pill. Contact ODM 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 ODM regulations for more information on sterilization.

Health Home program

Health Home provides community-based intensive care coordination and comprehensive care management to improve health outcomes and reduce service costs for some of the state's highest-need individuals. Health Home helps improve coordination of care, quality, and increase individual participation in their own care. The program reduces Medicaid inpatient hospital admissions, avoidable ER visits, inpatient psychiatric admissions, and the need for nursing home admissions. We work with area hospitals in providing transitional care services to members enrolled in Health Home. Hospitals and care providers may refer individuals to us for potential Health Home enrollment. Health Home eligibility is determined by Medicaid. The program provides services beyond those typically offered by care providers, including, but not limited to:

- Comprehensive care management
- Care coordination and health promotion,
- Individual and family support
- Referral to community services

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.

Home health care

Our Utilization Management oversees the authorization of home health care services. Home health care may include:

- Well-baby/post partum care
- Skilled nursing
- Physical therapy
- Respiratory therapy
- Occupational therapy
- Speech therapy
- IV therapy
- DME

Order home health care from any participating home health care provider. Obtain prior authorization for all home health care services.

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.

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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 five 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. ODM covers residential inpatient hospice services. ODM will cover hospice care provider benefits for both the hospice services provided and the facility residential services.

Laboratory

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

Use a UnitedHealthcare Community Plan in-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.

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.

Long-term services and supports (MyCare)

UnitedHealthcare Connected members may get long-term services and supports (LTSS), also called Medicaid "waiver services."

LTSS help members 18 years or older who are fully eligible for both Medicare and Medicaid and enrolled in MyCare Ohio stay in the community instead of going to a nursing home or hospital. If members are eligible for waiver services, their care manager helps meet their needs.

The plan covers the following home and community-based waiver services:

- Adult day health services
- Alternative meals service
- Assisted living services
- Choices home care attendant
- Chore services
- Community transition
- Emergency response services
- Enhanced community living services
- Home care attendant
- Home delivered meals
- Home medical equipment and supplemental adaptive and assistive device
- Home modification, maintenance, and repair
- Homemaker services
- Independent living assistance
- Nutritional consultation
- Out-of-home respite services
- Personal care services
- Pest control
- Social work counseling
- Waiver nursing services
- Waiver transportation

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Transition Requirements	Waiver Consumers	Non-Waiver Consumers with LTC Needs (HH and PDN use)	NF Consumers AL Consumers	No LTC Need Consumers
Physician	- 90 days for individuals identified for high-risk care management - 365 days for all others	- 90 days for individuals identified for high-risk care management - 365 days for all others	- 90 days for individuals identified for high-risk care management - 365 days for all others	- 90 days for individuals identified for high-risk care management - 365 days for all others
Pharmacy	90 days	90 days	90 days	90 days
Medicaid DME	Must honor prior authorizations (PAs) when item has not been delivered and must review ongoing PAs for medical necessity	Must honor prior authorizations (PAs) when item has not been delivered and must review ongoing PAs for medical necessity	Must honor prior authorizations (PAs) when item has not been delivered and must review ongoing PAs for medical necessity	Must honor prior authorizations (PAs) when item has not been delivered and must review ongoing PAs for medical necessity
Scheduled Surgeries	Must honor specified care provider	Must honor specified care provider	Must honor specified care provider	Must honor specified care provider
Chemo/Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified care provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified care provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified care provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified care provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified care provider	Must honor specified care provider	Must honor specified care provider	Must honor specified care provider
Medicaid Vision and Dental	Must honor PAs when item has not been delivered	Must honor PAs when item has not been delivered	Must honor PAs when item has not been delivered	Must honor PAs when item has not been delivered
Home Health and PDN	Keep service, care provider and Medicaid reimbursement rate at current levels. No changes unless: - A significant change occurs as defined in OAC 5101:3-45-01. - Member wants to self-direct services. - 365 days have passed.	Keep existing service for 90 days. Then review for medical necessity after an in-person assessment with care provider observation.	For AL: Keep existing service for 90 days. Then review for medical necessity after an in-person assessment with care provider observation.	N/A
Assisted Living Waiver Service	N/A	N/A	Care provider maintained at current rate for the life of demonstration.	N/A

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Transition Requirements	Waiver Consumers	Non-Waiver Consumers with LTC Needs (HH and PDN use)	NF Consumers AL Consumers	No LTC Need Consumers
Waiver Services - Direct Care: - Personal care - Waiver nursing - Home care attendant - Choice home care attendant - Out-of-home respite - Enhanced community living - Adult day health services - Social work counseing	Keep service, care provider and Medicaid reimbursement rate at current levels. No changes unless: - A significant change occurs as defined in OAC 5101:3-45-01. - Member wants to self-direct services. - 365 days have passed.	N/A	N/A	N/A
Waiver Services - all others	Keep current service level for 365 days and existing service provider for 90 days. Plan-initated change in service provider only occurs after an in-home assessment and a transition plan	N/A	N/A	N/A
Behavioral Health Services	Maintain service provider, level and rate documented in the BH plan of care at enrollment for 365 days.	Maintain service provider, level and rate documented in the BH plan of care at enrollment for 365 days.	Maintain service provider, level and rate documented in the BH plan of care at enrollment for 365 days.	Maintain service provider, level and rate documented in the BH plan of care at enrollment for 365 days.

Transition period

A transition period applies to individuals who were enrolled on any of the Ohio Medicaid waivers (PASSPORT, Choices, Assisted Living, Ohio Home Care, or Transitions Carve-Out) before enrolling on the MyCare Ohio Waiver. Exact periods are shown in the Transition Requirements table.

During this period, we keep members' existing service levels and care providers for a pre-determined amount of time, depending upon the service.

Exceptions:

We may change the member's existing care provider during the transition period in the following cases:

- The member requests a change.
- The care provider gives appropriate notice of intent (typically 30 days) to stop a member's services.
- We identify care provider performance issues that affect a member's health.

When the transition period ends, the member's services or care providers won't necessarily change. UnitedHealthcare Connected for MyCare Ohio only has the option to make changes to the member's services after this period. Before the end of the transition period, the member's Waiver Services Coordinator reviews their waiver service plan and discusses any needed changes with members. If a care provider change is required for any reason, the member is given information about other available care providers.

Email questions to UnitedHealthcare Connected for MyCare Ohio at icdsprovider@uhc.com. Members may call Member Services at **800-396-1942** (TTY 800-947-6644).

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Maternity/pregnancy/ well-child care

Pregnancy notification risk screening

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

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

HFS-Maternal care model

The HFS-Maternal care model 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.
- 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 United Healthcare for care coordination.

Pregnancy/maternity

Evaluate OB needs using the criteria indicated on the OB Needs Assessment Form. Send a copy of the form to Healthy First Steps. If you have questions, please call **877-353-6913** within 15 days from the initial assessment. You may also submit the form to the pregnancy care manager at any time during prenatal care if a member's condition constitutes a change of risk status.

Bill the initial pregnancy visit as a separate office visit. You may bill global days if the mother has been a UnitedHealthcare Community Plan member for three or more consecutive months or had seven or more prenatal visits.

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

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

1. The woman was 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.

In-office surgery

Any surgeries a gynecologic provider performs in the office do not require authorization prior to rendering services.

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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.

Complete the online Risk Assessment form to initiate case management outreach. Provide the following information within one business day of the admission:

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

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

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

Non-routine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires prior authorization. Infants remaining in the hospital after 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 a 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.

For additional pregnant member and baby resources, see Healthy First Steps Rewards in Chapter 6.

Post maternity care

UnitedHealthcare Community Plan covers post-discharge care to the mother and her newborn. Post-discharge care consists of a minimum of two visits, at least one in the home, according to accepted maternal and neonatal physical assessments. These visits must be conducted by a registered professional nurse with experience in maternal and child health nursing or a care provider. The first post-discharge visit should occur within 24 to 48 hours after the member's discharge date. 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 enrollment

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

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

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

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home visiting, child care, school-based health clinics, and many others. Materials developed for families are also available.

The primary goal of Bright Futures is to support primary care practices (medical homes) in providing well-child and adolescent care according to *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 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 Guidelines*. This objective will ensure that patients receive information and support that is consistent from family and youth perspectives.

Home care and all prior authorization services

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

Hysterectomies

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

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

Find the **form** at the Ohio Department of Medicaid (**medicaid.ohio.gov**).

See “Sterilization consent form” section on next page for more information. Exception: ODM does not require informed consent if:

1. As the care provider performing the hysterectomy, you certify in writing the member was sterile before the procedure. You must also state the cause of the sterility.
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 Ohio consent procedures for abortion.

Allowable pregnancy termination services do not require a referral from the member’s primary care provider. Members must use the UnitedHealthcare Community Plan 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 Ohio 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.

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

You may also find the form on the United States Department of Health and Human Services website at hhs.gov.

Have three copies of the consent form:

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

Neonatal Intensive Care Unit (NICU) case management

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

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

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

Inhaled nitric oxide

Use the NRS guideline for inhaled nitric oxide (iNO) therapy at UHCprovider.com > Resources > Plans, Policies, Protocols and Guides > **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 7am – 7pm CT.

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:

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

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

- ER
- Observation unit
- Urgent care
- Inpatient stay

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

Request prior authorization online or by phone at:

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

For a list of Advanced Outpatient Imaging Procedures that require prior authorization, a prior authorization crosswalk, and/or the evidence-based clinical guidelines, go to **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 four 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 or licensed substance use specialist for assessment and treatment of a substance use disorder. **This includes coordinating with the Alcohol and Drug Program in the county where the member resides for treatment.**

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

- The billing provider and servicing provider 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 four 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

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

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

Medication-assisted treatment

Medication-assisted treatment (MAT) combines behavioral therapy and medications to treat opioid use disorders (OUD). The Food and Drug Administration (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 in-house. 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 for a behavioral health professional on liveandworkwell.com.

To find a medical MAT provider in Ohio:

1. Go to UHCprovider.com.
2. Select "Our Network," "then "Find a Provider." "Select Search for Doctors, Clinics or Facilities by Plan Type."
3. Select the care provider information.
4. Click on "Medical Directory."
5. Click on "Medicaid Plans."
6. Click on applicable state.
7. Select applicable plan.
8. Refine the search by selecting "Medication Assisted Treatment."

For more SAMHSA waiver information:

Physicians — samhsa.gov
NPs and PAs — samhsa.gov

If you have questions about MAT, please call Provider Services at **800-600-9007**, enter your TIN then say "Representative," and "Representative" a second time, then "Something Else" to speak to a representative.

Opioid resources

- Interagency Guideline on Prescribing Opioids for Pain: agencymeddirectors.wa.gov > Interagency Guidelines > AMDG 2015 Interagency Guideline on Prescribing Opioids for Pain
- National Center for Biotechnology Information: ncbi.nlm.nih.gov > enter either "3218789" or "The Role of Psychological Interventions in the Management of Patients with Chronic Pain" in Search engine
- Opioid Use Disorder Diagnostic Criteria from the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition, 2013.

Screening tools

Pain Assessment Scale: painedu.org > Pain Assessment Scales CAGE-AID (Adapted to Include Drugs): opioid risk > Type in "CAGE-AID" in the Search engine > Select CAGE - "Aid Screen Tool" Patient Substance Use.

Treatment helpline

- Free, confidential service for UnitedHealthcare members. Specialized licensed clinicians provide treatment advocate services 24 hours a day, seven days a week.
- Phone: **855-780-5955**
- Website: liveandworkwell.com

For other questions, call **888-362-3368**.

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Pharmacy

With a few exceptions, UnitedHealthcare Connected members must use network pharmacies to get their outpatient prescription drugs covered. Generally, we only cover drugs filled at an out-of-network pharmacy when a network pharmacy is not available.

To find out what drugs are covered, go to **UHCprovider.com**.

