2024 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Ohio Medicaid

Doc#: PMG 20240404-163840_04192024 v66.5.2023

UnitedHealthcare Community Plan

Welcome

Welcome to the UnitedHealthcare Community Plan® provider manual. This up-to-date reference PDF manual allows you and your staff to find important information such as how to process a claim and submit prior authorization requests. It features important phone numbers and websites on the How to Contact Us section.

Click to access different manuals

- **Administrative Guide** – **UHCprovider.com/guides**
  Under UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage and D-SNP plans, click on View Guide. Some states may also have Medicare Advantage information in their Community Plan manual.
- **A different Community Plan manual** – **UHCprovider.com/guides**
  Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on **Find Your State**

Easily find information in this manual using the following steps

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

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

Find operational policy changes and other electronic transactions on our website at **UHCprovider.com**.

Using 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, the latter 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.

Participation Agreement

Terms and definitions as used in this manual:

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

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

© 2024 UnitedHealthcare

Table of Contents

Chapter 1: Introduction 1

Chapter 2: Care provider standards and policies 13

Chapter 3: Care provider office procedures and member benefits 24

Chapter 4: Medical management 28

Chapter 5: Care Management 48

Chapter 6: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)/prevention 51

Chapter 7: Value-added services 54

Chapter 8: Mental health and substance use 58

Chapter 9: Member rights and responsibilities 62

Chapter 10: Medical records 65

Chapter 11: Quality management program and compliance information 68

Chapter 12: Billing and submission 76

Chapter 13: Claim reconsiderations, appeals and grievances 85

Chapter 14: Care provider communications and outreach 96

Ohio Medicaid and CHIP Regulatory Requirements Appendix 98

Glossary 105

 © 2024 UnitedHealthcare

Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com** Chat with provider services: **UHCprovider.com** > Sign In > Contact Us	**1-800-600-9007**
Training	**UHCprovider.com/training**	**1-800-600-9007**
UnitedHealthcare Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID. Or go to UnitedHealthcare Provider Portal Self Service: **UHCprovider.com/en/resource-library/provider-portal-resources.html** New users: **UHCprovider.com** > **New User and User Access**	**1-800-600-9007**
CommunityCare Provider Portal training	**CommunityCare Provider Portal User Guide**	
UnitedHealthcare Provider Portal Support	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page	**1-855-819-5909**
Resource library	**UHCprovider.com** > Resources > **Resource Library**	

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

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

The Ohio Department of Medicaid determines enrollment eligibility.

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com.** Or call Provider Services at **1-800-600-9007.**

How to join our network

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

© 2024 UnitedHealthcare

Already in network and need to make a change?

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

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 services, the program helps address their needs holistically. Care Model examines medical, behavioral and social/environmental concerns and then provides interventions to help members get the right care.

These interventions address members' specific 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:

- Medical, behavioral and social care management using community resources
- An extended care team, including a 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 making 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 care providers, such as appointment reminders and help with transportation
- Foundation to build trust and relationships with hard-to-engage members

The Care Model program goals are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates
- Improve access to PCP and other needed services, measured by number of PCP visit rates within identified time frames
- Identify and discuss behavioral health needs, measured by number of behavioral health care provider visits within identified time frames
- Improve pharmacy access
- 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 provider networks to help ensure access to affordable care and the appropriate use of services

To refer a UnitedHealthcare Community Plan member to the Care Model program, call Member Services at **1-800-895-2017,** TTY **711**. You may also call Provider Services at **1-800-600-9007.**

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 care providers who handle business electronically.

© 2024 UnitedHealthcare

Cultural resources

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

UnitedHealthcare Community Plan offers the following support services:

- **Cultural competency training and education**
  Free continuing medical education (CME) and non-CME courses are available on our **Cultural Competency page** as well as other important resources. Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process**.
- **Language interpretation line**
  We provide oral interpreter services Monday-Friday from 8 a.m.- 8 p.m. ET. To arrange for interpreter services, please call **1-877-842-3210** (TTY 711).

The services are covered by UnitedHealthcare Community Plan of Ohio at no cost to you or the patient.

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

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

Cultural competency information as well as languages spoken by office location will be collected in the Ohio Department of Medicaid (ODM)'s Provider Network Management (PNM) system and used to populate ODM's centralized provider directory. Additionally, this information for credentialed care providers will be transmitted to UnitedHealthcare Community Plan on a weekly basis forour directories to align with the information contained in the PNM.

Obligations for translation, sign language

As agreed upon in the UnitedHealthcare Provider Agreement, you will (a) not discriminate in providing services to members on the basis of race, color, sex, age, national origin, religion, economic status, source of payment, health status or health care needs; (b) observe, protect and promote the rights of members as patients; (c) maintain a written sexual harassment policy and inform employees of the policy:

(d) comply with Title VI of the Civil Rights Act of 1964 in providing covered services hereunder; and (e) maintain written procedures as to interpretation and translation services for members requiring such services, including members with limited English proficiency.

Pursuant to regulations implementing the Americans with Disabilities Act ("ADA"), 28 C.F.R. 35.101 et seq., Provider shall not, on the basis of the disability, exclude any individual with a disability from participation herein or from activities provided for hereunder. You shall comply with the "General Prohibitions Against Discrimination," 28 C.F.R. 35.130, and similar regulations or guidelines that apply to the state of Ohio.

You must have a process to identify, keep a record of and report to UnitedHealthcare Community Plan upon request members requiring oral translation, oral interpretation or sign language services and provide the use of TTY or language assistance all free of charge for members.

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual® for medical care determinations.

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster. Learn the differences by viewing our Digital Solutions Comparison Guide at **UHCprovider.com** > Resources > **the UnitedHealthcare Provider Portal Resources** > Digital Solutions Comparison Guide. Care providers in the UnitedHealthcare network will conduct business with us electronically. This means using electronic means, where allowed by law, to submit claims and receive payment and
to submit and accept other documents. This includes appeals prior authorization requests and decisions.

© 2024 UnitedHealthcare

Using electronic transactions is fast, efficient and supports a paperless work environment. Use Application Programming Interface (API), Electronic Data Interchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

Application Programming Interface

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

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

Electronic data interchange

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

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

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

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

Getting started

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

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

Point of Care Assist

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

UHCprovider.com

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

© 2024 UnitedHealthcare

5 reasons to use UHCprovider.com

UnitedHealthcare Provider Portal

1

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**

Prior Authorization and Notification

2

Request approval for prescriptions, admissions and procedures.

UHCprovider.com/paan

EDI

3

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

UHCprovider.com/edi

Direct Connect

4

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

Policies and Protocols

5

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.

UnitedHealthcare Provider Portal

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

To access the portal, go to **UHCprovider.com/en/access.html** to create or sign in using a One Healthcare ID. To use the portal:

If you already have a One Healthcare ID (formerly known as Optum ID), simply go to **UHCprovider.com** and click Sign In in the upper right corner to access the portal.

If you need to set up an account on the portal, follow **these steps** to register.

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

- **Eligibility and benefits**
  View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.
- **Claims**
  Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims**.
- **Prior authorization and notification**
  Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/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**.

© 2024 UnitedHealthcare

- **Document Library**
  Access reports and claim letters for viewing, printing or downloading. The Document Library Roster provides member contact information in a PDF, and can only be pulled at the individual practitioner level. For more information, go to **UHCprovider.com/documentlibrary**.

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

Chat support

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

Direct Connect

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

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

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

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

Privileges

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

Provider representatives

Our provider advocate team offers the expertise and knowledge to support a long-term collaborative relationship and will help to make working with UnitedHealthcare as easy as possible. Whether you are looking for the latest resources available to simplify your claims submission process or need support resolving issues, our advocates can help.

What kind of support does the provider advocate team offer?

- Guide you to self-service claims, processing tools and care provider education resources
- Help with issues that have not been resolved through the standard service channels
- Help you understand the tools and tactics to help simplify your administrative process

Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page.

© 2024 UnitedHealthcare

How to contact us

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

Topic	Contact	Information
Behavioral Health Care Management	**1-800-888-2998**	Call Monday through Friday, 8 a.m.–5 p.m., ET. Call 24 hours a day, 7 days a week for help with referrals, prior authorizations, admissions, discharges and coordination of members' care.
Behavioral, mental health and substance abuse	Optum® **providerexpress.com** **1-866-209-9320**	Review eligibility, claims, benefits, authorization and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	**UHCprovider.com/benefits** **1-800-600-9007**	Confirm a member's benefits and/or prior authorization.
Care Management Medical Care Management Services (Medicaid)	**1-800-508-2581**	Call Monday through Friday, 8 a.m.–5 p.m., ET. Call 24 hours a day, 7 days a week for help with referrals, prior authorizations, admissions, discharges and coordination of members' care.
Care Model (care management/disease management)	**1-800-895-2017**	Refer high-risk members (e.g. asthma, diabetes, obesity) and members who need private-duty nursing.
Chiropractor care	**myoptumhealthphysicalhealth.com** **1-800-873-4575**	We provide members older than 21 with up to 6 visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.
Claims	**UHCprovider.com/claims** **1-800-600-9007** Mailing address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 1355 S 4700 West, Suite 100 Salt Lake City, UT 84104	Verify a claim status or get information about proper completion or submission of claims.

© 2024 UnitedHealthcare

Topic	Contact	Information
Claim overpayments	Sign in to **UHCprovider.com/claims** to access the UnitedHealthcare Provider Portal **1-800-600-9007** Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments. See the **Overpayment section** for requirements before sending your request.
Dental	UnitedHealthcare Dental: **uhcdental.com**	To find a dental provider, go to **UHCprovider.com** > Find Dr > Dental Providers by state.
Electronic Data Intake (EDI) Issues	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315**	Contact EDI Support for issues or questions.
Eligibility	**UHCprovider.com/eligibility** Interactive Voice Response **1-888- 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	**1-877-842-3210**	The Enterprise Voice Portal provides self-service functionality. Or call to speak with a contact center agent.
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** **1-800-455-452**1 or **1-877-401-9430**	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Laboratory services	**UHCprovider.com** > Our Network > **Preferred Lab Network** Labcorp 1-800-833-3984 Quest Diagnostics questdiagnostics.com	Labcorp and/or Quest Diagnostics are network laboratories.
Medicaid (Ohio Department of Medicaid)	medicaid.ohio.gov 1-800-324-8680	Contact Medicaid directly.

© 2024 UnitedHealthcare

Topic	Contact	Information
Medical claim, reconsideration and appeal	**UHCprovider.com/claims** **1-800-600-9007** Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5240 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.
Mental Health and Substance Abuse (Behavioral Health)	**1-800-600-9007**	Refer members for behavioral health services. A PCP referral is not required. [1] *See behavioral health row for more information.
Member Services	**myuhc.com®** **1-800-895-2017,** TTY **711**	Helps assist members with issues or concerns. Available 7 a.m.–8 p.m. ET, Monday through Friday.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	**1-800-895-2017,** TTY **711**	Available 7 a.m.–8 p.m. ET, Monday through Friday.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network management	**1-800-600-9007**	A team of provider relation advocates. Ask about contracting and care provider services.
Network Management Support	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. **1-877-842-3210**	Self-service functionality for medical network care providers to update or check credentialing information.
NurseLine	**1-800-542-8630**	Available 24 hours a day, 7 days a week
Obstetrics/pregnancy and baby care	Healthy First Steps® Pregnancy Notification Form at **UHCprovider.com**, then Sign In for the UnitedHealthcare Provider Portal. **1-800-599-5985** 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.

 © 2024 UnitedHealthcare

Topic	Contact	Information
Oncology prior authorization	**UHCprovider.com** > Prior Authorization > **Oncology** Optum **1-888-397-8129** Monday–Friday 7 a.m.–7 p.m. CT	For current list of CPT codes that require prior authorization for oncology.
One Healthcare ID support center	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. **1-855-819-5909**	Contact if you have issues with your ID. Available 7 a.m.–9 p.m. CT, Monday–Friday; 6 a.m.–6 p.m. CT, Saturday; and 9 a.m.–6 p.m. CT, Sunday.
Pharmacy services	spbm.medicaid.ohio.gov 1-833-491-0344 (Gainwell Technologies and technical help desk)	Gainwell Technologies oversees and manages the network pharmacies.
Prior authorization/ notification for pharmacy	spbm.medicaid.ohio.gov 1-800-310-6826 (Medicaid) 1-833-491-0344 (provider pharmacy prior authorization help desk)	Use the UnitedHealthcare Provider Portal to access the Gainwell tool. You can request prior authorization and receive results.
Prior authorization requests/ advanced and admission notification	To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N **UHCprovider.com/paan** Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications".	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required. • Complete the notification or prior authorization process. • Upload medical notes or attachments. • Check request status Information and advance notification/ prior authorization lists: **UHCprovider.com/ohcommunityplan > Prior Authorization**
Provider Advocate/ Provider Representative	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page.	
Provider Services	**UHCprovider.com/ohcommunityplan** **1-800-600-9007** **UnitedHealthcare Community Plan** 9200 Worthington Road, 3rd Floor Worthington, OH 43082	Available 7 a.m.–5 p.m. CT, Monday–Friday.
Radiology prior authorization	**UHCprovider.com/radiology** **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.

© 2024 UnitedHealthcare

Topic	Contact	Information
Referrals	**UHCprovider.com > Referrals** or use Referrals on the UnitedHealthcare Provider Portal. Click Sign in at the top right corner of **UHCprovider.com**, then click Referrals. Provider Services **1-800-600-9007**	Submit new referral requests and check the status of referral submissions.
Reimbursement policy	**UHCprovider.com/ohcommunityplan > Current Policies and Clinical Guidelines**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical support	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. **1-866-209-9320** for Optum support or **1-866-842-3278,** Option 1 for web support	Call if you have issues logging in to the UnitedHealthcare Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit Now	1-800-784-8669	Ask about services for quitting tobacco/smoking.
Transportation	1-800-269-4190	Call transportation directly or Member Services to schedule transportation or transportation assistance. To arrange nonurgent transportation, please call 48 hours in advance.
Utilization management	**1-800-600-9007**	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. For UM policies and protocols, go to **UHCprovider.com** > Resources > **Health Plans, Policies, Protocols and Guides**. Request a copy of our UM guidelines or information about the program.
Vaccines for Children (VFC) Program	1-800-282-0546	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. Care providers must enroll as VFC providers with DHSS to bill for the administration of the vaccine.

© 2024 UnitedHealthcare

Topic	Contact	Information
Vision Services (March Vision)	marchvisioncare.com 1-844-756-2724	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.