For Medicaid, bill prescriptions filled through retail pharmacies to OptumRx. All written prescriptions must be tamper resistant.

BIN/Processor Control Number/Group Numbers Claims Processor (Medicaid)

- Name of Processor: OptumRx
- Bank Identification Number (BIN): 610494
- Processor Control Number (PCN): 4141
- Submitted Group (Group): ACUOH

For UnitedHealthcare Connected, bill prescriptions through retail pharmacies to OptumRx. All written prescriptions must be tamper-resistant.

BIN/Processor Control Number/Group Numbers Claims Processor (UnitedHealthcare Connected)

- Name of Processor: OptumRx
- Bank Identification Number (BIN): 610097
- Processor Control Number (PCN): 9999
- Submitted Group (Group): MPDOHCSP

We cover the following:

- Drugs administered in a physician office, hospital, outpatient department, clinic, dialysis center, or infusion center. Previous prior authorization requirements still apply.
- Some medical supplies such as diabetic testing supplies, supplies for injection of insulin and other drugs, inhaler spacers and peak flow meters. Find more information on our Preferred Drug List (PDL).

Members may receive prescriptions at any network pharmacies. If a member is planning to travel out of state, work with the member to make sure they have enough of their medication. Members may call **Member Services** (TTY Relay: 711).

Pharmacy Preferred Drug List

UnitedHealthcare Community Plan determines and maintains its PDL of covered medications. This list applies to all UnitedHealthcare Community Plan 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 online Prior Authorization and Notification tool on the Provider Portal.

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

Pharmacy prior authorization

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

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

Specialty pharmacy medications

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

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

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- May be oral, injectable, or inhaled

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

Tuberculosis screening and treatment; direct observation therapy (DOT)

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

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 one day of identification.

Vision services

All members receive an eye exam every 12 months. They also have a choice of glasses or $125 toward any type of contacts (must use at one time) every 12 months. UnitedHealthcare Community Plan also offers an additional frame selection beyond what Medicaid covers at no cost to the member. Refer to the Provider Directory for a list of optometrists in the UnitedHealthcare Community Plan network to set up eye appointments.

Waiver programs

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

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

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

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

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

Other federal waiver programs

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

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Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

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

Call **800-366-7304** or use the Provider Portal to obtain a medical prior authorization. For Behavioral Health Services, call **866-261-7692**.

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

Additional requirements include:

- Ohio Medicaid managed care plans must respond to electronically submitted prior authorizations within 48 hours for urgent services and 10 calendar days for any non-urgent care services. This time period begins once the plan receives the request with all required information.
- Responses to prior authorization requests must indicate whether the request is approved, denied, or incomplete. When the response to a prior authorization is denied, the managed care plan must provide the specific reason.
- If the prior authorization request is incomplete, the department or its designee shall indicate the specific additional information that is required to process the request.

Some dental services require prior authorization. Submit requests to UnitedHealthcare Community Plan's dental administrator DentaQuest by calling **855-398-8411**. DentaQuest will respond to prior authorization requests by phone or secure fax within 15 days.

The Utilization Management (UM) department will respond to prior authorization requests within 10 days. If the member's condition requires an expedited response, notify Intake/Prior Authorization to consider the request as urgent.

Prior authorization requests are generally reviewed and decided within 72 hours of the request; however, you may be granted an extension of up to 10 days from the date of the original request to provide additional information. For peer-to-peer discussions, call the UM prior authorization line at **800-366-7304**.

See the following table for more information about requirements.

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

Concurrent review guidelines

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

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

Concurrent review details

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

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

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

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UnitedHealthcare Community Plan uses Interqual, CMS guidelines, 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.
- rPrevent 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 do not cover experimental treatments.

Services which are necessary for the diagnosis or treatment of disease, illness or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. A medically necessary service must:

1. Meet generally accepted standards of medical practice;
2. Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome;
3. Be appropriate to the intensity of service and level of setting;
4. Provide unique, essential, and appropriate information when used for diagnostic purposes;
5. Be the lowest-cost alternative that effectively addresses and treats the medical problem; and
6. Meet the general principles regarding reimbursement for Medicaid-Covered Services set forth in Rule 5160-1-02 of the Ohio Administrative Code.

Determination process

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

Medical and drug policies and coverage determination guidelines

Find medical policies and coverage determination guidelines at UHCProvider.com > Resources > 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.

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

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

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

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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 Link on **UHCprovider.com**, calling **Provider Services**, or the Ohio Medicaid Eligibility System.
- Submit documentation needed to support the medical necessity of the requested procedure.
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized.
- Determine if the member has other insurance that should be billed first.

UnitedHealthcare Community Plan will not reimburse:

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

Second opinion benefit

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

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. You 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 his or her report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact Provider Services.
- 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.

Covered services for Medicaid only

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

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

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

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

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

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

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lists to determine if the member's benefits require approval.

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

Services not covered by UnitedHealthcare Community Plan

Medicaid-only services

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

- Services considered not "reasonable and necessary," based on Medicare and Medicaid standards, unless we list the services as covered under our plan
- Experimental medical and surgical treatments, items and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or our plan
- Experimental treatment and items not generally accepted by the medical community
- Surgical treatment for morbid obesity, except when it is medically needed and Medicare covers it
- A private room in a hospital, except when medically needed
- Personal items in a member's room at a hospital or a nursing facility, such as a phone or a television
- Inpatient hospital custodial care
- Full-time nursing care in the member's home
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to correct a part of the body that is not shaped right. However, the plan will cover reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care other than diagnostic X-rays and manual spinal manipulation correct alignment consistent with Medicare and Medicaid coverage guidelines
- Routine foot care, except for the limited coverage provided based on Medicare and Medicaid guidelines
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the mother's life
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- Infertility services for males or females
- Voluntary sterilization if younger than age 21 or legally incapable of consenting to the procedure

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- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies
- Paternity testing
- Naturopath services (the use of natural or alternative treatments)
- Services provided to veterans in Veterans Affairs (VA) facilities
- Services to find cause of death (autopsy)
- Equipment or supplies that condition the air, wigs and their care, and other primarily non-medical equipment
- Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport), unless Medicare criteria are met

Medicaid-excluded services

The following items and services are not covered by our plan:

- Services considered not "reasonable and necessary," according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan
- Experimental treatment and items are those that are not generally accepted by the medical community
- Surgical treatment for morbid obesity, except when it is medically needed and Medicare covers it
- A private room in a hospital, except when it is medically needed
- Inpatient hospital custodial care
- Full-time nursing care in the home
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed
- Cosmetic surgery or other cosmetic work, unless needed due to an accidental injury or to improve a part of the body that is not shaped right. However, the plan will cover reconstruction of a breast after a
- mastectomy and for treating the other breast to match it
- Chiropractic care, other than diagnostic X-rays and manual manipulation (adjustments) of the spine to correct alignment consistent with Medicare and Medicaid coverage guidelines
- Routine foot care, except for the limited coverage provided according to Medicare and Medicaid guidelines
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- Infertility services for males or females
- Voluntary sterilization if younger than 21 years old or legally incapable of consenting to the procedure
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies
- Paternity testing
- Naturopath services (the use of natural or alternative treatments)
- Services provided to veterans in Veterans Affairs (VA) facilities
- Services to find cause of death (autopsy)
- Equipment or supplies that condition the air, wigs, and their care, and other primarily non-medical equipment
- Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport), unless Medicare criteria are met
- Immunizations for foreign travel

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Services requiring prior authorization

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

Direct Access Services – Native Americans

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

Seek prior authorization within the following time frames

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

Utilization management guidelines

Call **800-366-7304** to discuss the guidelines and utilization management.

Utilization Management (UM) is based on a member's medical condition and is not influenced by monetary incentives. UnitedHealthcare Community Plan pays its in-network PCPs and specialists on a fee-for-service basis. We also pay in-network hospitals and other types of care providers in the UnitedHealthcare Community Plan network on a fee-for-service 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.

Utilization management (UM) appeals

UM appeals are considered medically necessary appeals. Theycontest UnitedHealthcare Community Plan's UM decisions. These include UnitedHealthcare Community Plan's admission, extension of stay, level of care, or other health care services determination. They do not include benefit appeals, which are appeals for non-covered services. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal. See Appeals in **Chapter 12** for more details.

Peer-to-peer discussion

Prior authorization requests are reviewed by a physician medical director prior to any denial. We base the review on the information the ordering provider sends. We review and decide prior authorization requests within 72 hours of the request. However, you may get up to 10 days from the date of the original request to provide more information. Ordering care providers who disagree with a denial may contact the prior authorization area for a peer-to-peer discussion with the physician medical director. We recommend this intervention before filing an appeal.

To start a peer-to-peer discussion, call the UM prior authorization line at **800-366-7304**.

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

Key contacts

Topic	Link	Phone Number
EPSDT	medicaid.ohio.gov > For Ohioans > Programs > Children and Families > Healthchek	800-324-8680
Vaccines for Children	medicaid.ohio.gov > For Ohioans > Programs	800-282-0546

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.

Healthchek is Ohio's **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** benefit. It provides comprehensive and preventive health care services for children younger than age 21 who are enrolled in Medicaid.

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

For complete details about diagnoses codes as well as full and partial screening, examination, and immunization requirements, go to the EPSDT schedule.

Healthchek

The UnitedHealthcare Community Plan pediatric service requirements includes Healthchek screenings for children up to age 21. The PCP is responsible for complying with and coordinating services related to Healthchek.

It is essential that children enrolled in UnitedHealthcare Community Plan receive screening exams at the appropriate ages. The PCP member roster identifies those members who are due for a Healthchek screen in the upcoming month. UnitedHealthcare Community Plan will assist the PCP in notifying members due for a Healthchek screen. The PCP is also responsible for Healthchek outreach and follow-up care.

Learn more at medicaid.ohio.gov > For Ohioans > Programs > Children and Families > Healthchek.

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 individual who has a developmental disability.

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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.

First Steps program

The First Steps Program is handled by the state of Ohio and provides early intervention services to infants and toddlers with disabilities or developmental delays from birth to age 3 and their families.

Referring a child-refer a child to First Step services if the child has a visual, hearing, or severe orthopedic impairment, or any combination of these impairments, or if the child potentially requires other developmental intervention services.

Upon referral, the First Steps team will evaluate your request to determine eligibility, then a service coordinator will be assigned to help the child's parents through the process. The assigned coordinator from First Steps, who is employed by the state, will contact you to ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the Individualized Family Service Plan (IFSP). UnitedHealthcare Community Plan provides member case management and care coordination for the IFSP. If the child has complex needs, a care manager from UnitedHealthcare Community Plan will be assigned as well if we are aware of the situation.

Full screening

Perform a full screen. Include:

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

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

Interperiodic screens

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

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

Lead screening/treatment

Call **Provider Services** if you find a child has a lead blood level over 10ug/dL. Ohio law requires all health care providers to administer blood lead test to children at age 1 and 2 years, or up to age 6 if no previous test has been completed. PCPs must use a participating lab service for collection. PCPs may draw the blood in the office and use the selected lab's courier service if available. Direct the member to the selected lab's nearest draw site.

Pediatric services

During the Healthchek screening, PCPs should identify the need for other medically necessary services.

Children younger than 21 years old may receive other medically necessary services, including speech therapy, occupational therapy, physical therapy, nutritional counseling, specialized nursing care, behavioral health, psychological services and mental health wrap-around services. Submit requests for these services to the Utilization Management department.

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SAFE/Care examinations

Medicaid covers Sexual Assault Findings Examination (SAFE) and Child Abuse Resource Education (CARE) Examinations. It also covers related laboratory studies that determine sexual or physical abuse. The exam is performed by SAFE-trained providers certified by the Department of Health and Senior Services. Children enrolled in a managed health care plan receive SAFE-CARE services through Ohio Medicaid on a fee-for-service basis. Call Ohio Medicaid for more information.

Targeted case management

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

Identification – The five target populations include:

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

Referral – Members who are eligible for TCM services are referred to a Regional Center or local governmental health program as appropriate for the provision of TCM services.

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

Health management programs

The Adult Care Management portion of the program identifies and risk-stratifies the adult medically complex population with consideration to co-morbid conditions and social environment. Activities are designed to address members within the continuum of their disease, including educational outreach, ongoing-targeted short and long-term care management, as well as collaboration with the member's provider and other health care team members to effectively educate and develop an optimal treatment plan to help the member manage their disease.

The **Pediatric Care Management** portion of the program was intentionally designed to have a very broad diagnoses base to allow referrals for reasons other than catastrophic type illnesses or conditions.

Disease management programs offered through UnitedHealthcare Community Plan

Asthma Care Management

Each patient is assessed, stratified and the care plan intensity can range from basic education mailings for those members who require limited assistance to comprehensive care plans with frequent outreach, including face-to-face visits for high-risk members and their treating providers.

All children younger than 21 years with a diagnosis of asthma, regardless of severity, should be referred to care management services for screening/assessment.

High-Risk Pregnancy Care Management

The High-Risk Pregnancy program is through the Healthy First Steps program, which offers coaching for all pregnant members to encourage pre-natal care.

Members are identified as high-risk, primarily through the OB/GYN physician's submission of the Prenatal Risk Assessment Form that is completed during the first prenatal visit. The assessment form is designed to clearly identify members who are at risk of pre-term labor or a poor outcome of the pregnancy.

High-risk pregnancy indicators are as follows:

- Teen pregnancy – age 17 and younger (CSHCN indicator).

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- Pre-term labor.
- Premature rupture of membranes/cervical dilation.
- Uncontrolled insulin dependent diabetes.
- Fetal anomalies.
- Placental/uterine abnormalities.
- Hyper-emesis.
- Incompetent cervix.
- Uncontrolled asthma.
- Uncontrolled or chronic hypertension/pregnancy induced.
- Hypertension.
- Pre-eclampsia.
- Multiple gestation.
- History of 3 or more previous miscarriages after first trimester.
- Bleeding after first trimester.
- Current drug or alcohol abuse.

Diabetes Care Management

Diabetes care management focus is education and improved compliance with the provider's treatment plan. Patients are primarily identified through claims and pharmacy activity but as with all of the programs, members, treating providers and the plan's Utilization Management department are also a strong referral source. Each member is assessed, stratified and the care plan is customized to meet each member's needs. Members that require limited assistance will receive educational mailings and members who require a more intense approach, a comprehensive care plan will be developed that includes frequent outreach to both the member and the treating provider.

Transplant Care Management

The Transplant Care Management program monitors the member from initial evaluation throughout the transplant hospitalization. After the transplantation has occurred, the member is followed by the health plan's care managers. Activities are designed to address members within the continuum of care, provide ongoing-targeted care management, which includes collaboration with the member's providers and the facility transplant team.

The transplant care managers are assigned as the member enters the transplant evaluation process. The care manager performs the UM activities associated with the transplant evaluation, all inpatient admissions and related outpatient services. The care manager develops a relationship with the patient, family and the hospital transplant team, which allows the care manager to support the patient and family through a very difficult and stressful time of their lives.

Vaccines for Children program

The Vaccines for Children (VFC) program provides immunizations. Immunizations offered in the state VFC program must be ordered by your office. We do not reimburse for the vaccine ordered by the VFC Program, but we reimburse for administering the vaccine.

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

Contact **VFC** if you have questions.

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

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

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Chapter 6: Value-Added Services

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	800-600-9007
Healthy First Steps Rewards	uhchealthyfirststeps.com	800-599-5985
Value Added Services	UHCCommunityPlan.com/OH > View plan details	800-600-9007

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 **800-600-9007** 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 six visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.

Use the following 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.

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

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

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Referral – PCPs may make referrals to support practice-based interventions by contacting the Health Services team at **866-270-5785**.

Doctor Chat— virtual visits

Members will have access to UnitedHealthcare 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 solutions to expand and deliver access to care.

Early Intervention program

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

Foster care peer support specialist

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

Healthy First Steps Rewards

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

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

How It Works

Care providers and UnitedHealthcare Community Plan reach out to members to enroll them.

Members enter information about their pregnancy and upcoming appointments online. Members get reminders of upcoming appointments and record completed visits.

How You Can Help

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

Hypoallergenic bedding

Improve asthma control and reduce allergies caused by dust or synthetic bedding. Controlling these issues can help to lower asthma-related hospitalizations and ER visits.

Hypoallergenic bedding is limited to individuals with asthma in case management. It is limited to $150 annually per member. The program requires prior authorization and documentation stating they have severe asthma. The member's service coordinator will decide eligibility.

JOIN For Me

JOIN For Me is a childhood obesity program that helps create a healthier environment and behaviors in the home. Through a group intervention model, the child and caregiver learn healthy eating and exercise habits. JOIN For Me is for members ages 6-17. Call **Provider Services** for more information.

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Mindfulness: Be here now

We deliver this program to social worker and community partners. The focus is caregiver well-being. It provides mindfulness techniques to reduce burnout, raise performance and improve quality of care.

Mobile apps

Apps are available at no charge to our members. They include:

- **Health4Me** enables users to review health benefits, access claims information and locate in-network providers.
- **SMART** Patient allows users to track important numbers such as blood pressure, record appointments, and record doctors' orders. It also helps them view educational videos.
- **DocGPS** provides mobile users the ability to search UnitedHealthcare Community Plan's provider network and obtain travel directions to a care provider's location. The app provides users with the ability to call a care provider by tapping on the search result.

NurseLine

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

On My Way

This online program helps young adults who are either transitioning from foster care or from their parents'/ guardians' home to independent living. OMW teaches skills on budgeting, housing, job training and attending college.

Quit for Life®

The Quit For Life® Program is the nation's leading phone-based tobacco cessation program. It uses physical, psychological and behavioral strategies to help members take responsibility for and overcome their tobacco addiction. Using a mix of medication support, phone-based coaching, and web-based learning tools, the Quit For Life Program produces an average quit rate of 25.6% for a Medicaid population. It also has an 88% member satisfaction. Quit for Life is for members 18 years and older.

SUD Recovery Coaching

Our SUD (Substance Use Disorder) recovery coach works with members to develop coping skills. Skills include encouragement, safety and a sense of responsibility for their own recovery. This benefit also emphasizes support to those with a behavioral health diagnosis while working through SUD treatment and recovery.

Eligible members are identified through predictive modeling and claims data, a health risk assessment (HRA) or your referral. The program has no age limitation.

UHC Latino

uhclatino.com, our award-winning Spanish-language site, provides more than 600 pages of health and wellness information and reminders on important health topics.

Women, Infants and Children Supplemental Nutrition program (WIC)

State-funded program

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

For more information about WIC, call 614-644-8006

Email: OHWIC@odh.ohio.gov

Website: odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Women-Infants-Children

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Chapter 7: Mental Health and Substance Use

Key contacts

Topic	Link	Phone Number
Behavioral Health/Provider Express	providerexpress.com	800-888-2998
Provider Services	UHCprovider.com	800-600-9007

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 (SUD) benefits. The national Optum network manual generally applies to all types of business. Some sections may apply differently based on state law.

The National Optum Behavioral Health manual is located on providerexpress.com.

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

You must have an NPI number to see Medicaid members and receive payment from UnitedHealthcare Community Plan.

To request an ID number, go to the ODM website at medicaid.ohio.gov > Providers > Enrollment and Support > Provider Enrollment.

How to Join Our Network: Credentialing information is available at providerexpress.com > Clinical Resources > Guidelines/Policies & Manuals > Credentialing Plans > Optum.

Covered services

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

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

For member resources, go to providerexpress.com > 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.

Benefits include:

- Crisis stabilization services (includes treatment crisis intervention).
- Inpatient psychiatric hospital (acute and sub-acute).
- Psychiatric residential treatment facility.
- Outpatient assessment and treatment:
  - Partial hospitalization
  - Social detoxification
  - Day treatment
  - Intensive outpatient
  - Medication management

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  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)
  - Child-parent psychotherapy
  - Multi-systemic therapy
  - Functional family therapy
  - Electroconvulsive therapy
  - Telemental health
- Rehabilitation services
- Day treatment/intensive outpatient
- Dual-disorder residential
- Intermediate residential (SUD)
- Short-term residential
- Community support
- Psychiatric residential rehabilitation
- Secure residential rehabilitation

Self-referred services

Some services are available without a referral:

- Dental care
- Vision care
- Women's routine and preventive health care services provided by a women's health specialist (obstetrics, gynecology, certified nurse midwife)
- Specialty care (except for chemotherapy and pain management specialist services)
- Emergency care
- Services provided by qualified family planning providers (QFPP)
- Medicaid Community Mental Health Centers (CMHCs), certified Medicaid providers affiliated with the Department of Mental Health and Addiction Services (MHA) and certified providers affiliated with the MHA and any outpatient participating care provider for routine outpatient therapy.
- Mental health and substance abuse services
- Services provided at FQHC)/RHC
- Dialysis
- Radiation therapy
- Mammograms

Access to behavioral health services rendered by other care providers requires prior authorization. This includes outpatient ECT, home health and psychological testing.

Members must use a participating care provider for all self-referred services except for emergency care or for services provided at FQHC/Rural Health Clinics, QFPP, community mental health centers, and Ohio Department of Alcohol and Drug Addiction Services facilities, which are Medicaid providers.

Eligibility

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

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. Get prior authorization by going to **UHCprovider.com/priorauth** or calling **866-604-3267**.

Collaboration with other health care professionals

Coordination of care

When a member is receiving services from more than one 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.

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Portal access

Website: **UHCprovider.com**

Access the Provider Portal, the gateway to UnitedHealthcare Community Plan's online services, on this site. Use the online services 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 the Provider Services at **800-600-9007** to verify eligibility and benefit information (available 8 a.m. - 5 p.m. Central Time, Monday through Friday).

Website: **providerexpress.com**

Update provider practice information, review guidelines and policies, and view the national Optum Network Manual. Or call Provider Services at **800-600-9007**.

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 11.

Monitoring audits

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

Addressing the opioid epidemic

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

Brief summary of framework

- Prevention:
  - Prevent opioid-use disorders 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 and awareness of opioids

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

Access these resources at **UHCprovider.com** > Resources > **Drug Lists and Pharmacy**. Click "Opioid Programs and Resources - Community Plan" to find a list of tools and education.

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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.

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 one year.

Expanding medication-assisted treatment access and capacity

Evidence-based medication-assisted treatment (MAT) 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 Ohio:

1. Go to **UHCprovider.com**.
2. Select “Our Network,” then “Find a Provider.” Click on “Locate Providers: Mental Health or Substance Abuse Services.”
3. Select the care provider information.
4. Click on “Search for a Behavioral Health Provider.”
5. Enter “city” and “Ohio” for options.
6. If needed, refine the search by selecting “Medication-Assisted Treatment.”

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

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

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Chapter 8: OhioRISE

OhioRISE

Ohio resilience through integrated systems and excellence (OhioRISE) program is a specialized managed care program for youth with complex behavioral health and multisystem needs. On April 1, 2021, ODM selected Aetna Better Health of Ohio to serve as the new OhioRISE specialized managed care organization. OhioRISE aims to expand access to in-home and community-based services.

Aetna will contract with regional care management entities to ensure OhioRISE members and families have the resources they need to navigate their interactions with multiple systems such as juvenile justice, child protection, developmental disabilities, mental health and addiction, education, and others. An individual who is enrolled in the OhioRISE program will keep their managed care enrollment for their physical health benefit. The managed care organization also will be included in their care management.

ODM, state agencies, the Child and Adolescent Behavioral Health Center of Excellence (CABHCOE), providers, families, Aetna, and other stakeholders from local and state child-serving systems are engaging through an advisory council and workgroups to develop and implement major components of OhioRISE and the new and enhanced services. OhioRISE will also feature a new 1915(c) Medicaid waiver that will strive to improve cross-system outcomes for enrollees and help families prevent custody relinquishment.