© 2024 UnitedHealthcare

Chapter 2: Care provider standards and policies

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com**	**1-800-600-9007**
General provider assistance		**1-877-842-3210**
Eligibility	**UHCprovider.com/eligibility**	**1-800-600-9007**
Referrals	**UHCprovider.com** > **Referrals**	**1-800-600-9007**
Provider Directory	**UHCprovider.com** > Our Network > **Find a Provider**	**1-800-600-9007**

General care provider responsibilities

Nondiscrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them based on:

- Age
- Sex
- Race
- Physical
- 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 them 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 they 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

© 2024 UnitedHealthcare

3. Suspension, exclusion, debarment or other sanction from a state or federally-funded health care program
4. Loss or suspension of your license to practice
5. Departure from your practice for any reason
6. Closure of practice

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

Transition member care following termination of your participation

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

Termination, suspension or denial of contract

Except for emergency services, UnitedHealthcare Community Plan may not pay a care provider for services provided when the care provider has been terminated or suspended by Ohio Department of Medicaid (ODM) or has been terminated by Medicare, Medicaid or the Children's Health Insurance Program. When ODM notifies UnitedHealthcare Community Plan that a provider has been suspended, we must immediately suspend the care provider, including any payments due. We are required to continue to suspend the care provider until we receive notice from the ODM to lift the suspension.

When ODM notifies us that a care provider is no longer suspended then we must lift the suspension and process any suspended claims. Care providers must return episode, quality or other value-based payments when a provider is convicted of fraud and the time period of the fraudulent activity overlaps with the time period that the episode, quality or other value-based payment is based. We do not have to contract with a care provider but report any denial to the ODM.

Arrange substitute coverage

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

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

Administrative terminations for inactivity

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

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

Changing an existing TIN or adding a 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** using the UnitedHealthcare Provider Portal at **UHCprovider.com** > Sign In > My Practice Profile
- To update your information online, go to the UnitedHealthcare Provider Portal at **UHCprovider.com** > Sign In > My Practice Profile

© 2024 UnitedHealthcare

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 UnitedHealthcare Provider Portal on **UHCprovider.com**. Go to **UHCprovider.com**, then Sign In > My Practice Profile.
Or submit your change by:

- Completing the **Care Provider Demographic Change Form** and emailing it to the appropriate address listed at the bottom of the form
- Calling our general provider assistance line at **1-877-842-3210**

Updating your practice or facility information with Ohio Medicaid

You must keep your information up to date with Ohio Medicaid. If you need to make any updates, you can do so here.

After-hours care

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 into your schedule, refer them to an urgent care center.

If the member is in a life-threatening situation, refer them to the ER.

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 particular diseases and conditions. This is determined by the state's 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 6 years or longer if required by applicable statutes or regulations.

Performance data

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

Comply with protocols

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

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

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

 © 2024 UnitedHealthcare

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. The safeguards include 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 investigate your complaint. If you disagree with the outcome, you may file for arbitration. If your concern relates to certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, follow the dispute procedures in your Agreement.

After following those procedures, if one of us remains dissatisfied, you may file for arbitration.

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

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

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

Care provider enrollment — Ohio Department of Medicaid

Pursuant to 42 Code of Federal Regulations (CFR) 438.602, the Ohio Department of Medicaid (ODM) is required to screen, enroll and re-validate all managed care organization (MCO) network providers. This provision does not require MCO network providers to render services to fee-for-service (FFS) beneficiaries.

There are many resources available on the Ohio Department of Medicaid website about the requirements to become a participating provider. Please visit medicaid.ohio.gov for several useful documents that answer relevant questions.

Organizational provider types will be required to pay a fee. The fee applies to organizational providers only; it does not apply to individual providers and practitioners or practitioner groups. The fee is a federal requirement described in 42 CFR 445.460 and in OAC 5160-1-17.8. The fee for 2023 is $688 per application and is not refundable. The fee will not be required if the enrolling organizational provider has paid the fee to either Medicare or another state Medicaid agency within the past 5 years. However, Ohio Medicaid will require that the enrolling organizational providers submit proof of payment with their application (see OAC 5160-1-18,8(A)(1)).

Termination, suspension or denial of enrollment

For a list of termination, suspension and denial actions initiated by the state against a provider or applicant that allow for hearing rights, please refer to Ohio Revised Code 5164.38.

© 2024 UnitedHealthcare

For a list of termination, suspension and denial actions initiated by the state Medicaid agency against a care provider or applicant that allow for reconsideration, please refer to Ohio Administrative Code 5160-70-02.

Loss of licensure

In accordance with Ohio Administrative Code 5160-1-17.6, a Medicaid provider agreement will be terminated when any license, permit or certification that is required in the provider Agreement or department rule has been denied, suspended, revoked, not renewed or is otherwise limited and the care provider has been afforded the opportunity for a hearing in accordance with the hearing process established by the official, board, commission, department, division, bureau or other agency of state or federal government.

Enrollment and reinstatement after termination or denial

If a care provider's Medicaid provider Agreement is terminated or an applicant's application is denied, the applicant/care provider should contact ODM via the Provider Enrollment Hotline (1-800-686-1516) to discuss the requirements to reapply. This process may include conversations with the ODM Compliance unit who will provide specific instruction on re-instatement requirements, if applicable.

Provider maintenance

The provider network management (PNM) system serves as the system of record for care provider data for ODM and UnitedHealthcare Community Plan. As a result, data in the PNM system is used in both claims payment, the MCO's provider directory and ODM provider directory. To ensure care provider information remains current it is important for care providers to keep their information up to date in the PNM system. Please remember, as an ODM provider and in accordance with your provider Agreement, you are responsible for notifying ODM of changes within 30 days (see OAC 5160-1-17.2 F).

Updating the PNM system

When there is a change in your information, please log in to the PNM system, choose the provider you are editing, and click the appropriate button to begin an update. Self-service functions include, but are not limited to: location changes, specialty changes and key demographic (e.g., name, NPI, etc.) changes. Once information is accepted into the PNM system, the accepted information is sent to UnitedHealthcare Community Plan daily for use in the provider directories. You must update your information in the PNM system first. UnitedHealthcare Community Plan is required to direct care providers back to the PNM system if there are changes.

If you have questions or need assistance with your Ohio Medicaid provider enrollment, call the ODM provider call center at 1-800-686-1516 through the interactive voice response (IVR) system. It provides 24-hour, 7 days a week access to information regarding care provider information. Provider representatives are available via the IVR system weekdays from 8:00 a.m.–4:30 p.m.

Helpful information

- **Medicaid care provider resources -** medicaid.ohio.gov/resources-for-providers
- **Federal guidelines for enrollment and screening (42 CFR 455 Subpart E) -** law.cornell.edu/cfr/text/42/part-455/subpart-e
- **Ohio revised code -** codes.ohio.gov/ohio-revised-code/chapter-5160 and codes.ohio.gov/ohio-revised-code/chapter-3963
- **Ohio Administrative Code -** codes.ohio.gov/ohio-administrative-code/5160

Appointment standards (Ohio access and availability standards)

Comply with the following appointment availability standards:

Primary or emergent care

- Primary care – within 6 weeks
- Non-urgent sick primary care – within 3 calendar days
- Emergency service –24 hours, 7 days/week
- Urgent care (includes medical, behavioral health and dental services) –24 hours, 7 days/week within 48 hours of request

© 2024 UnitedHealthcare

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- First or second trimester – first appointment within 7 calendar days; follow-up appointments no more than 14 calendar days after request
- Third trimester or high-risk pregnancy – within 3 calendar days

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.

Behavioral health care

Behavioral health care providers should arrange appointments for:

- Behavioral health non-life-threatening emergency - within 6 hours
- Behavioral health routine care - within 10 business days or 14 calendar days, whichever is earlier

Specialty care and nonemergent dental

Specialists should arrange specialty care appointments within 6 weeks.

Provider Directory

You are required to tell us, within 5 business days, if you can no longer accept new patients to prevent any Provider Directory inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional help finding a care provider.

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

We allow you up to 45 business days to contact us. If you don't, we notify you that if you continue to be nonresponsive we will remove you from our directory after 10 business days.

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

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

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

- **Delegated care providers** – email your changes to **delprov@uhc.com**
- **Nondelegated care providers** – visit **UHCprovider.com** for the **Care Provider Demographic Change Submission Form** and further instructions

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

Care provider attestation

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

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

Medicaid addendum

The ODM Medicaid addendum supplements the base contract or Agreement between UnitedHealthcare Community Plan and care provider and runs concurrently with the terms of the base contract or Agreement.

The addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members. Attachments are only needed when care providers are offering different services or practitioners through this plan contract than are identified in the PNM system.

© 2024 UnitedHealthcare

Attachment A is needed for all PCPs to identify the care providers' capacity and service location. Attachment A is also required when a care provider has specific practitioner affiliates identified in the PNM who are agreeing to provide services under this plan contract. Attachment C is only required when the contract between the managed care entity and the care provider includes particular specialties rather than all specialties the provider identified in the PNM system. The most current Medicaid Addendum is posted on the ODM website: medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/mc-policy/managed-care-program-appendix/managed-care-program-addenda. The addendum must be completed along with the UnitedHealthcare Community Plan provider contract.

Non-contracted or unenrolled providers

Contracting and enrollment are two separate processes. Both should be completed if you want to provide services to managed care enrolled Medicaid beneficiaries. Contracting is the process a provider completes with the MCO whereas enrollment is a process completed with the ODM. All providers who are billing for services for Medicaid managed care enrolled beneficiaries should enroll with ODM through our PNM system. 42 CFR § 438.602 requires ODM to "screen and enroll, and periodically revalidate, all network providers of MCOs". Federal regulations allow for a 120-day temporary agreement for providers who require more time to enroll in the PNM System. To complete the temporary 120 agreement while you wait for your ODM enrollment to process you must complete the ODM 10295 form.

Provider education and training resources for PNM, including how to enroll, are located at .omes.maximus.com/OH_PNM_PROD/Resources.aspx.

Prior authorization request

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

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

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

- Verify eligibility using the UnitedHealthcare Provider Portal 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.
- Get prior authorization from the UnitedHealthcare 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 **1-866-842-3278,** option 3, 7 a.m.-9 p.m. CT, Monday–Friday.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

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

Requirements for PCP and specialists serving in PCP role

Specialists include internal medicine, pediatrics or obstetrician/gynecology

PCPs are an important partner in the delivery of care, and 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."

 © 2024 UnitedHealthcare

The PCP plays a vital role as a case manager in the UnitedHealthcare Community Plan system by improving health care delivery in 4 critical areas: access, coordination, continuity and prevention. As such, the PCP manages initial and basic care for members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide 24 hours a day, 7 days a week coverage and backup coverage when they are not available.

Medical doctors (M.D.s), doctors of osteopathy (D.O.s), nurse practitioners (N.P.s) and physician assistants (P.A.s) from any of the following practice areas can be PCPs:

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

N.P.s may enroll with the state as solo care providers, but P.A.s cannot. P.A.s must be part of a group practice.

Members may change their assigned PCP by contacting **Member Services**.

Customer service is available 7 a.m.–7 p.m., Monday–Friday.

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.

Members have direct access (without a referral or authorization) to any OB/GYNs, midwives, P.A.s or N.P.s 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. This includes PCP availability of 24 hours a day, 7 days a week.

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 nonemergency services.

Recorded messages are not acceptable.

Consult with other appropriate care providers to develop individualized treatment plans for UnitedHealthcare Community Plan members with special health care needs.

- Use lists supplied by the UnitedHealthcare Community Plan to identify members who may need preventive health procedures or testing
- Submit all accurately coded claims or encounters in a timely manner
- Provide all well-baby/well-child services
- Coordinate each UnitedHealthcare Community Plan member's overall course of care
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a 1-M.D. practice and at least 30 hours per week for a 2-or more-M.D. practice
- Be available to members by telephone any time
- Tell members about appropriate use of emergency services
- Discuss available treatment options with members

Responsibilities of PCPs and specialists serving in PCP role

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

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

- Offer office visits on a timely basis, based on the standards outlined in the Timeliness Standards for **Appointment Scheduling** section of this manual
- Conduct a baseline exam during the UnitedHealthcare Community Plan member's first appointment
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to Provider Services, UnitedHealthcare Community Plan Clinical or Pharmacy departments as appropriate

© 2024 UnitedHealthcare

- 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 based on UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. 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.
- 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

PCP checklist

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

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

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

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.

© 2024 UnitedHealthcare

Rural health clinic, federally qualified health clinic and primary care clinic

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

- **Rural health clinic (RHC)**
  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 (FQHC)**
  An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a P.A., N.P., social worker and/or another care provider
  - Mental health services
  - Immunizations (shots)
  - Home nurse visits
- **Primary care clinic (PCC)**
  A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a PCC that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

Specialist responsibilities

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

- Contact the PCP to coordinate the care/services
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer
- Verify the eligibility of the member before providing covered specialty care services
- Provide only those covered specialty care services, unless otherwise authorized
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at 1 UnitedHealthcare Community Plan participating hospital at a minimum
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws
- Comply with the 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, 7 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.

© 2024 UnitedHealthcare

Ancillary care provider responsibilities

Ancillary care providers include:

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

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

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

Ancillary care provider checklist

Verify the member's enrollment before rendering services. Sign in to the UnitedHealthcare 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.

© 2024 UnitedHealthcare

Chapter 3: Care provider office procedures and member benefits

Key contacts

Topic	Link	Phone Number
Member benefits	**UHCCommunityPlan.com/oh**	**1-800-895-2017,** TTY **711**
Member handbook	**UHCCommunityPlan.com/oh** > Plan Details > Member Resources > View Available Resources > **Member Handbook**	**1-800-895-2017,** TTY **711**
Provider Services	**UHCprovider.com**	**1-800-600-9007**
Prior authorization	**UHCprovider.com/paan**	**1-800-310-6826**

Benefits

Go to **UHCCommunityPlan.com/oh** Medicaid Plans to view plan details for Medicaid.

You may also use **Document Library** for member contact information in a PDF at the individual practitioner level.

You may also find the Document Library quick reference guide at UnitedHealthcare Provider Portal Resources > Document Library > **Document Library Interactive User Guide**.

Assignment to PCP panel roster

Once a member is assigned a PCP, view the panel rosters electronically by signing into the UnitedHealthcare Provider Portal at **UHCprovider.com**.