OhioRISE Eligibility

- Enrolled in Ohio Medicaid – either managed care or fee for service
- Under the age of 21
- Meet a functional needs threshold for behavioral health care, as identified by the Child and Adolescent Needs and Strengths (CANS) assessment tool, or use of an inpatient behavioral health service

OhioRISE Services:

In addition to the behavioral health services provided through chapter 5160-27 of the Administrative Code, the following new services available through OhioRISE include:

- Care Coordination at three different levels:
  - Tier 1: Limited Care Coordination delivered by Aetna for youth needing lower intensity care coordination
  - Tier 2: Moderate Care Coordination (MCC) will be consistent with principles of High-Fidelity Wraparound and will be delivered by a Care Management Entity (CME) - qualified agency for youth with moderate behavioral health needs
  - Tier 3: Intensive Care Coordination (ICC) will be consistent with principles of High-Fidelity Wraparound and will be delivered by a CME-qualified agency for youth with the greatest behavioral health needs
- Intensive Home-Based Treatment (IHBT): OhioRISE will make changes to existing IHBT services and align with the Family First Prevention Services Act (FFPSA).
- Psychiatric Residential Treatment Facility (PRTF): effective January 2023, this service is aimed at keeping youth with the most intensive behavioral health needs in-state and closer to their families and support systems.
- Mobile Response and Stabilization Service (MRSS): provide youth in crisis and their families with immediate behavioral health services to ensure they are safe and receive necessary supports and services (this new service will also be available to children who are not enrolled in OhioRISE).
- Behavioral Health Respite: provides short-term, temporary relief to the primary caregiver(s) of an OhioRISE plan enrolled youth, to support and preserve the primary caregiving relationship.

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- Wraparound supports/Flex Funds: provides services, equipment, or supplies not otherwise provided through the Medicaid state plan benefit or the OhioRISE program that address a youth's identified need as documented in the child and family-centered care plan. These are intended to enhance and supplement the array of services available to a youth enrolled on the OhioRISE program.
- For additional services available for youth enrolled in the OhioRISE waiver, see Ohio Administrative Code Rule 5160-59-05.

Additional information on the OhioRISE services is available in chapter 5160-59 of the Ohio Administrative Code.

Aetna Better Health of Ohio can be reached by calling 833-711-0773 or e-mailing **OHRise-Network@aetna.com**.

SPBM

The Single Pharmacy Benefit Manager (SPBM) is a specialized managed care program operating as a prepaid ambulatory health plan (PAHP) that will provide pharmacy benefits for the entire Medicaid Managed Care population (excluding MyCare members). ODM has selected Gainwell Technologies to serve as the SPBM. An additional integral component to the new pharmacy model is the Pharmacy Pricing and Audit Consultant (PPAC), which will conduct actual acquisition cost surveys, cost of dispensing surveys, and perform oversight and auditing of the SPBM. ODM has selected Myers and Stauffer, LLC as the PPAC vendor.

The SPBM will consolidate the processing of retail pharmacy benefits and maintain a pharmacy claims system that will integrate with the Ohio Medicaid Enterprise System (OMES), new MCOs, pharmacies, and prescribers. The SPBM also will work with pharmacies to ensure member access to medications, supporting ODM's goals of providing more pharmacy choices, fewer out-of-network restrictions, and consistent pharmacy benefits for all managed care members. SPBM will also reduce provider and prescriber administrative burden, by utilizing a single set of clinical policies and prior authorization procedures, as well as a single pharmacy program point of contact for all members.

All Medicaid managed care members will be automatically enrolled with the SPBM under a 1915(b) waiver. Additionally, Gainwell Technologies will be required to contract with all enrolled pharmacy providers that are willing to accept the SPBM contract terms, resulting in a broad pharmacy network that will ensure access for all members statewide.

For more information about the SPBM or PPAC initiatives, please email **MedicaidSPBM@medicaid.ohio.gov**.

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Chapter 9: Member Rights and Responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	UHCCommunityPlan.com/OH	Medicaid: 800-895-2017 MyCare: 877-542-9236
Member Handbook	UHCCommunityPlan.com/OH	Medicaid: 800-895-2017 MyCare: 877-542-9236

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

Privacy regulations

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

Access to 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 six 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

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or to others who are involved in their care or payment. You may deny this request. If you approve restriction, document the request and restriction details. You will be required to abide by the restriction.

Right to request confidential communications

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

Member rights and responsibilities

The following information is in the Member Handbook at the following link under the Member Information tab: **UHCCommunityPlan.com**.

Native American access to care

Native American members can access care to tribal clinics and Indian hospitals without approval.

Member rights

Members have the right to:

- Request information on advance directives.
- Be treated with respect, dignity and privacy.
  - To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services Bureau of Civil Rights (ODJFS) with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services:
  - **Office for Civil Rights**
    United States Department of Health and Human Services
    233 N. Michigan Ave., Suite 240
    Chicago, IL 60601
    312-886-2359 (TTY: 312-353-5693)
  - **Bureau of Civil Rights Ohio**
    Department of Job and Family Services
    30 E. Broad St., 30th Floor
    Columbus, OH 43215
    614-644-2703; **866-227-6353 (TTY: 866-221-6700)**
- Receive courtesy and prompt treatment.
- Receive cultural assistance, including having an interpreter during appointments and procedures.
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered.
- Know the qualifications of their health care provider.
- Give their consent for treatment unless unable to do so because life or health is in immediate danger.
- Discuss any and all treatment options with you.
- Refuse treatment directly or through an advance directive.
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do.
- Receive medically necessary services covered by their benefit plan.
- Receive information about in-network care providers and practitioners, and choose a care provider from our network.
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response.
- Tell us their opinions and concerns about services and care received.
- Register grievances or complaints concerning the health plan or the care provided.
- Appeal any payment or benefit decision we make.
- Review the medical records you keep and request changes and/or additions to any area they feel is needed.
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, and talk with you when making decisions about their care.
- Get a second opinion with an in-network care provider.
- Expect health care professionals are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage.
- Make suggestions about our member rights and

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responsibilities policies.

- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply.
- To change their PCP to another PCP on UnitedHealthcare Community Plan's panel at least monthly. UnitedHealthcare Community Plan must send members something in writing that says who the new PCP is and the date the change began.
- To be free to carry out their rights and know that the MCP, the MCP's providers, or ODJFS will not hold this against them.

Member responsibilities

Members should:

- Understand their benefits so they can get the most value from them.
- Show you their Medicaid member ID card.
- Prevent others from using their ID card.
- Choose their PCP.
- 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.

Our member rights and responsibilities help uphold the quality of care and services they receive from you. The three primary member responsibilities as required by the National Committee of 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 10: 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

You 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 determines compliance to the following requirements:

Topic	Contact
Confidentiality of Record	Office policies and procedures exist for: • Privacy of the member medical record. • Initial and periodic training of office staff about medical record privacy. • Release of information. • Record retention. • Availability of medical record if housed in a different office location. • Process for notifying United Healthcare 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 three 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, Diagnosis and Treatment (EPSDT). • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets. • Treatment plans are consistent with evidence-based care and with findings/diagnosis: - Timeframe for follow-up visit as appropriate - Appropriate use of referrals/consults, studies, tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review. • There is evidence of care provider follow-up of abnormal results. • Unresolved issues from a previous visit are followed up on the subsequent visit. • There is evidence of coordination with behavioral health care provider. • Education, including lifestyle counseling, is documented. • Member input and/or understanding of treatment plan and options is documented. • Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented.

***Critical element**

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Member copies

A member or their representative is entitled to one free copy of their medical record. Additional copies may be available at the member's cost. Medical records are generally kept for a minimum of five 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 two 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 three or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record.
- Tobacco habits, alcohol use and substance abuse (12 years and older).
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one.
- History of physical examination (including subjective and objective findings).
- Unresolved problems from previous visits addressed in subsequent visits; diagnosis and treatment plans consistent with finding.
- Lab and other studies as appropriate.
- Member education, counseling and/or coordination of care with other care providers.
- Notes regarding the date of return visit or other follow-up.
- Consultations, lab, imaging and special studies initialed by primary care provider to indicate review.
- Consultation and abnormal studies including follow-up plans.

Member hospitalization records should include, as appropriate:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- Documentation of appropriate preventive screening and services
- Documentation of behavioral health assessment (CAGE-AID, TWEAK AND PHQ-9)

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Chapter 11: Quality Management (QM) Program and Compliance Information

Key contacts

Topic	Link	Phone Number
Credentialing	Medical:Network Management Resource Team at Networkhelp@uhc.com Chiropractic: myoptumphysicalhealth.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 enhance patient safety
- Tracking member and provider satisfaction and take actions as appropriate

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

Cooperation with quality-improvement activities

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 Healthcare Effectiveness Data and Information Set (HEDIS®) record review.
- Providing requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email or secure email.
- Completing practitioner appointment access and availability surveys.

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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Care provider satisfaction

Every year, UnitedHealthcare Community Plan conducts care provider satisfaction assessments as part of our quality improvement efforts. We assess and promote your satisfaction through:

- Annual care provider satisfaction surveys.
- Regular visits.
- Town hall meetings.

Our main concern with the survey is objectivity. That's why UnitedHealthcare Community Plan engages independent market research firm Center for the Study of Services (CSS) to analyze and report findings.

Survey results are reported to our Quality Management Committee. It compares the results year over year as well as to other UnitedHealthcare Community Plan plans across the country. The survey results include key strengths and improvement areas. Additionally, we carry out improvement plans as needed.

Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. We respect our network care providers. We appreciate the collaboration to promote better health, improve health outcomes and lower overall costs to offer our members. You are encouraged to visit the following website to view the guidelines, as they are an important resource to guide clinical decision-making.

UHCprovider.com/cpg

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable Ohio statutes and the National Committee of Quality Assurance (NCQA). The following items are required to begin the credentialing process:

- A completed credentialing application, including Attestation Statement
- Current medical license
- Current Drug Enforcement Administration (DEA) certificate
- Current professional liability insurance

We verify information from primary sources regarding licensure, education and training. We also verify board certification and malpractice claims history.

Credentialing and Recredentialing Process

UnitedHealthcare Community Plan's credentialing and recredentialing process determines whether you are a good fit for the UnitedHealthcare Community Plan care provider network. You must go through the credentialing and recredentialing process before you may 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 Nurse Practitioners)
- Behavioral Health Clinicians (Psychologists, Clinical Social Workers, Clinical Counselors, 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, skilled nursing facilities and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements. Facilities must meet the following requirements or verification:

- State and federal licensing and regulatory requirements and an NPI number.

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- 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.

For chiropractic credentialing, call **800-873-4575** or go to **myoptumhealthphysicalhealth.com**.

Submit the following supporting documents to CAQH after completing the application:

- Curriculum vitae
- Medical license
- DEA certificate
- Malpractice insurance coverage
- IRS W-9 Form

Peer review

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 three years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website. Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have three chances to answer the request before your participation privileges are terminated.

Performance review

As part of the recredentialing process, UnitedHealthcare Community Plan looks in its Quality Management database for information about your performance. This includes member complaints and quality of care issues.

When evaluating your performance, UnitedHealthcare Connected (MyCare Ohio) reviews at a minimum the following areas:

- **Quality of care** - measured by clinical data related to the appropriateness of member care and member outcomes.
- **Efficiency of care** - measured by clinical and financial data related to a member's health care costs.
- **Member satisfaction** - measured by the members' reports about accessibility, quality of health care, relationships with members, and the comfort of the practice setting.
- **Administrative requirements** - measured by your methods and systems for keeping records and transmitting information.
- **Participation in clinical standards** - measured by your involvement with panels used to monitor quality of care standards.

Applicant rights and notification

You have the right to review information you submitted to support your credentialing/recredentialing application.

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This excludes personal or professional references or peer review protected information. You have the right to correct erroneous information you find. Submit updated information directly to your CAQH credentialing application. If the NCC finds erroneous information, a representative will contact you by phone or in writing. You must submit corrections within 30 days of notification by phone, or in writing to the number or address the NCC representative provided.

You also have the right to receive the status of your credentialing application, please 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 two business days from when we receive your request.

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Confidentiality

All credentialing information collected during the review process is kept confidential. It is only shared with your approval or as required by law with those involved in the credentialing process.

HIPAA compliance – your responsibilities

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 aims to improve the efficiency and effectiveness of the United States health care system. While the Act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have had the greatest impact on how the health care industry works. UnitedHealthcare Community Plan is a "covered entity" under these regulations. So are all health care 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 fee-for-service claims and on encounter submissions. For this reason, UnitedHealthcare Community Plan requires the NPI on paper transactions.

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES). Share it with all affected trading partners, such as care providers to whom you refer patients, billing companies and UnitedHealthcare Community Plan. If you don't have one, go to nppes.cms.hhs.gov.

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.

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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.

Compliance program

As a segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Community Plan Compliance program incorporates the required seven elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

- Oversight of the Ethics and Integrity program.
- Development and implementation of ethical standards and business conduct policies.
- Creating awareness of the standards and policies by educating employees.
- Assessing compliance by monitoring and auditing.
- Responding to allegations of violations.
- Enforcing policies and disciplining confirmed misconduct or serious neglect of duty.
- Reporting mechanisms for workers to alert management and/or the Ethics and Integrity program staff to violations of law, regulations, policies and procedures, or contractual obligations.

UnitedHealthcare Community Plan has compliance officers for each health plan. In addition, each health plan has a compliance committee consisting of senior managers from key organizational areas. The committee provides program direction and oversight.

Reporting and auditing

Report any unethical, unlawful or inappropriate activity by a UnitedHealthcare Community Plan employee to a UnitedHealthcare Community Plan senior manager or directly to the Compliance Office.

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

To facilitate the reporting process of questionable incidents involving members or care providers, call our **Fraud and Abuse line**. Or go to **uhc.com/fraud**.

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

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews to help ensure compliance with law, regulations and policies/contracts. When informed of potentially inappropriate or fraudulent practices within the plan or by you, UnitedHealthcare Community Plan will conduct an investigation. You must cooperate with the company and government authorities. This means giving access to pertinent records (as required by your applicable Provider Agreement and this manual) as well as access to office staff. If we establish activity in violation of law or regulation, we will advise appropriate governmental authorities.

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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.

Cooperation in meeting CMS requirements

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

Certification of diagnostic data

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

Risk adjustment data

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

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the State of Ohio 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 Ohio DHHS.

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 Ohio program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. Retain records based on Ohio Administrative Code. 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 one year after the resolution of all issues that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your 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 Ohio program standards.

You must cooperate with the state or any of its authorized representatives, the Ohio DHHS, CMS, the Office of Inspector General, or any other agency prior-approved by the state, at any time during your Provider Agreement.

These entities may, at all reasonable times, enter your premises. You agree to allow access to and the right to audit, monitor and examine any relevant books, documents, papers and records to otherwise evaluate (including periodic information systems testing) your performance and charges.

We will perform reviews and audits without delaying your work. If you refuse to allow access, this will constitute a breach of your Provider Agreement.

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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.

Delegation oversight

We may assign medical management to a medical group/ Independent Practice Association (IPA) with established medical management standards. We refer to the medical group/IPA as a "delegate." Care providers associated with these delegates may use the delegate's office and protocols for authorizations. The delegate's medical management protocols and procedures must comply with UnitedHealthcare Community Plan as well as all applicable state and federal regulatory requirements.

Before assigning medical management functions, we assess the delegate. Within 90 calendar days of the contract effective date, we assess it again to measure compliance with UnitedHealthcare Community Plan standards. We assess the delegate annually thereafter. We may also conduct an off-cycle assessment if needed.

Based on the assessment findings, we may have the delegate develop and implement a corrective action plan to bring the medical group/IPA back into compliance. Delegates who do not achieve compliance within the established timeframes may undergo further corrective action. If the action is not successful, the medical management function will be withdrawn.

Appeals

When we review a member or care provider's adverse determination appeal from a delegate, we use Interqual as the externally licensed medical management guidelines. This happens even if the delegate used different externally licensed medical management guidelines to make the determination.

Semi-annual reporting

The delegate provides UnitedHealthcare Community Plan with semi-annual reports as outlined in the delegation agreement. Reports must meet applicable requirements and accreditation standards.

Purpose of Medical Management Program

The Medical Management Program helps determine if medical services are:

- Medically necessary.
- Covered under the UnitedHealthcare Community Plan benefit.
- Performed at both the appropriate place and level of care.

Determining medical necessity

Delegates review nationally recognized criteria to determine medical necessity and appropriate level of care for services. This includes Medicaid coverage guidelines. For services not addressed in Medicaid coverage guidelines, delegates use UnitedHealthcare Community Plan's medical policies. If other nationally recognized criteria disagree with Medicaid coverage guidelines, delegates follow Medicaid coverage guidelines.

Members may call the delegate's general number (or the number listed in the denial letters) to request individual eligibility and benefit criteria. They may also call our Member Services department.

NCQA Accreditation standards require all health care organizations, health plans and delegates distribute a statement to members, care providers and employees who make UM decisions. The statement must note the following:

- UM decision-making is based only on appropriateness of care, service and coverage.
- You or others are not rewarded for issuing denials or encouraging decisions that result in under-utilization

Care provider requirements

Render covered services at the most appropriate level of care based on nationally recognized criteria. With few exceptions, we do not reimburse for non-covered services and those not medically necessary. We do not reimburse for the wrong procedures (e.g., notification requirements, preauthorization, verification guarantee process). Authorization receipts do not affect how payment policies determine reimbursement.

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We nor the member are responsible for reimbursing medical services, admissions, inappropriate facility days, and/or medically necessary services if you did not obtain required prior authorization. Regardless of the Medical Management Program determination, the decision to render medical services lies with the member and you, as the attending care provider. If you and the member decide to go forward with the medical services after UnitedHealthcare Community Plan or the delegate deny preauthorization, no care provider, facility or ancillary services will be reimbursed. The delegate's medical director can discuss the decisions and criteria with the member. The delegate also makes the medical policy decisions available upon request.

Medical management denials/adverse determinations

UnitedHealthcare Community Plan or a delegate may issue a denial when a non-covered benefit is requested but deemed not medically necessary. This may also happen when we receive insufficient information.

Denials, delays or modifications

UnitedHealthcare Community Plan or the delegate must make and communicate timely approvals, modifications or denials.

We or the delegate must also state the decision to delay a service based on medical necessity or benefit coverage appropriate to the member's medical condition,based on applicable state and federal law.

We base all authorization decisions on sound clinical evidence, including medical record review, consultation with the treating care providers, and review of nationally recognized criteria. You must clearly document the medical appropriateness with your authorization request. State and federal law applies to criteria disclosure.

The medical director, Utilization Management Committee (UMC) or you must review referral requests not meeting the authorization criteria. Otherwise, you must present the information to UMC or the subcommittee for discussion and a determination. Only a care provider (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist, as appropriate) may delay, modify or deny services for medical necessity reasons. Board- certified, licensed care providers from appropriate specialties must help make medical necessity decisions, as appropriate. Determination rules include:

- You may not review your own referrals.
- Care providers qualified to make an appropriate determination will review referral requests considered for denial.
- Any referral request where the medical necessity or the proposed treatment is not clear will be discussed with the care provider. Complex cases may be brought to the UMC/medical director for further discussion.
- Individuals who can hold financial ownership interest in the organization may not influence the clinical or payment decisions.

Possible request for authorization determinations include:

- Approved as requested – No changes.
- Approved as modified – Referral approved, but changed the requested care provider or treatment plan. (e.g., requested chiropractic, approved physical therapy).
- Extension – Delay of decision (e.g., need additional information, require consultation). CMS allows an extension when a Medicaid member requests one.
- Delay in Delivery – Postpone access to an approved service until a certain date. This is not the same as a modification. A written notification in the denial letter format is required.
- Denied – Non-authorization request for health care services.

Reasons for denials of requests for services include:

- Not a covered benefit – The requested service(s) is excluded under the member's benefit plan.
- Not medically necessary or benefit coverage limitation – Specify criteria or guidelines used to make the determination.
- Member not eligible at the time of service.
- Benefit exhausted - Include what benefit was exhausted and when.
- Not a participating care provider – A participating care provider/service is available within the medical group/ IPA in-network.
- Experimental or investigational procedure/treatment.
- Self-referred/no prior authorization (for non-emergent post-service).
- PCP can provide requested services.

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Written denial notice

The written denial is an important part of the member's chart and the delegate's records. Regardless of the form used, the denial letter documents member and care provider notification of:

- The denial, delay, partial approval or modification of requested services.
- The reason for the decision, including medical necessity, benefits limitation or benefit exclusion.
- Member-specific information about how the member did not meet criteria.
- Appeal rights.
- An alternative treatment plan, if applicable.
- Benefit exhaustion or planned discharge date.

CMS requires the use of the CMS Integrated Denial Notice/Notice of Denial of Medical Coverage (IDN/NDMC) for Medicaid plan members. Do not alter this template except to add text to the requested areas.

Most states require approved standardized templates for member notices, such as denial of services. UnitedHealthcare Community Plan will provide appropriate and approved templates to the delegates.

Minimum content of written or electronic notification

Written or electronic notices to deny, delay or modify a health care services authorization request must include the following:

- The requested services
- A reference to the benefit plan provisions to support the decision
- The reason for denial, delay, modification, or partial approval, including:
  - Clear, understandable explanation of the decision
  - Name and description of the criteria used
  - How those criteria were applied to the member's condition
- Notification the member can get a free copy of the benefit provision, guideline, protocol or other criterion used to make the denial decision
- Contractual rationale for benefit denials
- Alternative treatments offered, if applicable
- A description of additional information needed to complete that request and why it is necessary
- Appeal and grievance processes, including:
  - When, when, how and where to submit a standard or expedited appeal
  - The member's right to appoint a representative to file the appeal
  - The right to submit written comments, documents or other additional relevant information
  - The right to file a grievance or appeal with the applicable state agency, including information regarding the independent medical review process (IMR), as applicable
- The name and phone number of the health care professional responsible for the decision.

Medical group/IPA's responsibilities related to member grievance and appeals

Occasionally, a member may contact the delegate instead of the plan. In such cases, delegates must:

- Within one hour of receipt, forward all member grievances and appeals to UnitedHealthcare Community Plan for processing.
- Respond to UnitedHealthcare Community Plan requests for appeal or grievance information within the designated timeframe. (Standard appeals with 24 hours, expedited appeals within two hours. Timeframes apply to every calendar day.)
- Comply with all final UnitedHealthcare Community Plan determinations.
- Cooperate with UnitedHealthcare Community Plan and the external independent medical review organization or State Fair Hearing. This includes promptly forwarding all medical records and information related to the disputed health care service.
- Provide UnitedHealthcare Community Plan with the authorization (pre-service) within the requested timeframes on adverse determinations reversals.
- Respond to requests for proof of overturned appeals.

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Referrals

Referral authorization procedure

The delegate may initiate a member referral. (Refer to the delegated group's pre-authorization list, as applicable.) The following capitated medical services are examples of when a referral authorization may be needed:

- Outpatient services
- Laboratory and diagnostic testing (non-routine, performed outside the delegated medical group/ IPA's facility)
- Specialty consultation/treatment

The delegate, PCP and/or other referring care provider must verify the care provider participates in UnitedHealthcare Community Plan.