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

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

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

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 whether 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
- Obstetrics

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

© 2024 UnitedHealthcare

Deductibles/copayments

Deductibles and copayments are waived for covered services.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services. Medically necessary health care services or supplies are:

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

Member assignment

Assignment to UnitedHealthcare Community Plan

Ohio Department of Medicaid (ODM) assigns eligible members to UnitedHealthcare Community Plan daily. ODM manages the member's care from 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 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 > Member Information > Member handbook.

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, check the payer assignment of newborns daily.

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

Unborn enrollment changes

Encourage your members to notify the Ohio County Job and Family Services Offices when they know they are expecting. The offices notify UnitedHealthcare Community Plan daily of an unborn when Ohio Medicaid learns a member associated with the plan is expecting. UnitedHealthcare Community Plan or you may use the online change report at medicaid.ohio.gov to add the baby's birth. With that information, ODM verifies the birth through the mother. The UnitedHealthcare Community Plan 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.

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.

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.

© 2024 UnitedHealthcare

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. 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.

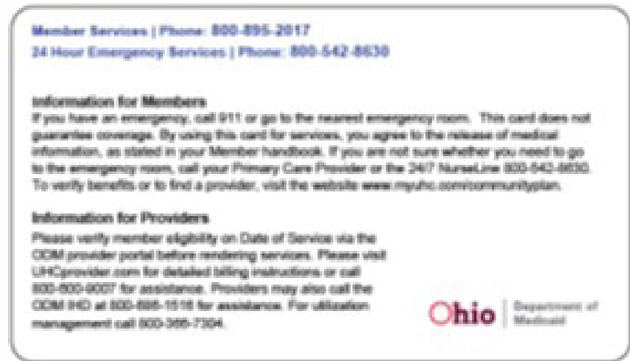
If a fraud, waste and abuse event arises from a care provider or a member's ID card, go to **uhc.com/fraud** to report it. Or call the **Fraud, Waste and Abuse Hotline**.

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 9-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. The ODM number is also on the member ID card.

Sample health member ID card



Information for members

If you have an emergency, call 911 or go to the nearest emergency room. 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 PCP or the 24/7 NurseLine **1-800-542-8630.** To verify benefits or to find a care provider, visit the website **myuhc.com/communityplan.**

Information for care providers

Please verify member eligibility on date of service via the ODM provider portal before rendering services. Please visit **UHCprovider.com** for detailed billing instructions or call **1-800-600-9007** for assistance. You may also call the ODM IHD at 1-800-686-1516 for assistance.

 © 2024 UnitedHealthcare

For utilization management, call **1-800-600-9007.**

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

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.

Verifying member enrollment

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

- UnitedHealthcare Provider Portal: access the UnitedHealthcare Provider Portal through **UHCprovider.com/eligibility**
- Phone: call the United Voice Portal at 1-877-842- 3210 or call the Customer Care number on the back of the member's ID card

© 2024 UnitedHealthcare

Chapter 4: Medical management

Key contacts

Topic	Link	Phone Number
Referrals	UHCprovider.com > Referrals	1-800-600-9007
Prior authorization	UHCprovider.com/paan	
Pharmacy	professionals.optumrx.com	
Dental (UnitedHealthcare Dental)	uhcdental.com	
Healthy First Steps	uhchealthyfirststeps.com	1-800-599-5985

Covered services for Medicaid only

Medicaid helps with medical costs for certain people with limited incomes and resources. This section is to assist with the navigation of covered services and additional benefits.

OhioRISE

UnitedHealthcare Community Plan is not required to cover behavioral health services for members enrolled in the OhioRISE Plan, except for certain behavioral health services in accordance with the OhioRISE Mixed Services Protocol developed by ODM.

Pharmacy

UnitedHealthcare Community Plan is not required to cover pharmacy services other than the limited pharmacy services described in this manual. All other pharmacy benefits are covered by ODM's single pharmacy benefit manager (SPBM).

Transportation

If a member must travel 30 miles or more from their home to receive covered health care services, UnitedHealthcare Connected will provide transportation to and from the care provider's office. These services must be medically necessary. A member must also have a scheduled appointment (except in the case of urgent/emergent care).

In addition to the transportation assistance that UnitedHealthcare provides, members can still receive assistance with transportation for certain services through the local county department of job and family services Nonemergency 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.

Medically necessary Medicaid-covered services

As a UnitedHealthcare 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 list to determine if the member's benefits may 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

© 2024 UnitedHealthcare

- Freestanding birth center services at a free-standing birth center
- 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
- Nursing facility and long-term care services and supports
- 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
- Services for children with medical handicaps (Title V)
- Hearing services, including hearing aids
- Vision (optical) services, including eyeglasses
- Yearly well-adult exams

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

Nonemergent air ambulance requires prior authorization.

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

Emergency ambulance transportation

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

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

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

Bill ambulance transport as a nonemergency 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.

Nonemergent ambulance transportation

UnitedHealthcare Community Plan members may get nonemergent stretcher/ambulance transportation services through Provide a Ride for covered services. Members may get transportation when they are bed-confined before, during and after transport.

Nonemergent stretcher/ambulance transportation must be requested at least 48 business hours in advance. Call 1-800-269-4190.

Schedule nonemergent ambulance or stretcher rides up to 30 days in advance.

Nonemergency transportation

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

UnitedHealthcare Community Plan provides 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 provides transportation to and from the care provider's office. These services must be medically necessary. Members must also have a scheduled appointment (except in the case of urgent/ emergent care). Rides to appointments can be scheduled with transportation by calling 1-800-269-4190 between 7 a.m. and 8 p.m. Scheduling can also be done through our Member Services at **1-800-595-2017.** Please schedule at least 48 hours in advance of the member's appointment for assistance.

© 2024 UnitedHealthcare

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 Nonemergency Transportation (NET) program. Call your County Department of Job and Family Services for questions or assistance with NET services.

Transportation for OhioRISE

Transportation is available for OhioRISE members and has no limitations. Please schedule all rides 2 days prior to the appointment. Rides to appointments can be scheduled with transportation by calling 1-800-269-4190 between 7 a.m. and 8 p.m. Scheduling can also be done through our Member Services at 1-800-595-2017.

The MCO must arrange and provide transportation for members who are enrolled with the OhioRISE plan in a manner that ensures that children, youth and their families served by the OhioRISE plan do not face transportation barriers to receive services regardless of Medicaid payer. The MCO is responsible for arranging transportation in cases where transportation of families, caregivers and sibling(s) (other minor residents of the home) is needed to facilitate the treatment needs of the member and their family even when the member is not being transported.

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:

- Emergency Room
- 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** > Sign In
- **Phone – 1-866-889-8054**, Monday–Friday

Make sure the medical record is available.

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

Dental services

UnitedHealthcare Community Plan works with UnitedHealthcare Dental 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, go to: **uhcdental.com.** To find a dental care provider, go to **UHCprovider.com** > Our Network > Find a Provider > **Dental Providers by State, Network or Location.**

Additional coverage

UnitedHealthcare Community Plan of Ohio covers:

21 and older

- 1 routine dental exam and cleaning every 6 months

All ages

- Preventative
- Diagnostic
- Restorative
- Oral surgery
- Emergency

© 2024 UnitedHealthcare

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

Emergency/urgent care services

Emergency services do not require prior authorization.

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

Covered services include:

- Hospital emergency department room and ancillary care provider service by in and out-of-network care providers
- Medical exam
- 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 1 hour for pre-approval for more care to make sure the member remains stable. If the hospital needs to appeal the decision or if does not receive a decision within 1 hour and/or they need to speak with a peer (medical director), call **1-800-955-7615.** The treating care provider may continue with care until the health plan's medical care provider is reached, or when 1 of these guidelines is met:

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

Depending on the need, the member may be treated in the ER, in an inpatient hospital room or in another setting. These are 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 (nonemergent)

Urgent care services are covered.

© 2024 UnitedHealthcare

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 member, the health of the member and the unborn child) in serious jeopardy
- Serious impairment to bodily functions
- 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 1 business day of notification.

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

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

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

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

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

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 exam
- 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.

Noncovered items include:

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

© 2024 UnitedHealthcare

Parenting/child birth education programs

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

Voluntary sterilization

In-network treatment with consent is covered. Before a member can get a tubal ligation or vasectomy, they first must give consent 30 days before surgery, be mentally competent and be at least 21 years old at the time of consent. Out-of-network services require prior authorization. View the ODM regulations for more information on sterilization.

Care coordination/ health education

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

The program goals are to:

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

Our program makes available population-based, condition-specific health education materials, websites, interactive mobile apps and newsletters that include recommended routine appointment frequency, necessary testing, monitoring and self-care. We send health education materials, based on 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 on the findings from our Health Education, Cultural and Linguistic Group Needs Assessment (GNA) and will identify the health education, cultural and linguistic needs.

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
- Skilled nursing facility (SNF) admissions
- Admissions following outpatient surgery
- Admissions following observation

Hearing services

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

Hospice

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

© 2024 UnitedHealthcare

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 hospice at the member's home during a medical crisis. A medical crisis is when a member requires continuous nursing care to manage symptoms.

Respite hospice

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

Inpatient hospice

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

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

Laboratory

Labcorp is the preferred lab care provider. Contact **Labcorp** directly.

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

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

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

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

Maternity/pregnancy/ well-child care

Pregnancy Risk Assessment Form (PRAF)

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

The Prenatal Risk Assessment Form (PRAF) is important for care and referral of patients. The PRAF is the preferred method of submission through the ODM online notification of pregnancy system: NurtureOhio. The PRAF ensures moms receive prompt care and support needed and it links the member to needed services on their first prenatal visit. There are multiple benefits to submitting the electronic PRAF in the NurtureOhio Portal:

- Serves as pregnancy notification to managed care plans and initiation of timely health care and connection to added resources, like care management, important for at-risk pregnancies
- It automatically notifies the Ohio Department of Job and Family Services County Office, and Home Health Care provider of the pregnancy, need for progesterone and any other need indicated on the form
- Allows for an Ohio Board of Pharmacy approved progesterone prescription to be printed and faxed to the appropriate pharmacy

© 2024 UnitedHealthcare

- Allows care provider staff updates by multiple users prior to submission
- Maintains a pregnant member's Medicaid eligibility without disruption in coverage, equating to prompt care provider payment for services throughout pregnancy

Care provider reimbursement opportunities

UnitedHealthcare Community Plan reimburses $90 for each PRAF submitted electronically through the NurtureOhio site. Use HCPCS code of H1000 + 33 Modifier when billing.

UnitedHealthcare Community Plan reimburses a $12.11 for each faxed/paper submission to Healthy First Steps at 1-877-353-6913. Use HCPCS code H1000 when billing.

The PRAF must be received by UnitedHealthcare Community Plan within 5 business days of the patient visit.

Changes in member condition

Bill us each time your office completes a new PRAF due to change in the member conditions.

Submitting the PRAF

- Open the NurtureOhio website to access the PRAF
- Instructions are available at medicaid.ohio.gov/provider/praf
- Users must be registered in the Medicaid Information Technology System (MITS). For username or password issues, visit ohmits.com.
- Difficulties with NurtureOhio, email: progesterone_pip@medicaid.ohio.gov
- The paper version of the PRAF can also be faxed to Healthy First Steps at 1-877-353-6913

HFS-Maternal care model

The HFS-Maternal care model strives to increase early identification of expectant mothers and facilitate case management enrollment. Provided case management services include:

- Assessing the member's risk level and provide member-specific needs that support the care provider's plan of care
- Helping members understand the importance of early and ongoing prenatal care and direct them to receiving it
- Providing multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care
- Increasing the member's understanding of pregnancy and newborn care
- Encouraging pregnancy and lifestyle self-management and informed healthcare decision-making
- Encouraging appropriate pregnancy, postpartum and infant care provider visits
- Fostering a care provider-member collaboration before and after delivery as well as for nonemergent settings
- Encouraging members to stop smoking with our Quit for Life tobacco program
- Helping identify and build the mother's support system including referrals to community resources and pregnancy support programs
- Acting as a liaison between members, care providers and UnitedHealthcare for care coordination

Pregnancy/maternity

Evaluate OB needs using the criteria indicated on the Pregnancy Risk Assessment Form (PRAF). Submit the form to the Nurture site or fax to HFS at 1-877-353-6913. 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 member has been a UnitedHealthcare Community Plan member for 3 or more consecutive months or had 7 or more prenatal visits. Medicaid does not consider ultrasounds medically necessary if they are done only to determine the fetal sex or provide parents with a photograph of the fetus. We allow the first 3 obstetrical ultrasounds per pregnancy.

The fourth and subsequent obstetrical ultrasound procedures will only be allowed for identified high-risk members. High-risk member claims must include the corresponding diagnosis code.

 © 2024 UnitedHealthcare

For prior authorization maternity care, including out-of-plan and continuity of care, call **1-800-600-9007** or go to **UHCprovider.com/paan.** For more information about prior authorization requirements, go to **UHCprovider. com/ ohcommunityplan** > **Prior Authorization and Notification Resources.**

Pregnant UnitedHealthcare Community Plan members should receive care from UnitedHealthcare Community Plan care providers only. UnitedHealthcare Community Plan considers exceptions to this policy if both of the following apply:

1. The member was in their second or third trimester of pregnancy when they became a UnitedHealthcare Community Plan member
2. If they have an established relationship with a nonparticipating obstetrician

UnitedHealthcare Community Plan must approve all out-of-plan maternity care.

A UnitedHealthcare Community Plan member does not need a referral from their 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.

Maternity admissions

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

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

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

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

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

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

A CNM must identify a licensed care provider or 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 N.P., P.A. 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 birth parent and their newborn. Post-discharge care is based on accepted maternal and neonatal physical assessments and consists of a minimum of 2 visits. At least 1 visit is in the home. 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 postpartum follow-up. The

© 2024 UnitedHealthcare

attending care provider decides the location and post-discharge visit schedule.

Newborn enrollment

The hospital must 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. It is supported by the US DHHS, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

The Bright Futures Guidelines informs all preventive care screenings and well-child visits. You may incorporate Bright Futures into health programs such as home visits, child care and school-based health clinics. 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 based on 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
- 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 they were told before the surgery the procedure will result in permanent sterility.

Find the form on the Ohio Department of Medicaid website: medicaid.ohio.gov.

See “Sterilization consent form” section below for more information.

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. You cannot bill members if you do not submit consent forms.