You must also comply with the following procedures:

- Review the service request for medical necessity.
- If the treatment is not medically necessary, discuss an alternative treatment plan with the member.
- If the treatment requires referral or prior authorization, submit the request to the delegate UMC for determination.

If the request is not approved, the delegate must issue the member a denial letter.

Referral authorization form

The delegate may design its own authorization form, without approval from UnitedHealthcare Community Plan. The form should include all the following:

- Member identification (e.g., Member ID number and birth date)
- Services requested (including appropriate ICD-10-CM and/or CPT codes)
- Authorized services (including appropriate ICD-10-CM and/or CPT codes)
- Proper billing procedures (including the medical group/ IPA address)
- Verification of member eligibility

The delegate provides this form to the following:

- Referral care provider
- Member
- Member's medical record
- Managed care administrative office

The delegate does so within 36 hours of receipt of information necessary to make a decision. This includes one working day and does not exceed 14 calendar days.

If UnitedHealthcare Community Plan is financially responsible for the services, the delegate submits the authorization information to the plan.

Continuity of care

Continuity of care lets members temporarily continue receiving services from a non-participating care provider. It is intended to last a short period.

The delegate facilitates continuity of care for medically necessary covered services. If a member entering the health plan is receiving medically necessary services (in addition to or other than prenatal services) the day before enrollment, the health plan covers the continued costs of such services without prior approval. This is regardless of whether in-network or out- of-network care providers grant these services.

- The health plan provides continuation of such services for the lesser of 1) 60 calendar days or 2) until the member has transferred without disruption of care to an in-network care provider.
- For members eligible for care management, the new health plan provides service continuation authorized by the prior health plan for up to 60 calendar days after the member's enrollment in the new health plan. Services will not be reduced until the new health plan assesses the situation.

Members in their third trimester of pregnancy may receive services from their prenatal care provider (whether in-network or out-of-network) without any form of prior authorization through the postpartum period (defined as 60 calendar days from date of birth).

A member should not continue care with a non-participating care provider without formal approval by UnitedHealthcare Community Plan or the delegate. Except for emergent or urgent out-of-area (OOA) care, payment for services performed by a non-participating medical group/IPA become the member's responsibility.

UnitedHealthcare Community Plan (or the delegate) reviews all requests for continuity of care. We consider the member's condition and the potential effect on the member's treatment.

We also consider how changing the care provider can

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affect the health outcome.

A member may request to continue covered services with a care provider who has terminated from UnitedHealthcare Community Plan for reasons other than cause or disciplinary action. As the care provider, you must agree in writing:

- To agree to the same contractual terms and conditions imposed on participating care providers, including credentialing, facility privileging, utilization review, peer review and quality assurance requirements; and
- To be compensated at rates and payment methods similar to those used by UnitedHealthcare Community Plan and participating care providers granting similar services who are not capitated and are practicing in the same geographic area.

Notification requirements for facility admissions when UnitedHealthcare pays claims

Contracted facilities are accountable to provide timely notification to both the delegate and UnitedHealthcare Community Plan within 24 hours of admission for all inpatient cases. This information is needed to verify eligibility, authorize care, and initiate concurrent review and discharge planning. In maternity cases, notify vaginal delivery or C-section delivery on or before the end of the mandated period 48 hours or 96 hours, respectively. We require notification if the baby stays longer than the mother. In all cases, separate notification is required immediately when a baby is admitted to the neonatal intensive care unit.

For emergency admissions, notification occurs once the member has been stabilized in the emergency department.

Authorization log and denial log submission

Authorization logs for all inpatient acute, observation status and skilled nursing facility cases must be accurately submitted at least twice a week to the Authorization Log Unit at clinicaloperations@uhc.com. When no inpatient acute, observation statuses or skilled nursing facility cases are active, the delegate must submit its weekly authorization log indicating either “no activity” or “no admissions” for each designated admission service type specified in this section and for the applicable reporting time.

Authorization logs covering facility and skilled nursing facility daily information includes the following:

- Member ID
- Member name
- Member date of birth
- Attending care provider: (Name and address, with TIN if available)
- Facility care provider: (Name and address, with TIN if available)
- Admitting diagnosis (ICD-10-CM or its successor code)
- Planned and actual admission dates
- Planned and actual discharge dates
- Level of care (i.e., bed type, observation status, outpatient procedures at acute facilities)
- Length of stay (LOS) (i.e., number of days approved, as well as the number of days denied)
- Procedure/surgery (CPT Code)
- Discharge disposition
- Service type
- Authorization number (if available)

The delegate must clearly define medical necessity and authorizing outpatient services paid as either shared risk or plan risk per the medical group/IPA contract. It must submit authorization or denials for services the group authorized or denied care on behalf of UnitedHealthcare Community Plan.

For more information, please contact your provider advocate.

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of care/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.

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- Available handicapped parking.
- Handicapped accessible facility.
- Available adequate waiting room space
- Adequate exam rooms for providing member care.
- Privacy in exam rooms.
- Clearly marked exits.
- Accessible fire extinguishers.
- Post file inspection record in the last year.

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	One 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	Two complaints in six months
Other	All other complaints concerning the office facilities	Three complaints in six months

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Chapter 12: 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

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

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

We follow the same claims process as UnitedHealthcare. See Chapter 10 of the Administrative Guide for Commercial, Medicare Advantage and DSNP on UHCprovider.com/guides.

Claims: From submission to payment

1. **You submit EDI claims to a clearinghouse or paper claims to us. We scan paper claims.**
2. All claims are checked for compliance and validated.
3. Claims are routed to the correct claims system and loaded.
4. Claims with errors are manually reviewed.
5. Claims are processed based on edits, pricing and member benefits.
6. Claims are checked, finalized and validated before sending to the state.
7. Adjustments are grouped and processed.
8. Claims information is copied into data warehouse for analytics and reporting.
9. We make payments as appropriate.

Claims reconsideration and appeals
If you think we processed your claim incorrectly, please see the Claims Reconsiderations, Appeals and Grievances chapter in this manual for next steps.

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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 a 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 dates 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.

Payment in full

Based on OAC Rule: 5101:3-1-60, payment by UnitedHealthcare Community Plan is considered payment in full. Participating and non-participating care providers may not bill a member unless all the following are met:

1. You notified the member of the financial liability before the service delivery.
2. You gave the notification in writing, specific to the service being rendered. It clearly states the member is financially responsible for the service.
3. The member dates and signs the notification.
4. The reason we don't cover the service is specified and is one of the following reasons:
   - The service is a benefit exclusion.
   - The care provider is not in network, so we have denied approval for the service because it is available from a contracted provider.
   - The care provider is not in network and has not requested approval to provide the service.

Fee schedule

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

Modifier codes

Use the appropriate **modifier codes** on your claim form. 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 1500 and UB-04 claim forms.

Use the 02/12 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services. Use the 1500 Form for Hospice Nursing Facility Room and Board (T2046).

Use the UB-04 form for hospital inpatient and outpatient services, dialysis services, skilled nursing homes, inpatient services, long-term care facilities, hospice services and other care providers.

Clean claims and submission requirements

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

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

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- 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'.

Submit paper claims to:

UnitedHealthcare Community Plan
P.O. Box 8207
Kingston, NY 12402

Care provider coding

UnitedHealthcare Community Plan complies with 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.

Electronic claims submission and billing

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

- All claims are set up as "commercial" through the clearinghouse.
- Our payer ID is 87726.
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit.
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for HCFA 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 on **UHCprovider.com/edi** > Go to companion guides

Clearinghouse and status reports

Software vendor reports only show the claim left your office and was either accepted or rejected. They don't confirm the claim status. Acknowledgment reports confirm the information you sent has been received. Review your reports, clearinghouse acknowledgment reports and the status reports to reduce processing delays and timely filing penalties.

For clearinghouse options, use our EDI at UHCprovider.com > Resources > Resource Library > Electronic Data Interchange > **EDI Clearinghouse Options**.

e-Business support

Call Provider Services for help with online billing, claims, Electronic Remittance Advices (ERAs), and Electronic Funds Transfers (EFTs).

For all of our claims and payment options, such as business support and EDI claims, go to Chapter 1 under Online Services.

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

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Electronic payment solutions

UnitedHealthcare has launched the replacement of paper checks with electronic payments and will no longer be sending paper checks for provider payment. You will have the option of signing up for Automated Clearing House (ACH)/direct deposit, our preferred method of payment, or to receive a Virtual Card payment (Virtual Card). The only alternative to a Virtual Card is direct deposit. Both of these options allow you to get paid quickly and securely.

Why choose ACH/direct deposit?

- Direct deposit puts payment directly into your bank account
- Easy and fast way to get paid
- Improved financial control; no paper checks or remittance information to lose or misplace
- Ability to track information on online portal

What does this mean to you?

- If your practice/healthcare organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a Virtual Card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, 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.

Completing the CMS 1500 claim form

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

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

Additional claim submission requirements

Follow these tips for 837 claim formats:

1. Use the 2010AA Billing Provider loop when the billing and rendering provider are the same.
2. Use te 2310B Rendering Provider loop when the rendering and billing provider are NOT the same.
3. You may use the 2420A Rendering Provider Line Level when there are multiple rendering providers. However, for claims that process on the Facets system, use one rendering provider per claim. Claims with multiple rendering providers will have to be formatted at separate claims.

Completing the UB-04 form

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

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

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Capitated services

Capitated care providers

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period. We pay you whether that person seeks care. In most instances, the capitated care provider is either a medical group or an Independent Practice Association (IPA). In a few instances, however, the capitated care provider may be an ancillary provider or hospital.

We use the term 'medical group/IPA' interchangeably with the term 'capitated care providers'. Capitation payment arrangements apply to participating physicians, health care providers, facilities and ancillary care providers who are capitated for certain UnitedHealthcare Community Plan products. This applies to all benefit plans for members:

- Who have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare Community Plan for such member, and
- Who are covered under an applicable benefit plan insured by or receiving administrative services from UnitedHealthcare Community Plan.

Additionally, capitated care providers may be subject to any or all delegated activities. Capitated care providers should refer to their Delegation Grids within their participation agreements to determine which delegated activities the capitated providers are performing on behalf of UnitedHealthcare Community Plan.

For capitated services, include all services related to an inpatient stay on the UB-04 when a member is admitted to the hospital and they received ER treatment, observation or other outpatient hospital services.

We deny claims submitted with service dates that don't match the itemization and medical records. This is a billing error denial.

Form reminders

- Note the attending provider name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims.
- Send the referring provider 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.

Subrogation and coordination of benefit

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

- **Subrogation:** We may recover benefits paid for a member's treatment when a third party causes the injury or illness.
- **COB:** We coordinate benefits based on the member's benefit contract and applicable regulations.

UnitedHealthcare Community Plan is the payer of last resort. Other coverage should be billed as the primary carrier. When billing UnitedHealthcare Community Plan, submit the primary payer's Explanation of Benefits or remittance advice with the claim.

Hospital and clinic method of billing professional services

Hospital and clinics must bill for professional services bill 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.

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

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

- Member name
- Member's date of birth and sex
- Member's UnitedHealthcare Connected ID number
- Indication of:

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  - Job-related injury or illness, or
  - Accident-related illness or injury, including pertinent details
- Appropriate diagnosis, procedure and service codes
- Date of services (including admission and discharge date)
- Charge for each service
- Provider's ID number and locator code, if applicable
- Provider's Tax ID Number
- Name/address of Participating Provider

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 > 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 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 the **cms.gov**.

Billing multiple units

When billing multiple units:

- If the same procedure is repeated on the same date of service, enter the procedure code once with the appropriate number of units.
- The total bill charge is the unit charge multiplied by the number of units.

Billing guidelines for obstetrical services

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

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

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Reporting birth weight on newborn claims

You must report newborn weight to UnitedHealthcare Community Plan.

To report this data, use the appropriate value code:

- **UB-04:** Report in block 39, 40 or 41 using value code "54" and the newborn's weight grams.

If billing electronically, please report birth weight in loop 2300, segment HI, with the qualifier BE and the value code "54" in HI01-2 and the newborn's weight in grams in HI01-5.

We reference the following codes to identify newborn claims. Therefore, include birth weight on all claims containing these codes:

ICD-10 Procedure Codes:

- **72.x** Forceps, vacuum, and breech delivery.
- **73.51** Manually assisted delivery; Manual rotation of fetal head.
- **73.59** Manually assisted delivery; Other.
- **74.0** Cesarean section and removal of fetus; Classical cesarean section.
- **74.1** Cesarean section and removal of fetus; Low cervical cesarean section.
- **74.2** Cesarean section and removal of fetus; Extraperitoneal cesarean section.
- **74.4** Cesarean section and removal of fetus; Cesarean section of other specified type.
- **74.99** Cesarean section of unspecified type.

ICD-10 Diagnosis Codes:

- **080** Normal Delivery.
- **V27.x** Outcome of Delivery.

The following codes must have a 5th digit equal to 1 or 2:

- **640-648** Complications mainly related to pregnancy.
- **651-659** Normal delivery and other indications for care in pregnancy, labor, and delivery.
- **660-669** Complications occurring mainly during the course of labor and delivery.
- **670-676** Complications of the puerperium.

CPT Codes:

- **59409** Vaginal delivery (with or without episiotomy or forceps).
- **59514** Cesarean delivery only.
- **59612** Vaginal delivery only, after previous cesarean delivery (with or with our episiotomy or forceps).
- **59620** Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery.

Reporting date of last menstrual period

You must report the date of a member's last menstrual period to UnitedHealthcare Community Plan. If billing on paper, report the date of the last menstrual period as follows:

- **UB-04:** Report anywhere in blocks 32-36 using occurrence code "10" in one block with the date of the last menstrual period in the next block.
- **CMS-1500:** Report in block 14 using the date of the last menstrual period.

If billing electronically, please report the date of the last menstrual period as follows:

- **837I:** Report using occurrence code "10" and the date of the last menstrual period in loop 2300, segment HI, qualifier BH.
- **837P:** Report the date of the last menstrual period in loop 2300, segment DTP, qualifier 484.

Billing guidelines for transplants

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

Ambulance claims (emergency)

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

National Drug Code

Claims must include:

- National Drug Code (NDC) and unit of measurement for the drug billed.

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- HCPCS/CPT code and units of service for the drug billed.
- Actual metric decimal quantity administered.

Submit the NDC on all claims with procedure codes for care provider-administered drugs in outpatient clinical settings. The claims must show the NDC that appears on the product. Enter the identifier N4, the 11–digit NDC code, unit/basis of measurement qualified, and metric decimal quantity administered. Include HCPCS/CPT codes.

Medical necessity

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

Place of Service codes

Go to **CMS.gov** for Place of Service codes.

Asking about a claim

You can ask about claims through UnitedHealthcare Community Plan **Provider Services** and the UnitedHealthcare Community Plan Provider Portal. To access the portal, go to **UHCprovider.com**. Follow the instructions to get a user ID. You will receive your user ID and password within 48 hours.

Provider Services

Provider Services helps resolve claims issues. Have the following information ready before you call:

- Member's ID number
- Date of service
- Procedure code
- Amount billed
- Your ID number
- Claim number

Allow Provider Services 45 days to solve your concern. Limit phone calls to five 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 OneHealthcare ID. This portal offers you with online support any time. If you are not already registered, you may do so on the website.

The Provider Portal lets you move quickly between applications. This helps you:

- Check member eligibility.
- Submit claims reconsiderations.
- Review coordination of benefits information.
- Use the integrated applications to complete multiple transactions at once.
- Reduce phone calls, paperwork and faxes.

You can even customize the screen to put these common tasks just one click away.

Find Provider Portal training at **UHCprovider.com/training** and Self Service Tool training at UHCprovider.com > Resources > Resource Library > **Training**.

Provider Portal training course is available using the **Community Care Provider Portal User Guide**.

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:

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- 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 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

You may not bill MyCare members. Do not balance bill Medicaid members if:

- The charge amount and the UnitedHealthcare Community Plan fee schedule differ.
- We deny a claim for late submission, unauthorized service or as not medically necessary.
- UnitedHealthcare Community Plan is reviewing a claim

You may balance bill the member for non-covered services if the member provides written consent prior to getting the service. If you have questions, please contact your provider advocate.

If you don't know who your provider advocate is, call **Provider Services**.

Third-party resources

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible members. Therefore, you must bill and obtain an explanation of benefits (EOB) from any other insurance or health care coverage resource before billing UnitedHealthcare Community Plan, as required by contract. Refer to your Agreement for third-party claim submission deadlines. Once you bill the other carrier and receive an EOB, the claim may then be submitted to UnitedHealthcare Community Plan. Please attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or denial reason.

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Chapter 13: Claim Reconsiderations, Appeals and Grievances

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 contract. 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**.

The following grid lists the types of disputes and processes that apply. We no longer use fax numbers. Please use either the online tool or phone number.

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

SITUATION	DEFINITION	WHO MAY SUBMIT?	SUBMISSION ADDRESS	ONLINE FORM FOR EMAIL	CARE PROVIDER CONTACT INFORMATION	CARE PROVIDER WEBSITE FOR ONLINE SUBMISSIONS	CARE PROVIDER FILING TIME FRAME	UNITEDHEALTHCARE COMMUNITY PLAN RESPONSE TIME FRAME
Care Provider Claim Resubmission	Creating a new claim. If a claim was denied and you resubmit the the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission.	Care Provider	UnitedHealthcare Community Plan P.O. Box 8207 Kingston, NY 12402	UHCprovider.com/claims	800-600-9007	Use the Claims tool in the Provider Portal.To access the portal, go to UHCprovider.com, then Sign In or go to UHCprovider.com/claims.	Must receive within 45 days	30 business days
Care Provider Claim Reconsideration (step 1 of claim dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care Provider	UnitedHealthcare Community Plan P.O. Box 8207 Kingston, NY 12402	UHCprovider.com/claims	800-600-9007	Use the Claims tool in the Provider Portal.To access the portal, go to UHCprovider.com, then Sign In or go to UHCprovider.com/claims.	45 calendar days	45 business days

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APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
Care Provider Claim Formal Appeal (step 2 of claim dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care Provider	UnitedHealthcare Community Plan Grievance/Appeal Coordinator P.O. Box 31364 Salt Lake City, UT 84131	UHCprovider.com/claims	800-600-9007	Use the Claims tool in the Provider Portal.To access the portal, go to UHCprovider.com, then Sign In or go to UHCprovider.com/claims.	45 calendar days	30 business days
Member Appeal	A request to change an adverse benefit determination that we made.	• Member • Member's authorized representative (such as friend or family member) with written member consent • Care provider on behalf of a member with member's written consent	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131	UHCprovider.com/claims *AOR Consent Form on this site for member appeals	800-895-2017, TTY 711	N/A	Urgent appeals - must receive within 5 business days. Standard appeals - 60 calendar days	Urgent appeals - We will respond within 2 business days. Standard apeals - 30 days
Member Grievance	A member's written or oral expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	• Member • Member's authorized representative (such as friend or family member) with written member consent • Care provider on behalf of a member with member's written consent	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131	N/A	800-895-2017, TTY 711	N/A	N/A	Access related - 2 business days Non-claims related- 30 calendar days Claims related- 60 calendar days

The above 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 contracts than described in the standard process.

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Denial

Your claim may be denied for administrative or medical necessity reasons.

An **administrative denial** is when we didn't get notification before the service, or the notification came in too late.

Denial for **medical necessity** means the level of care billed wasn't approved as medically necessary.

If a claim is denied for these reasons, you may be able to request a claim reconsideration or file an appeal.

Other top reasons for denial include:

Duplicate claim – This is one of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.

Claim lacks information. Basic information is missing, such as a person's date of birth; or information incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information.

Eligibility expired. Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.

Claim not covered by UnitedHealthcare Community Plan. Another claim denial you can avoid is when procedures are not covered by us. You can easily avoid this problem by using real-time verification.

Time limit expired. This is when you don't send the claim in time.

Claim correction

What is it?

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 Provider Portal, sign in to **UHCprovider.com** using your OneHealthcare ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Mailing address:

UnitedHealthcare Community Plan
P.O. Box 8207
Kingston, NY 12402-5240

Additional Information:

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

Resubmitting a claim

What is it?

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

When to use it:

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

Common Reasons for Rejected Claims:

Some of the common causes of claim rejections happen due to:

- Errors in member demographic data – name, age, date of birth, sex or address.
- Errors in care provider data.
- Wrong member insurance ID.
- No referring care provider ID or NPI number.

How to use:

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

UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

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Claim reconsideration (step one of dispute)

What is it?

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

When to use:

Reconsiderations can be done repeatedly, but should include new information each time. Submit a claim reconsideration when you think a claim has not been properly processed. You have 45 days from the date of the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) to submit your claim reconsideration.

For administrative denials:

- In your reconsideration request, please ask for a medical necessity review and include all relevant medical records.

For medical necessity denials:

- In your request, please include any additional clinical information that may not have been reviewed with your original claim.
- Show how specific information in the medical record supports the medical necessity of the level of care performed – for example, inpatient instead of observation.

How to use:

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

- **Electronically:** Use the Claim Reconsideration application on the Provider Portal. Include electronic attachments. You may also check your status using the Provider Portal.
  - If you have a request involving 20 or more paid or denied claims, aggregate these claims on the Claim Project online form and submit the form for research and review. Go to **UHCprovider.com** > Claims & Payments > Claim Research Project.
- **Phone:** Call Provider Services at **800-600-9007** or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.
- **Mail:** Submit the Claim Reconsideration Request Form to:

  UnitedHealthcare Community Plan
  P.O. Box 8207
  Kingston, NY 12402

  Available at **UHCprovider.com/claims**.

Valid proof of timely filing documentation (Reconsideration)

What is it?

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

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

A submission report is not proof of timely filing for electronic claims. It must be accompanied by an acceptance report. Timely filing denials are often upheld due to incomplete or wrong documentation submitted with a reconsideration request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use:

Submit a reconsideration request electronically, 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.

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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.

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved.
- Call **Provider Services** if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim.
- File adjustment requests and claims disputes within contractual time requirements.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

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 identification number.
- Date of service.
- Original claim number (if known).
- Date of payment.
- Amount paid.
- Amount of overpayment.
- Overpayment reason.
- Check number.

Where to send:

Mail refunds with an Overpayment Return Check or the Overpayment Refund/Notification form to:

UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0800

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

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

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

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

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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

Appeals (step two of dispute)

What is it?

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

When to use/file:

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

We resolve disputes within 45 days of receiving the disputed claim and remittance advice.

How to use:

Submit related documents with your appeal. These may include a cover letter, medical records and additional information. Send your information electronically or by mail. In your appeal, please include any supporting information not included with your reconsideration request.

- **Electronic claims:** Use Claims Management or Claims on the Provider Portal. Click Sign in on the top right corner of **UHCprovider.com**, then click Claims. You may upload attachments.
- **Mail:** Send the appeal to:

  UnitedHealthcare Community Plan
  Attn: Appeals and Grievances Unit
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

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

Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses CMS definitions for appeals and grievances.

Initial decisions

The “initial decision” is the first decision UnitedHealthcare Connected makes regarding coverage or payment for care. In some instances, you, acting on

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behalf of UnitedHealthcare Connected, may make an initial decision about whether a service will be covered.

If a member asks us to pay for medical care the member has already received, this is a request for an initial decision about payment for care.

If you or a member asks for preauthorization for treatment, this is a request for an "initial decision" about whether the treatment is covered by UnitedHealthcare Connected.

If a member asks you for a specific type of medical treatment, this is a request for an initial decision about whether the treatment the member wants is covered by UnitedHealthcare Connected.