Pregnancy termination services

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

© 2024 UnitedHealthcare

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

Sterilization and hysterectomy procedures

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

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

Sterilization informed consent

A member has only given informed consent if the 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

- 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.
- Complete your statement section 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 Ohio Department of Medicaid website: medicaid.ohio.gov.

Have 3 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 case management

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

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

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

© 2024 UnitedHealthcare

Inhaled nitric oxide

Use the NRS guideline for inhaled nitric oxide (iNO) therapy at **UHCprovider.com** > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > **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 and Notification > **Oncology**. Or call **1-888-397-8129** Monday–Friday 7 a.m.–7 p.m. CT.

Pharmacy

Pharmacy Preferred Drug List

UnitedHealthcare Community Plan determines and maintains its Preferred Drug List (PDL) of covered medications. This list applies to all UnitedHealthcare Community Plan of Ohio 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 nonpreferred medication, call Pharmacy Prior Authorization at **1-800-310-6826** or use the online Prior Authorization and Notification tool on the UnitedHealthcare 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**.

Single pharmacy benefit manager

The single pharmacy benefit manager (SPBM) is a specialized managed care program operating as a prepaid ambulatory health plan (PAHP) that provides pharmacy benefits for the entire Medicaid managed care population (excluding MyCare Ohio members). ODM 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 conducts actual acquisition cost surveys, cost of dispensing surveys and performs oversight and auditing of the SPBM. Myers and Stauffer, LC is the PPAC vendor.

The SPBM consolidates the processing of pharmacy benefits and maintains a pharmacy claims system that will integrate with the Ohio Medicaid Enterprise System (OMES), new MCOs, pharmacies and prescribers. The SPBM also works 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 care provider and prescriber administrative burden, by using 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 are automatically enrolled with the SPBM under a 1915(b) waiver. Additionally, Gainwell Technologies is required to contract with all enrolled pharmacy providers who are willing to accept the SPBM contract terms, resulting in a broad pharmacy network that will ensure access for all members statewide.

SPBM provides coverage for medications dispensed from contracted pharmacy providers. Provider-administered medications supplied by non-pharmacy providers (such as hospitals, clinics and physician practices) will continue to be covered by the MCOs or the OhioRISE plan, as applicable.

For more information about the SPBM or PPAC initiatives, please email medicaidspbm@medicaid.ohio.gov or visit the SPBM website at spbm.medicaid.ohio.gov.

© 2024 UnitedHealthcare

Specialty pharmacy medications

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

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

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

Radiology

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

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

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

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

- Emergency Room
- 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** > Sign In
- **Phone** – **1-866-889-8054** from 8 a.m.–5 p.m. CT, Monday–Friday. Make sure the medical record is available. An authorization number is required for each CPT code.

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

Screening, brief interventions and referral to treatment services

Screening, brief interventions and referral to treatment (SBIRT) services are covered when:

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

What is included in SBIRT?

Screening

With just a few questions on a questionnaire or in an interview, you can identify members who have alcohol or other drug/substance use problems and determine

© 2024 UnitedHealthcare

how severe those problems already are. Three of the most widely used screening tools are the Alcohol Use Disorders Identification Test (AUDIT), the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and the Drug Abuse Screening Test (DAST).

Brief intervention

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

Referral to treatment

Refer members whose screening indicates a severe problem or dependence to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. This includes coordinating with the alcohol and drug program in the county where the member resides for treatment.

SBIRT services will be covered when all are met:

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

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

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

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

Medication-assisted treatment

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

To prescribe Buprenorphine, you must 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 care provider, call the number on the back of the member's health plan ID card or search for a behavioral health professional on **liveandworkwell.com**.

To find a medical MAT care provider in Ohio:

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

If you have questions about MAT, please call Provider Services at **1-800-600-9007** and enter your TIN. Say "Representative," and "Representative" a second time. Then say "Something Else" to speak to a representative.

© 2024 UnitedHealthcare

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.

Treatment helpline

Free, confidential service for UnitedHealthcare Community Plan members. Specialized licensed clinicians provide treatment advocate services 24 hours a day, 7 days a week.

Phone: **1-855-780-5955**

Website: **liveandworkwell.com**

For other questions, call **1-888-362-3368.**

Tuberculosis screening and treatment

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

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

Vision

All members receive an eye exam every 12 months. They 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.

Vision services are provided through March Vision. Visit marchvisioncare.com or call 1-844-756-2724.

Waiver programs

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

The human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) in-home waiver services program is available to members who would otherwise require long-term institutional services.

Identification

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

Referral

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

Continuity of care

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

© 2024 UnitedHealthcare

Other federal waiver programs

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

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

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

For behavioral health and substance use disorder authorizations, please contact Optum at **1-866-209-9320.**

If you have questions, go to Ohio's prior authorization page at **UHCprovider.com/OHcommunityplan** > Medicaid > **Prior Authorization and Notification Resources.**

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

© 2024 UnitedHealthcare

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent pre-service	Within 5 working days of receipt of medical record information required but no longer than 14 calendar days of receipt	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/expedited pre-service	Within 3 days of request receipt	Within 3 days of the request	Within 3 days of the request
Concurrent review	Within 24 hours or next business day following	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within 2 business days
Retrospective review	Within 30 calendar days of receiving all pertinent clinical information	Within 24 hours of determination	Within 24 hours of determination and member notification within 2 business days

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 or phone review for each day's stay using InterQual, CMS or other nationally recognized guidelines to help clinicians make informed decisions in many health care settings. You must work with UnitedHealthcare Community Plan for all information, documents or discussion requests. This includes gathering clinical information on a member's status for concurrent review and discharge planning. When criteria are not met, the case is sent to a medical director.

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

Concurrent review details

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

Your cooperation is required with all UnitedHealthcare Community Plan requests for information, documents or discussions related to concurrent review and discharge planning. This includes:

- Primary and secondary diagnosis
- Clinical information
- Care plan
- Admission order
- Member status
- Discharge planning needs
- Barriers to discharge
- Discharge date

When available, provide clinical information by access to electronic medical records (EMR).

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

UnitedHealthcare Community Plan uses MCG (formally Milliman Care Guidelines), CMS guidelines or other nationally recognized guidelines to assist clinicians

© 2024 UnitedHealthcare

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
- Ambulatory facilities

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

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

We don't consider experimental treatments medically necessary.

Determination process

Benefit coverage for health services is determined by the member 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.

Evidence-based clinical guidelines

UnitedHealthcare Community Plan uses evidence-based clinical guidelines to guide our quality and health management programs. For more information on our guidelines, go to **UHCprovider.com**.

Medical and drug policies and coverage determination guidelines

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

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.

Reimbursement

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

- Determine if the member is eligible on the date of service by using the UnitedHealthcare Provider Portal on **UHCprovider.com**, contacting UnitedHealthcare Community Plan's Provider Services department, or the Ohio Medicaid Eligibility System

© 2024 UnitedHealthcare

- 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
- Noncovered services
- Services provided to members not enrolled on the date(s) of service

Second opinion benefit

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the 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. Care providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward their report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a nonparticipating care provider. The participating care provider should contact UnitedHealthcare Community Plan at **1-800-600-9007.**
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations
- If follow-up care is recommended, the member meets with the PCP before receiving treatment

Services not covered by UnitedHealthcare Community Plan

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

- Any health care not given by a doctor from our list (except emergency treatment)
- Any care covered by Medicaid but not through managed care:
  - Prescription drugs
  - Long-term care services in a nursing home
  - Nursing facility services
  - Intermediate care facilities for members with mental handicap
  - Home-and community-based waiver services
  - Dental services, except for those performed in an outpatient setting. UnitedHealthcare
  - Community Plan covers the facility and anesthesia services when deemed medical necessary. Prior authorization is required
  - Residential inpatient hospice services
- Mental health and substance abuse care. This service is covered by Optum.
- Phones and TVs used when in the hospital
- Personal comfort items used in the hospital, such as a barber
- Contact lenses, unless used to treat eye disease
- Sunglasses and photo-gray lenses
- Ambulances, unless medically necessary
- Infertility services

Medicaid-excluded services

UnitedHealthcare Community Plan will not pay for services or supplies received that are not covered by Medicaid:

- Services that are experimental in nature and are not performed in accordance with standards of medical practice
- Services that are related to forensic studies
- Autopsy services
- Services for the treatment of infertility
- Abortion services that do not meet the criteria for coverage in accordance with Ohio Administrative Code rule 5160-17-01

© 2024 UnitedHealthcare

- Services pertaining to a pregnancy that is a result of a contract for surrogacy services
- Assisted suicide and other measures taken actively with the specific intent of causing or hastening death
- Services that do not meet the criteria for coverage set forth in any other rule in Ohio Administrative Code 5160

UnitedHealthcare Community Plan will not pay for services or supplies received that are not covered by Medicaid:

- All services or supplies that are not medically necessary
- Paternity testing
- Services to find cause of death (autopsy) or services related to forensic studies
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual

Services requiring prior authorization

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:

- Verify eligibility at **UHCprovider.com/eligibility** or by calling Provider Services. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- Obtain a prior authorization from the UnitedHealthcare Provider Portal
- Inpatient psychiatric prior authorization requests for members under the age of 21 should be submitted to the OhioRISE Plan. UnitedHealthcare Community Plan will deny these authorization requests because this service is covered by another payer.

If you have questions, please call the UnitedHealthcare Connectivity Help Desk at **1-866-842-3278,** option 3, 7 a.m.-8 p.m. ET, Monday–Friday.

Direct access services – Native Americans

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

Prior authorization submission

Online - You can submit prior authorization requests online using the Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal. Sign in to the UnitedHealthcare Provider Portal by going to **UHCprovider.com** and clicking on the Sign in button in the top-right corner. Then, select the Prior Authorization and Notification tile on your Link dashboard. For additional information, go to **UHCprovider.com/ohcommunityplan >** Prior Authorization and Notification Resources.

Phone - 1-800-600-9007

For after-hours requests, follow the prompts for "Prior Authorization Requests."

Forms - Prior authorization forms are available at **UHCprovider.com/ohcommunityplan > Forms, Billing and Reference Guides.**

Referring - PCPs, OB-GYN and other consulting physicians should refer members to participating care providers. If you're referring a member for lab services, please use a participating lab. Referrals to out-of-network labs require prior authorization. Chromosome or genetic testing, also require prior authorization.

Call **1-800-600-9007** for assistance with prior authorizations, admissions, discharges and coordination of care from 8 a.m.–5 p.m. CT, Monday–Friday. Our on-call staff is available 24 hours a day, 7 days a week for emergency prior authorization purposes. If you need a peer-to-peer review, call **1-800-955-7615** or email **uhc_peertopeer_scheduling@uhc.com.**

© 2024 UnitedHealthcare

Response timeframe

UnitedHealthcare Community Plan responds to prior authorization requests:

- **Urgent services –** within 48 hours for urgent services
- **Nonurgent services –** within 10 calendar days

This time period begins once we receive the request with all required information.

Our responses indicate whether the request is approved, denied or incomplete. If the prior authorization is denied, the response includes the specific denial reason.

If the prior authorization request is incomplete, the response includes the specific additional information required.

Peer-to-peer

Prior authorization requests are reviewed by a physician medical director prior to any denial. We base the review on the information the ordering care 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.

You may request a peer-to-peer consultation when a prior authorization request is denied. The peer-to-peer consultations are conducted with health care professionals who have clinical expertise in treating the member's condition, with the equivalent of higher credentials as the requesting/ordering care provider. The peer-to-peer consultation clearly identifies what documentation you must provide to obtain approval of the specific item, procedure or service; or a more appropriate course of action based upon accepted clinical guidelines.

Care provider appeals

You may request a care provider appeal if your prior authorization request is denied. The care provider appeal is separate from the peer-to-peer or member appeal processes. You may submit the appeal within 60 calendar days from the date of the initial notice of action. We respond to care provider appeals within 48 hours for urgent care services and within 10 calendar days for all other matters.

External medical review

The review process conducted by an independent, external medical review (EMR) entity that is initiated by a care provider who disagrees the decision to deny, limit, reduce, suspend or terminate a covered service for lack of medical necessity. Permedion is contracted by ODM to perform EMRs.

Requesting an EMR

To request an EMR, you must first appeal the decision to deny, limit, reduce, suspend or terminate a covered service for lack of medical necessity using our internal care provider appeal or claim dispute resolution process. Failure to exhaust the internal appeals or claim dispute resolution process results in your inability to request an EMR. EMR is only available to care providers for services delivered to members enrolled in Medicaid managed care and/or OhioRISE.

An EMR can be requested as a result of:

- A service authorization denial, limitation, reduction, suspension or termination (includes pre-service, concurrent or retrospective authorization requests) based on medical necessity
- A claim payment denial, limitation, reduction, suspension or termination based on medical necessity

Denials, limitations, reductions, suspensions or terminations based on lack of medical necessity include, but are not limited to, decisions made by UnitedHealthcare Community Plan where:

- Clinical documentation or medical record review is required in making the decision to deny (includes preservice, concurrent and retrospective reviews)
- Clinical judgement or medical decision making (i.e. referred to a licensed practitioner for review) is involved

© 2024 UnitedHealthcare

- A clinical standard or medical necessity requirement (e.g. InterQual®, MCG®, ASAM or OAC 5160-1-01, including EPSDT criteria, and/or the MCO's clinical coverage or utilization management policy or policies) is not met

We inform you of your option to request an EMR as part of any denial notification.

Submitting an EMR

The request for an EMR must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals or care provider claim dispute process has been exhausted.

Complete the Ohio Medicaid MCE External Review Request form located at gainwelltechnologies.com/permedion > Ohio Medicaid and submit to Permedion together with the required supporting documentation including:

- Copies of all adverse decision letters (initial and appeal)
- All medical records, statements (or letters) from treating health care providers, or other information that you want considered in reviewing case

Upload the request form and all supporting documentation to Permedion's provider portal located at ecenter.hmsy.com. If you are a new user, send your documentation through secured email at imr@gainwelltechnologies.com to establish portal access. Note: When requesting an EMR, you may submit new or other relevant documentation as part of the EMR request.

If Permedion determines that your EMR request is not eligible for an EMR and you disagree, ODM or its designee will determine if an EMR is appropriate.

The EMR process does not interfere with your right to request a peer-to-peer review, a member's right to request an appeal or state hearing or the timeliness of appeal and/or state hearing resolutions.

Once you have submitted the EMR request, you do not need to take further action.