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

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

A decision about whether UnitedHealthcare Connected will cover medical care can be a standard decision made within the standard time frame (typically within 15 days) or it can be an expedited decision that is made more quickly (within 72 hours).

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

At each encounter with a UnitedHealthcare Connected member, you must notify the member of their right to receive, upon request, a detailed written notice from UnitedHealthcare Connected regarding the member's services. Your notification must provide the member with the information necessary to contact UnitedHealthcare Connected and must comply with any other CMS requirements. If a member requests UnitedHealthcare Connected to provide a detailed notice of your decision to deny a service in whole or part, UnitedHealthcare Connected must give the member a written notice of the determination.

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

Member appeals

What is it?

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

You (with a member's written consent) or a member may appeal when the plan:

- Lowers, suspends or ends a previously authorized service.
- Refuses, in whole or part, payment for services.
- Fails to provide services in a timely manner, as defined by the state or CMS.
- Doesn't act within the time frame CMS or the state requires.

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.

We resolve urgent appeals within 48 hours if the member's condition requires.

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 8413-0364

Phone: **800-895-2017 (TTY 711)**

If you appeal by phone, you must follow up in writing, ask the member to sign the written appeal, and mail it to UnitedHealthcare Community Plan. Expedited appeals do not need to be in writing.

How to use:

Whenever we deny a service, you must provide the member with UnitedHealthcare Community Plan appeal rights. The member has the right to:

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- Receive a copy of the rule used to make the decision.
- Present evidence, and allegations of fact or law, in person and in writing.
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal.
- Ask for an expedited appeal if waiting for this health service could harm the member's health.
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. 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:

1. Member requests we take longer.
2. We request additional information and explain how the delay is in the member's interest.

If submitting the appeal by mail, you must complete the Authorization of Review (AOR) form-Claim Appeal.

A copy of the form is online at **UHCprovider.com**.

Member grievance

What is it?

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

When to use:

You may act on the member's behalf with their written consent.

Where to send:

You or the member may call or mail the information anytime to:

Mailing address:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 84131-0364

Phone: **800-895-2017 (TTY 711)**

We will send an answer no longer than 90 calendar days from when you filed the complaint/grievance or as quickly as the member's health condition requires.

Further appeal rights

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

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

State hearings

What is it?

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

When to use:

Members have 90 calendar days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter.

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How to use:

For details, visit jfs.ohio.gov. The UnitedHealthcare Community Plan member may ask for a state hearing by writing a letter to:

ODJFS Bureau of State Hearings
P.O. Box 182825
Columbus, OH 43218-2825

The member may ask UnitedHealthcare Community Plan Member Services for help writing the letter.

- The member may have someone attend with them. This may be a family member, friend, care provider or lawyer. Written consent is required.

Processes related to reversal of our initial decision

If the state fair hearing outcome is to not deny, limit, or delay services while the member is waiting on an appeal, then we provide the services:

- As quickly as the member's health condition requires or
- No later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal.

If the state fair hearing decides UnitedHealthcare Community Plan must approve appealed services, we pay for the services as specified in the policy and/or regulation.

Fraud, waste and abuse

Call the **Fraud, Waste and Abuse Hotline** to report questionable incidents involving plan members or care providers. You can also go to **uhc.com/fraud** to learn more or to report and track a concern.

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money 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/OHcommunityplan > **Integrity of Claims, Reports, and Representations to the Government.**

The Deficit Reduction Act (DRA) has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least $5 million in annual Medicaid payments must have written policies for entity employees and contractors. They must provide detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

This policy details our commitment to compliance with the federal and state false claims acts. It provides a detailed description of these acts and of organizational mechanisms that detect and prevent fraud, waste and abuse. It also details how whistleblowing employees are protected. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

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State laws

States where UnitedHealthcare Community Plan does business have laws that contain civil or criminal penalties for false claims and statements that are in addition to the penalties provided in the Act. Certain states also have whistle-blower protections similar to the Act. In Ohio the applicable laws are ORC Sections 5164.35, 5162.15, 2913.40, 124.341, 4113.52, and 3901.44. For more information on a specific state law, please contact the UnitedHealthcare Community Plan compliance officer or legal department.

Exclusion checks

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month. For more information or access to the publicly accessible, excluded party online databases, please see the following links:

- **Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE)**
- **General Services Administration (GSA) System for Award Management** > 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.

Sanctions under federal health programs and state law

You must help ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other federal health care programs are employed or subcontracted by the participating care provider.

You must disclose to UnitedHealthcare Connected whether you or any staff member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of Ohio, the federal government, or any public insurer.

Notify UnitedHealthcare Connected immediately if any such sanction is imposed on you, a staff member or subcontractor.

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Chapter 14: Care Provider Communications & Outreach

Key contacts

Topic	Link	Phone Number
Provider Education	UHCprovider.com > Resources > Resource Library	800-600-9007
News and Bulletins	UHCprovider.com > Resources > News	800-600-9007
Provider Manuals	UHCprovider.com/guides	800-600-9007

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:

The UnitedHealthcare Community Plan care provider education and training program is built on years of experience with you and Ohio's managed care program. It includes the following care provider components:

- Website
- Forums/town hall meetings
- Office visit
- Newsletters and bulletins
- Manual

Care provider websites

UnitedHealthcare Community Plan promotes the use of web-based functionality among its provider population. The UHCprovider.com portal facilitates care provider communications related to administrative functions. Our interactive website empowers you to electronically determine member eligibility, submit claims, and view claim status.

We have also implemented an internet-based prior authorization system on UHCprovider.com. This site lets you request medical and advanced outpatient imaging procedures online rather than by phone. The website also has:

- An online version of this manual
- Clinical practice guidelines (which cover diabetes, ADHD, depression, preventive care, prenatal, and other guidelines)
- Electronic data interchange
- Quality and utilization requirements
- Educational materials such as newsletters and bulletins
- Provider service updates – new tools and initiatives (e.g., PreCheck MyScript)

In addition, we have created a member website that gives access to the Member Handbook, newsletters, provider search tool and other important plan information. It is UHCCommunityPlan.com > select Member.

You may also find training on various topics at UHCprovider.com > Resources > Resource Library. Look under More Resource Topics, then click Training.

Care provider office visits

Care provider advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a care

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provider group to deliver face-to-face support. We do this to create program awareness, promote compliance and problem resolution.

Care provider newsletters and Network Bulletins

UnitedHealthcare Community Plan produces a care provider newsletter to the entire Ohio network at least three times a year. The newsletters include articles about:

- Program updates
- Claims guidelines
- Information regarding policies and procedures
- Cultural competency and linguistics
- Clinical practice guidelines
- Special initiatives
- Emerging health topics

Network Bulletins

The Network Bulletin is a monthly publication that features important protocol and policy changes, administrative information and clinical resources.

View the latest news or sign up to receive the monthly bulletin at **UHCprovider.com** > Resources > **News**.

Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for Provider Services, a removable quick reference guide and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting **Provider Services**.

State websites and forms

Find the following forms on the state's website at **medicaid.ohio.gov**:

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

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Chapter 15: Glossary

Abuse (by care provider)
Care provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost, or in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost, as defined by 42 CFR 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.

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 his or her 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.

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.

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 member request that their health insurer or plan review an adverse benefit determination.

Authorization
Approval obtained by care providers from UnitedHealthcare Community Plan for a service before the service is rendered. Used interchangeably with "preauthorization" or "prior authorization."

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.

Case Manager
The individual responsible for coordinating the overall service plan for a member in conjunction with the member, the member's representative and the member's Primary Care Provider (PCP).

Centers for Medicare & Medicaid Services (CMS)
A federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and SCHIP programs.

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CHIP
Children's Health Insurance Program.

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.

Contracted Health Professionals
Primary care providers, care provider 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 two or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

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

Credentialing
The verification of applicable licenses, certifications and experience. This process assures care provider status is extended only to professional, competent care providers who continually meet UnitedHealthcare Community Plan qualifications, standards and requirements.

Current Procedural Terminology (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.

Disallow Amount (Amt)
Medical charges for which the network provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member. Examples are:

- The difference between billed charges and in-network rates.
- Charges for bundled or unbundled services as detected by Correct Coding Initiative edits.

Discharge Planning
Screening eligible candidates for continuing care following treatment in an acute care facility. It involves care planning, scheduling, arranging and steps that move a member from one level of care to another.

Disenrollment
The discontinuance of a member's eligibility to receive covered services from a contractor.

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.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday and extended use, for medical reasons other than convenience or comfort. DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT)
A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA Section 1905 (R). 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 use, mental health and hearing. They also include any medically necessary services found during the preventive exam.

Electronic Data Interchange (EDI)
The electronic exchange of information between two or more organizations.

Electronic Funds Transfer (EFT)
The electronic exchange of funds between two or more organizations.

Electronic Medical Record (EMR)
An electronic version of a member's health record and the care they have received.

Eligibility Determination

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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.

Encounter
A record of health care-related services by care providers registered with Medicaid to a patient enrolled with UnitedHealthcare Community Plan on the date of service. You are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan electronically reports these encounters to state Medicaid. The state audits encounter submission accuracy and timeliness on a regular basis.

Enrollee
Enrollee is interchangeable with the term member. Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber or dependent.

Enrollment
The process where a person is determined eligible to receive Medicaid or Medicare benefits becomes an enrollee or member of a health plan.

Evidence-Based Care
An approach that helps care providers use the most current, scientifically accurate research to make decisions about members' care.

Expedited Appeal
An expedited review process for appeals determines that 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.

Fee For Service (FFS)
A method of payment to care providers on an amount-per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule.

FHC
Family Health Center

Fraud
A crime that involves misrepresenting or concealing information to receive benefits or to make a financial profit.

Grievance
Unhappiness about the plan and/or care provider regarding any matter including quality of care or service concerns. Does not include adverse benefit determination (see appeals/dispute). Grievances may include, but are not limited to, the quality of care or services provided, and relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed to make an authorization decision.

Healthcare Effectiveness Data and Information Set (HEDIS®)
A rating system developed by NCQA that helps health insurance companies, employers, and consumers learn about the value of their health plan(s) and how it compares to other plans.

HIPAA
Health Insurance Portability and Accountability Act. A federal law that provides data privacy protection and security provisions for safeguarding health information.

Home Health Care (Home Health Services)
Health care services and supplies provided in the home, under physician's orders. Services may be provided by nurses, therapists, social workers or other licensed 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.

Medicaid
A federal health insurance program for low-income families and children, eligible pregnant women, people with disabilities, and other adults. The federal government pays for part of Medicaid and sets guidelines for the program. States pay for part of Medicaid and have choices in how they design their program. Medicaid varies by state and may have a different name in your state.

Medical Emergency
An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention you could reasonably expect one of the following to result:

- Their health would be put in danger; or
- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or

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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.

Member
An individual who is eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement.

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.

Preventive Health Care
Health care emphasizing priorities for prevention, early detection and early treatment of conditions. It generally includes routine/physical examination and immunization.

Primary Care Provider (PCP)
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the plan who provides, coordinates or helps members access a range of health care services.

Prior Authorization (Notification)
The process where health care providers seek approval prior to rendering health care services, drugs or DME as required by UnitedHealthcare Community Plan policy.

Provider Group
A partnership, association, corporation, or other group of care providers.

Quality Management (QM)
A methodology that professional health personnel use to achieve desired medical standards and practices. The formal program includes activities to help improve and maintain quality service and care and involve multiple organizational components and committees.

Rural Health Clinic
A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics may receive enhanced payments for services provided to enrolled members.

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by Ohio ODM.

Specialist
A care provider licensed in Ohio and has completed a residency or fellowship focusing on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a care provider who has special training in a specific area of health care.

State Fair Hearing
An administrative hearing requested if the member does not agree with a Notice of 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.

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,

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serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

Utilization Management (UM)
Involves coordinating how much care members get. It also determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.

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