EMR Results

- After the EMR request has been submitted, Permedion shares the documentation with UnitedHealthcare Community Plan
- Following the review of the information, we may reverse the denial, in part or in whole
  - If reversed, you will receive a written decision within 1 business day for expedited prior authorization requests and 5 business days for standard prior authorization requests and notify Permedion
  - If we decide to reverse the decision in part, the remaining will continue as an EMR
- Permedion has 30 calendar days for a standard request and 3 business days for an expedited request to perform its review and issue a decision
- If the decision reverses the coverage decision in part or in whole, that decision is final and binding
- If the decision agrees with UnitedHealthcare Community Plan's decision to deny, limit, reduce, suspend or terminate a service, that decision is final
- For reversed service authorization decisions, we authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when we receive the EMR decision
- For reversed decisions associated solely with care provider payment (i.e. the service was already provided to the member), we pay for the disputed services within the timeframes established for claims payment in Appendix L of the Provider Agreement

Call Permedion at 1-800-473-0802 (option 2) for more information about the EMR.

Utilization management guidelines

Call **1-800-600-9007** to discuss the guidelines and utilization management.

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

© 2024 UnitedHealthcare

underuse. The UM staff does not receive incentives for UM decisions.

UM appeals

UM appeals are considered medically necessary appeals. They contest UnitedHealthcare Community Plan's UM decisions. This includes such things as UnitedHealthcare Community Plan's admission, extension of stay, level of care or other health care services determination. They do not include benefit appeals, which are appeals for noncovered 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 13** for more details.

 © 2024 UnitedHealthcare

Chapter 5: Care Management

Key contacts

Topic	Links	Phone Number
Care Coordination Program		1-800-508-2581

The UnitedHealthcare Community Plan and state of Ohio Care Coordination program serves to optimize the health and well-being of its' members with acute gaps in care, Social Determinants of Health (SDOH) needs, chronic illness or at high risk for adverse medical outcomes. This program also serves to encompass the full spectrum of care coordination activities, ranging from short-term assistance to meet care gaps to longer-term, intensive and holistic care coordination for members with the most intense needs.

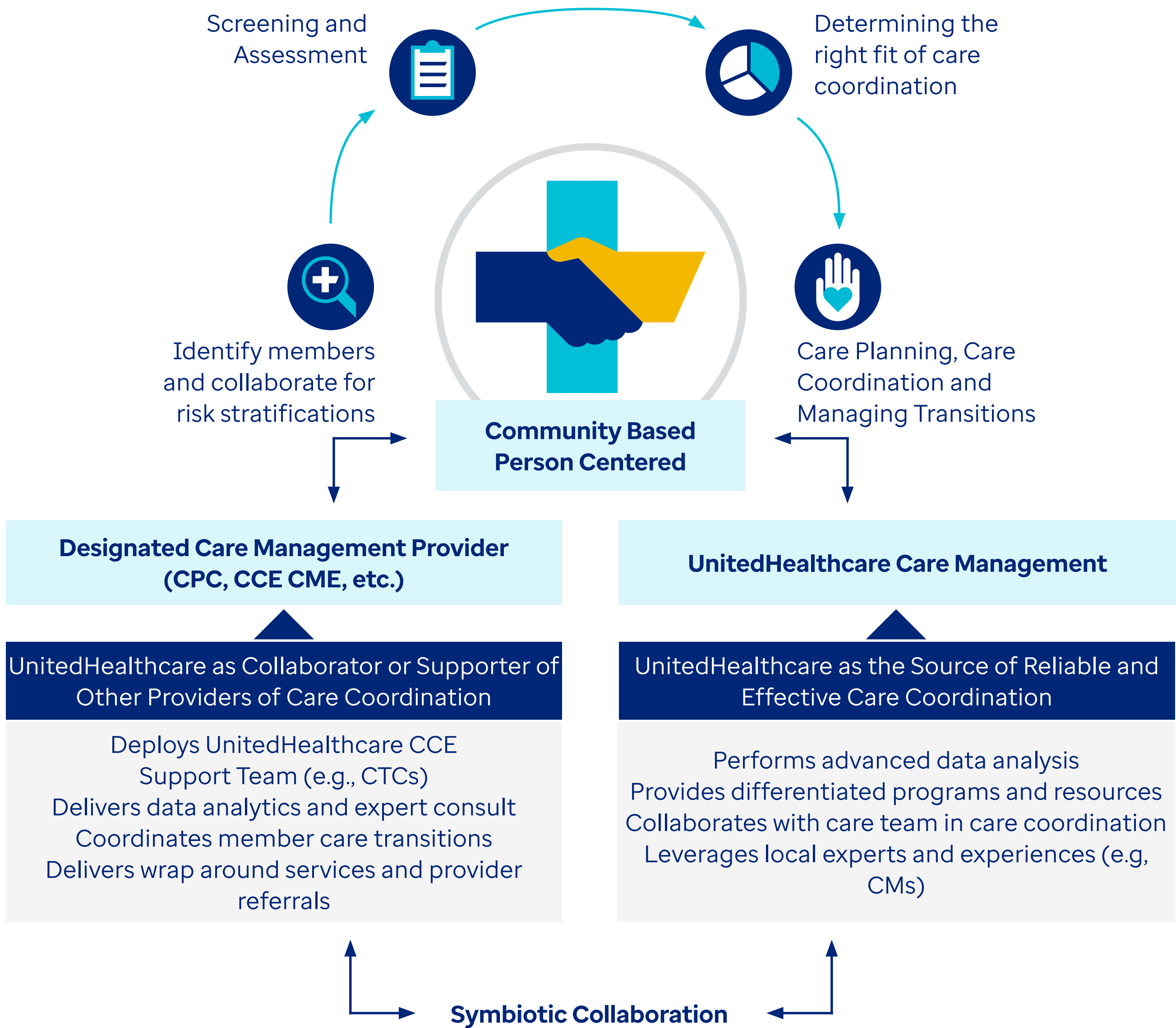
To accomplish this, UnitedHealthcare developed an integrated, clinical management model that is member-centric and facilitates collaboration between our members and their health care teams. These initiatives focus on identifying and addressing physical, behavioral, psychosocial and social determinants of health needs of our members, while also supporting member goals and choices through a person-centered, trauma-informed and culturally attuned and equitable approach.

Care model

The care model encourages member self-management skills, active decision-making and participation in interventions personalized to their risk profile and conditions. It serves as the foundation to ensure that our members have access to quality care coordination, whether the member is receiving care coordination from UnitedHealthcare, an external Care Coordination Entity (CCE) or the OhioRISE Plan and their contracted Case Management Entity (CME). The care model works to preserve the existing relationships between members and any involved care coordination entities and leverages the strengths of these entities through collaboration, partnership and active support.

UnitedHealthcare Community Plan retains care coordination services for all Medicaid members in the state of Ohio except for children under the age of 19 who reside in 1 of 34 counties in central and southeastern Ohio. Partners for Kids (PFK) is delegated to assume care coordination responsibilities for children with the highest needs in those counties.

© 2024 UnitedHealthcare



© 2024 UnitedHealthcare

All UnitedHealthcare Community Plan members have direct access to assistance via our Care Coordination program. To refer a member, call **1-800-508-2581.**

Care provider responsibility with termination of services - notification of Medicare noncoverage

As a participating UnitedHealthcare skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (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 3 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, deliver the NOMNC no later than 2 days before the end of coverage. If services are expected to end in fewer than 2 days, deliver the NOMNC upon admission. If there is more than a 2-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.

How to deliver the NOMNC

You 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

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. Members may call Livanta at 1-888-524-9900.

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 > Forms & notices > Beneficiary Notices Initiative (BNI) > MA Expedited Determination Notices.

© 2024 UnitedHealthcare

Chapter 6: Early Periodic Screenings, Diagnosis and Treatment (EPSDT)/prevention

Key contacts

Topic	Links	Phone Number
EPSDT	medicaid.ohio.gov	1-800-324-8680
Vaccines for Children	odh.ohio.gov	1-800-282-0546

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

Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members up to age 21, including pregnant members. EPSDT screening including the following:

- Immunizations
- Hearing
- Vision
- Speech screening and nutritional assessments
- Dental screening
- 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.

For more information on Healthchek visit medicaid.ohio.gov > Families and Individuals > Programs and Initiatives > Healthchek.

Coding guidelines

To receive proper payment for the Healthchek - EPSDT services you provide, bill for:

- Healthchek – EPSDT services using the appropriate preventive medicine CPT codes and ICD-10-CM diagnosis codes
- All services provided

The **Healthcheck/EPSDT Service Coding Guidelines table** includes the billing codes for some of the most common provider services that are payable when they are medically necessary and performed as part of a periodic Healthchek - EPSDT exam.

*Interperiodic examinations will be covered when medically necessary to determine the existence of suspected physical or mental illnesses.

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

© 2024 UnitedHealthcare

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.

Continuity of Care

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

Ohio Early Intervention

Ohio Early Intervention is a statewide system that provides coordinated services to parents of infants and toddlers with disabilities or developmental delays in Ohio.

Referring a child

Refer a child for services if the child has a visual, hearing, severe orthopedic impairment, any combination of these impairments or if the child potentially requires other developmental intervention services.

How to refer

Visit ohioearlyintervention.org.

Next steps

The Ohio Early Intervention team will evaluate your request to determine eligibility. Then a First Steps service coordinator will be assigned to help the child's parents through the process. The assigned coordinator 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 UnitedHealthcare Community Plan care manager 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
- 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. 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.

© 2024 UnitedHealthcare

Pediatric services

During the Healthcheck 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 UM department.

SAFE examinations

The Sexual Assault Forensic Examinations (SAFE) program, through the Ohio Attorney General's Office, provides reimbursement for a comprehensive medical assessment related to sexual trauma. It covers related laboratory studies for gathering evidence of abuse as well as antibiotics to prevent sexually transmitted infections.

Information on the SAFE program is located at ohioattorneygeneral.gov or call the Ohio Attorney General's office at 1-614-466-5610.

Targeted case management

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

Identification

The 5 target populations include:

- 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 TB, HIV/AIDS, etc., or who have been exposed to communicable diseases, until the risk of exposure has passed

Referral

Members 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 care provider and for determining the medical necessity of diagnostic and treatment services recommended by the TCM care provider that are covered services under the contract.

Vaccines for Children

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.
Phone: 1-800-282-0546

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

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

© 2024 UnitedHealthcare

Chapter 7: Value-added services

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com**	**1-800-600-9007**
Health First Steps® Rewards	**uhchealthyfirststeps.com**	**1-800-599-5985**
Value-added services	**UHCCommunityPlan.com/oh/medicaid/ community-plan**	**1-800-600-9007**

We offer the following services to our UnitedHealthcare Community Plan members. if you have questions or need to refer a member, call UnitedHealthcare Provider Services at **1-800-600-9007** unless otherwise noted.

In accordance by 42 CFR 438.3(e){1)(i), UnitedHealthcare Community Plan may elect to provide services in addition to those covered under the Ohio Medicaid fee-for-service (FFS) program. Before UnitedHealthcare Community Plan notifies potential or current members of the availability of those services, UnitedHealthcare Community Plan will first notify ODM of its plans to make such services available.

If any value-added service will be decreased or ceased, we provide a 90-day advance notice to ODM, members and care providers.

Adult pain management/ chiropractic services

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

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

Use the following steps to access the fee schedules online:

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

For more information on chiropractic care, go to **myoptumhealthphysicalhealth.com** or call **1-800-873-4575**

Assurance Wireless

In partnership with Assurance Wireless, we promote the federal Lifeline program to our members. This enables members to receive a free smartphone with an unlimited data plan and unlimited text messaging.

Chronic condition management

We use educational materials and newsletters to remind members to get their immunizations, check-ups and 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 on 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. They provide information necessary to successfully manage their condition and live a healthy lifestyle.

Members at highest risk with conditions such as asthma, congestive heart failure, diabetes, chronic obstructive pulmonary disease and coronary artery disease 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 illnesses.

© 2024 UnitedHealthcare

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.

Referral

PCPs may make referrals to support practice-based interventions by contacting the Health Services team at **1-800-600-9007.**

Dental

We offer one routine dental exam and cleaning every 6 months to improve the overall health of our members.

Discount and reward card

While UnitedHealthcare Communtiy Plan is not responsible for outpatient pharmacy services, we provide members debit cards to purchase over-the-counter medications not covered by the Ohio Medicaid program:

The discount and reward card provides discounts on health and wellness items at local stores in the OTC network. The card can be loaded with incentives for taking part in the member advisory council meetings as well as completing health and wellness activities such as the tobacco cessation program. Rewards are placed on the card after members attend a member advisory council meeting or at completion of a wellness activity.

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.

Health First Steps Rewards

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

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

How it works

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

Members enter information about their pregnancy and upcoming appointments online. They 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

Housing navigator services

This program provides personalized screening and support for members at risk for housing insecurity. The services include screening, identification of housing options, assistance with applications and wrap-around support to promote housing stability.

Hypoallergenic bedding

Improve asthma control and reduce allergies caused by dust or synthetic bedding. Controlling these issues can

© 2024 UnitedHealthcare

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 decides 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.

In lieu of services policy

UnitedHealthcare Community Plan of Ohio does not have any In Lieu of Services (ILOS). UnitedHealthcare Community Plan of Ohio will not require a member to use an ODM-approved ILOS as an alternative to a service covered under the Ohio Medicaid plan. This is in accordance with 42 CFR 438.3(e)(2).

Mindfulness: Be here now

We deliver this program to social worker and community partners. It focuses on caregiver well-being. The program 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 care providers
- **SMART Patient** allows users to track important numbers such as blood pressure, record appointments and record doctors' orders. It also help them view educational videos.
- **DocGPS** lets users search UnitedHealthcare Community Plan's provider network and obtain travel directions to a care provider's location. The app lets them call a care provider by tapping on the search result.

Myuhc.com

Members can print an ID card, review benefits, find a doctor, clinic or hospital, take a personal health assessment and keep track of coverage.

NurseLine

NurseLine is available at no cost to our members 24 hours a day, 7 days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the ER or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **1-800-542-8630** to reach a nurse.

Ohio Statewide Family Engagement Center

This program provides training to families to help them understand ways to support their child's learning, emotional health and plans for the future.

Ohio Quitline tobacco cessation rewards program

Any member who enrolls into the Ohio Quitline is eligible for the rewards program. We offer reward dollars, loaded directly to a rewards card, to use for many helpful health and wellness items. To reach the Ohio Quitline, visit ohio.quitlogix.org or call 1-800-QUITNOW.

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, this program produces an average quit rate of 25.6% for a Medicaid population.

© 2024 UnitedHealthcare

It also has an 88% member satisfaction. Quit for Life is for members 18 years and older.

Pilot incentive programs

We offer pilot incentive programs as a short-term program in a specified region(s) or with a defined member population that is measured to determine if it meets the specified program goal. A health care quality improvement activity is a structured quality improvement activity meeting the requirements specified in 45 CFR158.150. A trial incentive program is a time limited monetary or non-monetary reward offered to a member who complies with the intended goals of the program as outlined (e.g., recommended health screenings) in the submission.

Following approval by ODM, we engage appropriate care provider partners to participate in pilot programs, with a focus on structured quality improvement. Trial incentive programs may be employed in a pilot program, dependent on the overall project aim. We will not discriminate against members based on race, national origin, limited English proficiency, gender, disability, chronic disease, whether a person resides or receives services in an institutional setting, frailty, health status or other prohibited basis. We implement incentive programs to ensure equal access for members eligible for the proposed incentive program.

UHC Doctor Chat — virtual visits

Members have access to UHC Doctor Chat, an innovative, chat-first platform supported by live video to connect with a doctor from their computer or mobile device for nonemergent care. A board-certified emergency medicine physician assesses the severity of the enrollee's situation, provides treatment (including prescriptions) and recommends 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 expand and deliver access to care.

UHC Latino

Latino | UnitedHealthcare (uhc.com)
our award winning Spanish language site, provided more than 600 pages of health and wellness information and reminders on important health topics.

Vision

We offer 1 comprehensive wellness exam every 12 months to detect early signs of eye disease for appropriate treatment and preservation of vision. Members have a choice of eyeglasses with a $25 benefit toward frames or $150 toward contact lenses annually.

Women, Infants and Children Supplemental Nutrition

State-funded program

The state also has programs such as women, infants and children (WIC) supplemental nutrition programs to help with nutritional needs for low-income families.

For more information about WIC, call 1-614-644-8006 or go to odh.ohio.gov/wps/portal/gov/odh/know-ourprograms/women-infants-children.

© 2024 UnitedHealthcare

Chapter 8: Mental health and substance use

Key contacts

Topic	Link	Phone Number
Behavioral health/Provider Express	**providerexpress.com**	**1-800-888-2998**
Provider Services	**UHCprovider.com**	**1-877-614-0484**

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

The Optum Behavioral Health National Network 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 obtain an NPI, refer to the ODM NPI Reference Guide at medicaid.ohio.gov.

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 use disorder diagnoses, symptoms, treatments, prevention and other resources in one place.

liveandworkwell.com, accessed through a link on **myuhc.com** or **providerexpress.com,** includes mental health and well-being information plus articles on health conditions, addictions and coping. It also provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.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 address 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
  - Day treatment
  - Intensive outpatient
  - Medication management
  - Outpatient therapy (individual, family or group), including injectable psychotropic medications
  - SUD outpatient treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - SUD residential treatment
  - Electroconvulsive therapy
  - Telemental health

© 2024 UnitedHealthcare

- Rehabilitation services
- Day treatment/intensive outpatient
- Dual-disorder residential
- Intermediate residential (SUD)
- Short-term residential
- Community support
- Psychiatric residential rehabilitation
- Secure residential rehabilitation

Eligibility

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

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 nonemergent services. Get prior authorization by going to **UHCprovider.com/priorauth,** calling **1-866-209-9320.**

Collaboration with other care providers

Coordination of care

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

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

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

Portal access

Website: **UHCprovider.com**

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

View the Prior Authorization list, find forms and access the care provider manual. Or call Provider Services at **1-877-614-0484** to verify eligibility and benefit information (available 8 a.m.–5 p.m. CT, Monday–Friday).

Website: **providerexpress.com**

Update your provider practice information, review guidelines and policies and view the national Optum Network Manual. Or call Provider Services at **1-877-614-0484.**

Claims

Submit claims using the CMS 1500 Claim Form (v 02/12) or UB-04 form, whichever is appropriate. Use applicable coding, including ICD diagnosis code(s), CPT, Revenue and HCPCS coding. Include all necessary data to process a complete claim. Find out more about filing claims in **Chapter 11**.

Addressing the opioid epidemic

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

Brief summary of framework

- **Prevention**
  Prevent OUD before they occur through pharmacy management, care provider 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

© 2024 UnitedHealthcare

- **Enhanced solutions for pregnant members and child** Prevent neonatal abstinence syndrome and supporting birth parents in recovery
- **Enhanced data infrastructure and analytics** Identify needs early and measure progress

Increasing education and awareness of opioids

You must be up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep OUD-related trainings and resources available on our UnitedHealthcare 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 need behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, "The Role of the Health Care Team in Solving the Opioid Epidemic," and "The Fight Against the Prescription Opioid Abuse Epidemic." While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing and key resources.

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

Prescribing opioids

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

Expanding medication assisted treatment access and capacity

Evidence-based MAT treatment is central to OUD treatment. MAT takes a chronic condition approach and incorporates medication use in addition to other comprehensive services, such as counseling, cognitive behavioral therapies and recovery support. 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"
3. Select under "Specialty Directory and Tools" the option of Optum Behavioral Health, EAP, Worklife & Mental Health Services
4. Click on "Search for a Behavioral Health Provider"
5. Enter "(city)" and "(state)" 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.

OhioRISE

OhioRISE (Resilience through Integrated Systems and Excellence) is a specialized Medicaid managed care program for children and youth with complex behavioral health and multisystem needs. OhioRISE aims to expand access to in-home and community-based behavioral health services and supports.

An individual enrolled in OhioRISE has their physical health services covered by their managed care organization or fee-for-service Medicaid, and the OhioRISE plan, Aetna Better Health of Ohio, covers their behavioral health services. The MCO is included in the child or youth's care coordination team, whenever their inclusion is requested by the member and family. OhioRISE care coordinators can also help OhioRISE members and families access support from their MCO.

© 2024 UnitedHealthcare

Eligibility

- Enrolled in Ohio Medicaid – either managed care or fee-for-service
- Be age 20 or younger at the time of enrollment
- Not be enrolled in a MyCare Ohio plan
- Meet a functional needs threshold for behavioral health care, as identified by the Child and Adolescent Needs and Strengths (CANS) assessment tool, or an inpatient in a hospital with a primary diagnosis of mental illness or substance use disorder

Services

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

- Care coordination: Depending on a child or youth's needs, they will receive one of three levels or "tiers" of care coordination. This service is delivered by Aetna or their care management entities (CMEs) in a child or youth's community. OhioRISE members are assigned a care coordinator who has experience working with children, youth, and their families. Care coordinators assist young people and their families with:
  - Making a care plan to ensure the young person's behavioral health needs are met.
  - Helping young people access services and resources.
  - Talking to and providing information to other providers who are involved in the child or youth's care.
- Intensive home-based treatment (IHBT) – Provides intensive, time-limited behavioral health services for children, youth, and families in their homes. IHBT helps stabilize and improve a young person's behavioral health.
- Psychiatric residential treatment facility (PRTF) – PRTFs are facilities, other than hospitals, that provide inpatient psychiatric services to individuals 20 years or younger. Ohio's PRTF service will keep young people with the most intensive behavioral health needs in-state and closer to their families and support systems. This service will be available in-state in the near future.
- Behavioral health respite – Provides short-term, temporary relief to a child or youth's primary caregivers in a home or community-based environment.
- Flex funds – Provides funding of $1,500 in a 365-day period to purchase services or items that address a need in a child or youth's service plan. These items should otherwise not be provided through Medicaid. Funds must be used to purchase services or items that will:
  - Reduce the need for other Medicaid services,
  - Keep young people and their families safe in their homes, or
  - Help a child or youth be better integrated into the community.

For additional services available for youth enrolled in the OhioRISE waiver, see Ohio Administrative Code Rule 5160-59-05.

Additional information regarding who to bill for behavioral health services provided to youth who are enrolled in the OhioRISE plan is located in the OhioRISE Mixed Services Protocol on the OhioRISE website.

The OhioRISE resources for community partners and providers website also contains helpful billing information for providers.

Aetna Better Health of Ohio can be reached by calling 1-833-711-0773 or emailing OHRISE-Network@aetna.com.

 © 2024 UnitedHealthcare

Chapter 9: Member rights and responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	**UHCCommunityPlan.com/oh**	**1-800-895-2017,** TTY **711**
Member handbook	**UHCCommunityPlan.com/oh** > Community Plan > Member benefits	**1-800-895-2017,** TTY **711**

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 protected health information

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

Accounting of disclosures

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

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

Right to request restrictions

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

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

© 2024 UnitedHealthcare

could endanger them. Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Member right 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.

Members rights

Members have the right to:

- Request information on advance directives
- Be treated with respect, dignity and privacy
- Receive courtesy and prompt treatment
- Receive cultural assistance, including having an interpreter during appointments and procedures
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered
- Know the qualifications of their care provider
- Give their consent for treatment unless unable to do so because life or health is in immediate danger
- Discuss any and all treatment options with you
- Refuse treatment directly or through an advance directive
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do
- Receive medically necessary services covered by their benefit plan
- Receive information about in-network care providers and practitioners, and choose a care provider from our network
- Change care providers at any time for any reason
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response
- Tell us their opinions and concerns about services and care received
- Register grievances or complaints concerning the health plan or the care provided
- Appeal any payment or benefit decision we make
- Review the medical records you keep and request changes and/or additions to any area they feel is needed
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, and talk with you when making decisions about their care
- Get a second opinion with an in-network care provider
- Expect care providers are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage
- Make suggestions about our member rights and responsibilities policies
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply

Member responsibilities

Members should:

- Understand their benefits so they can get the most value from them
- Show you their Medicaid member ID card
- Prevent others from using their ID card
- Understand their health problems and give you true and complete information
- Ask questions about treatment
- Work with you to set treatment goals
- Follow the agreed-upon treatment plan
- Get to know you before they are sick
- Keep appointments or tell you when they cannot keep them
- Treat your staff and our staff with respect and courtesy
- Get any approvals needed before receiving treatment
- Use the 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

© 2024 UnitedHealthcare

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

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

© 2024 UnitedHealthcare

Chapter 10: Medical records

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 could include any of the following items to determine compliance:

Topic	Contact
Confidentiality of record	Office policies and procedures exist for: • Privacy of the member medical record • Initial and periodic training of office staff about medical record privacy • Release of information • Record retention • Availability of medical record if housed in a different office location • Process for notifying UnitedHealthcare Community Plan upon becoming aware of a patient safety issue or concern • Coordination of care between medical and behavioral health care 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
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*

***Critical element**

© 2024 UnitedHealthcare

<table>
<tr><th>Topic</th><th>Contact</th></tr>
<tr><td>History</td><td>An initial history (for members seen 3 or more times) and physical is performed. It should include:
Medical and surgical history*
A family history that includes relevant medical history of parents and/or siblings
A social history that includes information about occupation, living situations, education, smoking, alcohol use and/or substance abuse use/history beginning at age 11
Current and history of immunizations of children, adolescents and adults
Screenings of/for:
Recommended preventive health screenings/tests
Depression
High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit
Medicare members for functional status assessment and pain
Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise, nutrition and counseling, as appropriate</td></tr>
<tr><td>Problem evaluation and management</td><td>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:
Time frame for follow-up visit as appropriate
Appropriate use of referrals/consults, studies and 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 and practitioner are documented</td></tr>
</table>

***Critical element**

© 2024 UnitedHealthcare

Member copies

A member or their representative is entitled to 1 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 5 years unless federal requirement mandate a longer time frame (i.e. immunization and TB records required for lifetime).

Medical record review

On an ad hoc basis, we conduct a review of our members' medical records. We expect you to achieve a passing score of 85% or better. To achieve this score, the medical records you maintain should contain an initial health assessment, including a baseline comprehensive medical history. This assessment should be completed in less than 2 visits, with ongoing physical assessments occurring on following visits. It should also include:

- Problem list with:
  - Biographical data with family history
  - Past and present medical and surgical intervention
  - Significant medical conditions with date of onset and resolution
  - Documentation of education/counseling regarding HIV pre- and post-test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions (or note if none are known)
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen 3 or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions
- Immunization record
- Tobacco habits, alcohol use and substance abuse (12 years and older)
- Copy of advance directive, or other document as allowed by state law, or note the member does not want one
- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits; diagnosis and treatment plans consistent with finding
- Lab and other studies as appropriate
- Member education, counseling and/or coordination of care with other care providers
- Notes regarding the date of return visit or other follow-up
- Consultations, lab, imaging and special studies initialed by PCP to indicate review
- Consultation and abnormal studies including follow-up plans

Member hospitalization records should include, as appropriate:

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

© 2024 UnitedHealthcare

Chapter 11: Quality management program and compliance information

Key contacts

Topic	Link	Phone Number
Credentialing	Medical: Network management Support Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. Chiropractic: **myoptumhealthphysicalhealth.com**	**1-877-842-3210**
Fraud, waste and abuse (payment integrity)	**uhc.com/fraud**	**1-800-455-4521**

What is the Quality Improvement program?

UnitedHealthcare Community Plan's comprehensive Quality Improvement program falls under the leadership of the CEO and the chief medical officer. A copy of our Quality Improvement program is available upon request.

The program consists of:

- Identifying the scope of care and services given
- Developing clinical guidelines and service standards
- Monitoring and assessing the quality and appropriateness of services given to our members based on the guidelines
- Promoting wellness and preventive health, as well as chronic condition self-management
- Maintaining a network of care providers that meets adequacy standards
- Striving for improvement of member health care and services
- Monitoring and enhancing patient safety
- Tracking member and care provider satisfaction and taking 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 QI 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)

© 2024 UnitedHealthcare

Care provider satisfaction

Every year, we conduct 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. You are encouraged to visit **UHCprovider.com/cpg** to view the guidelines, as they are an important resource to guide clinical decision-making.

Credentialing standards

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

- A completed credentialing application, including Attestation Statement
- Current medical license
- Current DEA certificate
- Current professional liability insurance

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

Credentialing and recredentialing process

ODM is responsible for credentialing all Medicaid managed care providers. The credentialing and recredentialing processes are paired with enrollment and revalidation, respectively, in the provider network management system. This process adheres to NCQA and CMS federal guidelines for both processes and the types of providers who are subject to the credentialing process.

Please note, you are not able to render services to Medicaid members until you are fully screened, enrolled and credentialed (if required) by Ohio Medicaid. For a complete list of provider types that require credentialing, please refer to Ohio Administrative Code (OAC) rule 5160-1-42.

For individual providers, the general guidance is that licensed providers who can practice independently under state law are required to go through this process.

Medical students, residents, fellows and providers who practice strictly in an inpatient setting are exempt from credentialing. It is recommended that you begin the contracting process with each managed care organization (MCO) you wish to participate with while you are enrolling and being credentialed at ODM, in order to be able to render services as of your effective date. While the credentialing process is being centralized at the state Medicaid level, you are still required to contract with the MCOs.

When you submit your initial application to be an Ohio Medicaid provider, you can designate managed care organization interest in the PNM system. Once your application is submitted, demographic data for your provider is transmitted automatically to the MCOs so they can start contracting with you.

© 2024 UnitedHealthcare

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- M.D.s (Doctors of Medicine)
- D.O.s (Doctors of Osteopathy)
- D.D.S.s (Doctors of Dental Surgery)
- D.M.D.s (Doctors of Dental Medicine)
- D.P.M.s (Doctors of Podiatric Surgery)
- D.C.s (Doctors of Chiropractic)
- C.N.M.s (Certified Nurse Midwives)
- C.R.N.P.s (Certified Nurse Practitioners)
- Behavioral health clinicians (psychologists, clinical social workers, masters prepared therapists)

Excluded from this process are practitioners who:

- Practice only in an inpatient setting
- Hospitalists employed only by the facility
- N.P.s and P.A.s who practice under a credentialed UnitedHealthcare Community Plan care provider

Health facilities

Facility care providers such as hospitals, home health agencies, SNFs and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements. Facilities must meet the following requirements or verification:

- State and federal licensing and regulatory requirements and an NPI number
- Have a current unrestricted license to operate
- Have been reviewed and approved by an accrediting body
- Have malpractice coverage/liability insurance that meets contract minimums
- Agree to a site visit if not accredited by the Joint Commission (JC) or another 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 at caqh.org.

Go to **UHCprovider.com/join** to submit a participation **request**.

For chiropractic credentialing, call **1-800-873-4575** or go to **myoptumhealthphysicalhealth.com**.

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

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

Peer review

Credentialing process

A peer review committee reviews all credentialing applications and makes a final decision. The decisions may not be appealed if they relate to mandatory criteria at the time of credentialing. We will notify you of the decision in writing within 60 calendar days of the review.

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every 3 years. This process helps ensure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website. Not responding to our request for recredentialing information results in administrative termination of privileges as a
UnitedHealthcare Community Plan care provider. You have 3 chances to answer the request before your participation privileges are terminated.

© 2024 UnitedHealthcare

Performance review

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

Applicant rights and notification

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

You also have the right to receive the status of your credentialing application, chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page.

Confidentiality

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

Failure to meet recredentialing requirements

If you don't meet our recredentialing requirements, we will end your participation with our network. We will send you a written termination notice in compliance with applicable laws, regulations and other requirements.

Resolving disputes

Contract concerns

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

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

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

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

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

If a member has authorized you in writing to appeal a clinical or coverage determination on their behalf, that appeal follows the member appeals process as outlined in the Member Handbook and **Chapter 12** of this manual.

HIPAA compliance – your responsibilities

HIPAA aims to improve the efficiency and effectiveness of the United States health care system. While the Act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have had the greatest impact on how the health care industry works. UnitedHealthcare Community Plan is a "covered entity" under these regulations. So are all care providers who conduct business electronically.

© 2024 UnitedHealthcare

Transactions and code sets

If you conduct business electronically, submit claims using the standard formats adopted under HIPAA. Otherwise, submit claims using a clearinghouse.

Unique identifier

HIPAA also requires unique identifiers for employers, care providers, health plans and individuals for use in standard transactions.

National Provider Identifier

The NPI is your standard unique identifier. It is a 10-digit number with no embedded intelligence that covered entities must accept and use in standard transactions. While HIPAA only requires you to use the NPI in electronic transactions, many state agencies require it on FFS claims and on encounter submissions. For this reason, UnitedHealthcare Community Plan requires the NPI on paper transactions.

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES). Share it with all affected trading partners, such as care providers to whom you refer patients, billing companies and UnitedHealthcare Community Plan.

Privacy of individually identifiable health information

The privacy regulations limit how health plans, pharmacies, hospitals and other covered entities can use members' medical information. The regulations protect medical records and other identifiable health information. This includes electronic, paper or spoken data.

They enhance consumers' rights by giving them access to their health information and controlling its inappropriate use. They also improve health care delivery by extending the privacy efforts of states and health systems to a national level.

Security

Covered entities must meet basic security measures:

- Help ensure the confidentiality, integrity and availability of all electronic PHI the covered entity creates
- Protect against any reasonably anticipated threats, uses or disclosures of information not permitted or required under the Privacy Regulations
- Help ensure compliance with the security regulations by the covered entity's staff

UnitedHealthcare Community Plan expects you to comply with all HIPAA regulations.

Find additional information on HIPAA regulations at cms.hhs.gov.

Ethics and integrity

UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with you, members, suppliers and government officials and agencies. Making sound decisions as we interact with you, other care providers, regulators and others is necessary for our continued success and that of our business associates. It's also the right thing to do.

Compliance program

As a segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Community Plan Compliance program incorporates the required 7 elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

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

UnitedHealthcare Community Plan has compliance officers for each health plan. In addition, each health

© 2024 UnitedHealthcare

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 report questionable incidents involving members or care providers, call our **Fraud, Waste and Abuse line** or go to **uhc.com/fraud**.

Please refer to the **Fraud, Waste and Abuse section** of this manual for additional details.

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 laws, regulations and policies/contracts. When informed of potentially inappropriate or fraudulent practices within the plan or by you, UnitedHealthcare Community Plan will conduct an investigation. You must cooperate with the company and government authorities. This means giving access to pertinent records (as required by your applicable Provider Agreement and this manual) as well as access to office staff. If we establish activity in violation of law or regulation, we will advise appropriate governmental authorities.

If you become the subject of a government inquiry or investigation, or a government agency requests documents relating to your operations (other than a routine request for documentation), you must provide UnitedHealthcare Community Plan with the details. You must also reveal what triggered the inquiry.

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the state of 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 ODM.

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. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

If any litigation, claim, negotiation, audit or other action involving the records has been started before the 10-year period ends, you agree to keep the records until 1 year after the resolution of all issues that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your Provider Agreement.

To help ensure members receive quality services, you must also comply with requests for on-site reviews conducted by the state. During these reviews, the state will address your capability to meet Ohio program standards.

You must cooperate with the state or any of its authorized representatives, the ODM, CMS, the Office of Inspector General (OIG), 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.

© 2024 UnitedHealthcare

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

Delegating and subcontracting

If you delegate or subcontract any function, the delegate or subcontractor must include all requirements of your applicable Provider Agreement and this manual.

Undelivered, inappropriate or substandard health care services

We only consider reimbursing claims if you met billing and coverage requirements. 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, undelivered 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.

Care provider-preventable conditions

UnitedHealthcare Community Plan may not use Medicaid funding to pay for a service resulting from a care provider-preventable condition (PPC)(42 CFR 447.26). In accordance with 42 CFR 438.3(g), UnitedHealthcare Community Plan is required to identify and report all PPCs, regardless of the care provider's intention to bill for that event, to the ODM.

Incident reporting

UnitedHealthcare Community Plan must report the following incident types upon notification for all members: abuse, neglect, exploitation, misappropriation of greater than $500 and unnatural/ accidental death/ unexplained death to the ODM. You are expect to promptly report such incidents by calling Provider Services.

Providers are required to assure the immediate health and safety of members when becoming aware of abuse, neglect, exploitation, misappropriation greater than $500, and accidental/unnatural deaths. If actions were not taken to assure the immediate health and safety of the member, the provider will do so immediately. Such actions may include calling police or EMS, reporting to county Adult Protective Services (APS), the county Public Child Services Agency (PCSA) or regulatory agencies such as the Ohio Department of Health. Providers are required to report these types of incidents to the MCO within 24 hours of becoming aware of the incident.

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of care (QOC) and service concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set clinical site standards for all PCP office sites to help ensure facility quality.

UnitedHealthcare Community Plan requires you and your facilities meet the following site standards:

- Clean and orderly overall appearance
- Available handicapped parking
- Handicapped accessible facility
- Available adequate waiting room space
- Adequate exam room(s) for providing member care
- Privacy in exam room(s)
- Clearly marked exits
- Accessible fire extinguishers
- Post file inspection record in the last year

© 2024 UnitedHealthcare

Criteria for site visits

The following table outlines the criteria used to require a site visit. When the threshold is met, we conduct a site visit according to UnitedHealthcare Community Plan policy.

QOC Issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	1 complaint
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	2 complaints in 6 months
Other	All other complaints concerning the office facilities	3 complaints in 6 months

© 2024 UnitedHealthcare

Chapter 12: Billing and submission

Key contacts

Topic	Link	Phone Number
Claims	**UHCprovider.com/claims**	**1-866-633-4449**
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	1-800-465-3203
EDI	**UHCprovider.com/edi**	**1-866-633-4449**

Our claims process

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

We follow the same claims process as UnitedHealthcare. See the Claims Process chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) 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.

© 2024 UnitedHealthcare

National Provider Identifier

HIPAA requires you have a unique National Provider Identifier (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 meet billing and coverage requirements. Submitting a referral does not guarantee we will pay you. Payment depends on the member's coverage on the date(s) of service, medical necessity, plan rules about limitations and exclusions and UnitedHealthcare Community Plan policies. We don't reimburse excessive, inappropriate or noncovered charges. To comply with applicable standards, policies and law, we may adjust previous payments for services and audit claims. We may seek reimbursement for overpayments or offset future payments as allowed by law.

Fee schedule

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

Modifier codes

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

Member ID card for billing

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

Acceptable claim forms

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

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

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

Clean claims and submission requirements

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

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

We may require additional information for some services, situations or state requirements.

Submit any services completed by N.P.s or P.A.s who are part of a collaborative agreement. Use their tax ID and NPI, and we will process the claims according to their agreement.

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.

© 2024 UnitedHealthcare

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

Electronic claims submission and billing

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

- All claims are set up as "commercial" through the clearinghouse
- Payer IDs
  - Ohio Medicaid: 88337
  - Ohio Medicaid vision: 83572
  - Ohio Medicaid dental: 83244
  - Ohio Medicaid dental DBP: UHMD3
- 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, see **EDI Claims**.

Trading partner

You may submit claims, eligibility inquiries, claim status inquiries and associated attachments using EDI by being a trading partner (TP) authorized by ODM or by contracting with an ODM authorized TP.

For more information, medicaid.ohio.gov.

ODM's expectation is that for each Medicaid provider system and data are current and consistent with information held by ODM's system of record, the PNM system. Therefore, it is important that providers keep their records up to date in ODM's PNM system.With the PNM system as the ODM's system of record, MCOs have been instructed to direct providers to update their ODM record in the PNM system when discrepancies are identified between the MCO's data and the PNM PMF. UnitedHealthcare Community Plan is instructed by ODM to not accept changes from providers into their own systems that are inconsistent with PNM system data shared through the PNM for their Medicaid line of business.

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. Share these documents with your software vendor for any programming and field requirements.

The companion documents are located on **UHCprovider.com/edi** > **EDI Companion Guides**.

Clearinghouse and status reports

Software vendor reports only show the claim left your office and was either accepted or

© 2024 UnitedHealthcare

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, go to **UHCprovider.com/edi** > **EDI Clearinghouse Options**.

e-Business support

Call **Provider Services** for help with online billing, claims, electronic remittance advices (ERAs) and electronic funds transfers (EFTs).

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

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

Electronic payment solution: OptumPay

UnitedHealthcare Community Plan sends electronic care provider payments instead of paper checks. You can sign 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/health care 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/health care organization is already enrolled and receiving your claim payments through ACH/direct deposit from OptumPay® or receiving virtual cards, you don't need to take action
- 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 UnitedHealthcare 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**, Click Resources, then Resource Library to find the **EDI** section.

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

Completing the UB-04 form

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

- Include ICD-10-CM diagnosis codes
- Identify other services by the CPT/HCPCS and modifiers

© 2024 UnitedHealthcare

Capitated services

Capitation is a payment arrangement for 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 or not 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, care providers, facilities and ancillary providers who are capitated for certain UnitedHealthcare Community Plan products. This applies to all benefit plans for members:

1. Who have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare Community Plan for such member
2. 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 care 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, 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 care provider name and identifiers for the member’s medical care and treatment on institutional claims for services other than nonscheduled transportation claims
- Send the referring care provider NPI and name on outpatient claims when this care provider is not the attending care provider
- Include the attending care provider’s NPI in the Attending 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 benefits

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 (EOB) or remittance advice with the claim.

Monitoring explaination of benefits

We actively monitor claims pre-processing and post- processing with the goal of ensuring payment is appropriate and accurate. In accordance with 42 CFR 455.20, UnitedHealthcare Community Plan sends explanation of benefits as a method for verifying with members whether services billed by providers were received. Any discrepancies are reported to the ODM.

Hospital and clinic method of billing professional services

Hospital and clinics must bill for professional services on a CMS 1500. Place the servicing care provider’s name in box 31 and the servicing care provider’s group NPI number in box 33a.

Global days

Global days include the billable period involving pre-operative visits, the procedure itself and post-operative visits in which the care provider performs all necessary services. The visits must be performed by the same care provider or another care provider reporting the same TIN in either an inpatient hospital, outpatient hospital,

© 2024 UnitedHealthcare

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 1 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 1 unit with the appropriate charge in the charge column

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.
- **Billing electronically**
  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

© 2024 UnitedHealthcare

  - 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
- 70-676 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

The ODM covers medically necessary, nonexperimental 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
- 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.

© 2024 UnitedHealthcare

Asking about a claim

You can ask about claims through Provider Services and the UnitedHealthcare Provider Portal.

Provider Services

Call **1-800-600-9007.** Have the following information ready before you call:

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

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

UnitedHealthcare Provider Portal

Go to **UHCprovider.com** and sign in to view your claims transactions.

Resolving claim issues

To resolve claim issues, contact **Provider Services**, use the UnitedHealthcare 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.

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 EOB
- 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 we reject a claim and don't receive corrections 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.

Providers have 365 days to file a claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) rule 5160-1-19.

Balance billing

Do not balance bill members if:

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

You may balance bill the member for noncovered services if the member provides written consent prior to getting the service.

If you have questions, please contact your provider advocate.

If you don't know who your provider advocate is, chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page

© 2024 UnitedHealthcare

Payment in full

Payment by UnitedHealthcare Community Plan is considered payment in full. Participating and nonparticipating care providers may not bill a member unless all the following are met:

- You notified the member of the financial liability before the service delivery
- You gave the notification in writing, specific to the service being rendered. It clearly states the member is financially responsible for the service
- The member dates and signs the notification
- 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

Third-party resources

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible members. Therefore, you must bill and obtain an EOB from any other insurance or health care coverage resource before billing UnitedHealthcare Community Plan, as required by contract. Refer to your Agreement for third-party claim submission deadlines. Once you bill the other carrier and receive an EOB, you may submit the claim 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.

© 2024 UnitedHealthcare

Chapter 13: Claim reconsiderations, appeals and grievances

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider Agreement. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

For claims, billing and payment questions, go to **UHCprovider.com/claims.** We no longer use fax numbers. Please use our online options or call Provider Services at **1-800-600-9007.**

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

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form or mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care Provider Claim Correction (Resubmission)	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will receive a duplicate claim rejection on your resubmission.	Care Provider	UnitedHealthcare Community Plan P.O. Box 5270 Kingston, NY 12402-5270	**UHCprovider.com/claims**	**1-800-600-9007**	Use the claims and payments tab on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com,** then click Claims.	Must receive within 365 calendar days from the date of service	30 business days
Care Provider Claim Reconsideration (step 1 of 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 5240 Kingston, NY 12402-5240	N/A	**1-800-600-9007**	Use the Claims Management or Claims on the portal. Click Sign in on the top right corner of **UHCprovider.com,** then click Claims.	12 months from date of service or 60 calendar days after the payment, denial or partial denial of a timely claim submission	30 calendar days for claims disputes resulting from a denial, limitation, reduction, suspension or termination of a covered service for lack of medical necessity and 15 calendar days for all other disputes
Care Provider Claim Formal Appeal (step 2 of dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care Provider	UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364	N/A	**1-800-600-9007**	Use the Claims Management or Claims on the portal. Click Sign in on the top right corner of **UHCprovider.com,** then click Claims.	12 months from date of service or 60 calendar days after the payment, denial or partial denial of a timely claim submission	30 calendar days for claims disputes resulting from a denial, limitation, reduction, suspension or termination of a covered service for lack of medical necessity and 15 calendar days for all other disputes

© 2024 UnitedHealthcare

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form or mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Member Appeal	A request to change an adverse benefit determination that we made.	• Member • 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 P.O. Box 31364 Salt Lake City, UT 84131-0364	**UHCprovider.com/claims** • **AOR Consent Form** on this site for member appeals	**1-800-895-2017,** TTY **711**	N/A	Urgent appeals – must receive within 5 business days Standard appeals - 60 calendar days	Urgent appeals – We will respond within 2 calendar days Resolution of non-urgent appeal within 15 calendar days
Member Grievance	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	• Member • Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent	UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364	N/A	**1-800-895-2017,** TTY **711**	N/A	Grievance can be filed at any time.	Access related - 2 business days Non-claims related - 30 calendar days Claims related - 60 calendar days

© 2024 UnitedHealthcare

These definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements.

UnitedHealthcare Community Plan and its in-network care providers may agree to more stringent requirements within care provider contracts than described in the standard process.

Denial

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

- **Administrative denial**
  When we didn't get notification before the service, or the notification came in too late
- **Medical necessity**
  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**
  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 is 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 UnitedHealthcare Provider Portal. To access the UnitedHealthcare Provider Portal, sign in to **UHCprovider.com** using your One Healthcare ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response

Mailing address:

UnitedHealthcare Community Plan
P.O. Box 5240
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.

© 2024 UnitedHealthcare

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

Claim reconsideration (step 1 of dispute)

What is it?

Care provider claim disputes are any care provider inquiries, complaints, appeals or requests for reconsideration ranging from general questions about a claim to a care provider disagreeing with a claim denial.

You may file a claim dispute within 12 months from the date of service or 60 calendar days after the payment, denial or partial denial of a timely claim submission, whichever is later. You may submit claim disputes verbally or in writing, including through the provider portal.

A claim reconsideration request is the quickest way to address your concern about whether the claim was paid correctly. When you send a reconsideration, please send additional support information.

When to use:

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

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

For medical necessity denials:

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

How to use:

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

Electronically – Use the Claim Reconsideration application on the UnitedHealthcare Provider Portal. Include electronic attachments. You may also check your status using the UnitedHealthcare Provider Portal.

- **Phone –** Call Provider Services at **1-800-600-9007** 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 5240
  Kingston, NY 12402-5240

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

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.

© 2024 UnitedHealthcare

- 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.

External medical review

After exhausting the care provider claims dispute resolution process, you may request an external medical review (EMR) if the claim payment denial, limitation, reduction, suspension or termination was based on medical necessity. For more information on EMR, please see the Utilization Management section of this manual.

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 or by mail with the following information:

- **Electronic claims –** Include the EDI acceptance report stating we received your claim
- **Mail reconsiderations –** Submit a screenshot from your accounting software that shows the date you submitted the claim. The screenshot must show:
  - Correct member name
  - Correct date of service
  - Claim submission date

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.

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 based on 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

© 2024 UnitedHealthcare

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

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

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

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

© 2024 UnitedHealthcare

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 2 of dispute)

What is it?

An appeal is a review of a reconsideration claim. It is a 1-time formal review of a processed claim that was partially paid or denied.

When to use:

If you do not agree with the outcome of the claim reconsideration decision in step 1, use the claim appeal process.

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 UnitedHealthcare 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

Questions about your appeal or need a status update?

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

Care provider grievance

What is it?

Grievances are complaints related to your UnitedHealthcare Community Plan policy, procedures or payments.

When to file:

You may file a grievance about:

- Benefits and limitations
- Eligibility and enrollment of a member or care provider
- Member issues or UnitedHealthcare Community Plan issues
- Availability of health services from UnitedHealthcare Community Plan to a member
- The delivery of health services
- The quality of service

How to file:

File verbally or in writing.

© 2024 UnitedHealthcare

- **Phone** – Call Provider Services toll free at **1-800-600-9007**
- **Mail** – Send care provider name, contact information and your grievance to:

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

You may only file a grievance on a member's behalf with the written consent of the member.

Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses CMS definitions for appeals and grievances.

Initial decisions

What is it?
The "initial decision" is the first decision UnitedHealthcare Community Plan makes regarding coverage or payment for care.

- 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
- 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 Community Plan
- 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 Community Plan

UnitedHealthcare Community Plan generally makes decisions regarding payment for care that members have already received within 30 days. A decision about whether UnitedHealthcare Community Plan will cover medical care can be a standard decision that is made within the standard time frame (typically within 10 days) or it can be an expedited decision that is made more quickly (within 48 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, we will automatically provide an expedited decision.

If we do not make a decision within the timeframe and does not notify the member about why the timeframe 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.

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

Phone – 1-800-587-5187 (TTY **711**)

© 2024 UnitedHealthcare

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:

- 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 care provider, you cannot ask for a continuation. Only the member may do so.

We resolve a standard appeal within 10 calendar days from the day we receive it.

We resolve an expedited appeal within 48 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

Prior to extending the response, UnitedHealthcare Community Plan must receive approval from the ODM.

Further appeal rights

If a member's appeal is denied in whole or part, the member may submit a state fair hearing.

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:

An authorized representative 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 – 1-800-895-2017 (TTY **711**)

All grievances are reviewed within the following timeframes, or as the member's health condition requires:

- 2 business days for access related issues
- 30 calendar days for non-claims related issues
- 60 calendar days for claims-related issues

State fair hearings

What is it?

A stare fair 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.

How to use:

For details, visit 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 Service 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.

© 2024 UnitedHealthcare

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:

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

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

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies based on state and federal law. UnitedHealthcareCommunity 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 laws, 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.

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

© 2024 UnitedHealthcare

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.

Claims Payment Systemic Error report

Claims Payment Systemic Error (CPSE) is defined as the UnitedHealthcare claims adjudication incorrectly underpaying, overpaying or denying claims that impact 5 or more providers. A report containing all active CPSEs is updated monthly and can be found on **UHCprovider.com.** If you experience issues with your claims, please contact your advocate or provider services at **1-800-600-9007.**

© 2024 UnitedHealthcare

Chapter 14: Care provider communications and outreach

Key contacts

Topic	Link	Phone Number
Provider education	**UHCprovider.com** > Resources > **Resource Library**	**1-800-600-9007**
News and bulletins	**UHCprovider.com** > Resources > **News**	**1-800-600-9007**
Provider manuals	**UHCprovider.com/guides**	**1-800-600-9007**

Communication with care providers

Chat support now available

UnitedHealthcare is on a **multi-year effort** to enhance our digital delivery channels and transition paper transactions to electronic, whenever possible. Our goal is to make it easier for you to work with us and reduce the time it takes for you to perform claim and clinical activities. We may provide electronic notice of policy, protocol and payment policy changes; news and other important updates.

Accordingly, there are a number of ways clinicians, practice managers, administrative staff, facilities and hospitals can stay up to date on items of interest from UnitedHealthcare:

- **UHCprovider.com**
  This public website is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates and quality programs.
- **UHCprovider.com/ohcommunityplan**
  The UnitedHealthcare Community Plan of Ohio page has state-specific resources, guidance and rules
- **Policies and protocols**
  UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols
- **Ohio health plans**
  UHCprovider.com/oh is the fastest way to review all of the health plans UnitedHealthcare offers in Ohio. To review information for another state, use the drop-down menu at **UHCprovider.com** > Resources > **Health Plans**. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **Social media**
  Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics.
  - **Facebook**
  - **Instagram**
  - **LinkedIn**
  - **YouTube**
  - **X (Twitter)**
- **UnitedHealthcare Provider Portal**
  This secure portal is accessible from **UHCprovider.com**. It allows you to access patient information such as eligibility and benefit information and digital ID cards.
- You can learn more about the portal in **Chapter 1** of this manual or by visiting **UHCprovider.com/portal**. You can also access **UHCprovider.com/training** > **Digital Solutions** for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News**
  Bookmark **UHCprovider.com** > Resources > **News**. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans. You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your

© 2024 UnitedHealthcare

practice and care for patients. This includes the communication formerly known as the Network Bulletin.

Receive personalized Network News emails twice a month by subscribing at **cloud.provideremail.uhc.com/subscribe**. You'll get the latest news, policy and reimbursement updates we've posted on our news webpage. These email briefs include monthly notification of policy and protocol updates, including medical and reimbursement policy changes. They also include announcements of new programs and changes in administrative procedures. You can tailor your subscription to help ensure you only receive updates relevant to your state, specialty and point of care.

Care provider education and training

To help ensure you are reimbursed accurately and patients have access to the care they need, we have developed a full range of training resources, including interactive self-paced courses and quick reference guides along with registration for instructor-led sessions. Topics include the digital solutions available on the UnitedHealthcare Provider Portal, plan and product overviews, clinical tools and state-specific training.

View the training resources at **UHCprovider.com/training**. Content is updated frequently and organized by categories to make it easy to find what you need.

Provider Advisory Council (PAC) meetings

PAC meetings are conducted twice a year between UnitedHealthcare Community Plan of Ohio, ODM and a provider panel. These meetings are designed to gather input, discuss and learn about issues affecting care providers, identify challenges and barriers, problem solve, share information, opinions, perspectives and collectively find ways to improve and strengthen the healthcare service delivery system.

Email communication – required contact information

We must have a valid email address on file to send you required notifications and important information.

Submit your email address in 1 of the following ways:

1. Sign up for a **One Healthcare ID**, which also gives you access to the UnitedHealthcare Provider Portal
2. **Subscribe** to Network News email briefs to receive regular email updates. Need to update your information? It takes just a few minutes to manage your **email address** and **content preferences**.

Already have a One Healthcare ID? To review or update your email, simply sign in to the portal. Go to "Profile & Settings," then "Account Information" to manage your email.

Care provider office visits

Provider advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a provider group to deliver face-to-face support. We do this to create program awareness, promote compliance and problem resolution.

Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for Provider Services and a list of additional care provider resources. You can 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)

© 2024 UnitedHealthcare

Ohio Medicaid and CHIP Regulatory Requirements Appendix

Provider

This Ohio Medicaid and CHIP Regulatory Requirements Appendix (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between UnitedHealthcare Insurance Company or one of its Affiliates ("United") and the party named in the Agreement ("Provider").

Section 1 - Applicability

This Appendix applies to benefit plans sponsored, issued or administered by United under the State's Medicaid program, CHIP program and, as applicable, benefit plans for other state-based healthcare programs (the "State Program") as governed by the State's designated agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law.

Section 2 - Definitions

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the applicable state program, the definitions shall have the meaning set forth under the applicable state program.

2.1

Covered service means health care service or product for which a customer is enrolled with UnitedHealthcare Community Plan to receive coverage under the state program

2.2

Medicaid agency or agency means the single state agency of administering or supervising the administration of the state program

2.3

State is the state of Ohio

2.4 State contract

State contract is the contract between UnitedHealthcare and the Medicaid agency for the purpose of providing and paying for covered services to customers enrolled in the state program.

Section 3 - Provider requirements

The state program, through contractual requirements and federal and state statutes and regulations, requires the Agreement to contain certain conditions that UnitedHealthcare and provider agree to undertake, which include the following:

3.1

Definitions related to the provision of covered services. Provider shall follow the applicable State program requirements for the provision of covered services. Provider's decisions affecting the delivery of acute or chronic care services to customers shall be made on an individualized basis and in accordance with the following definitions:

- Emergency medical condition means 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 any of the following: (a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to body functions; or (c) serious dysfunction of any body organ or part.
- Emergency services means inpatient and outpatient covered services furnished by a provider qualified to furnish those health services and that are needed to evaluate or stabilize an emergency medical condition.
- Medically necessary or medical necessity has the same meaning as contained in 42 C.F.R. § 438.210(a)

© 2024 UnitedHealthcare

(5) and as indicated in state statutes and regulations, the state contract and other state policy and procedures.

- Post-stabilization care services means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under circumstances described in condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. § 422.113(c), to improve or resolve the enrollee's condition.

3.2 Provider participation requirements

Provider hereby acknowledges and certifies to the best of its knowledge the following:

- **State program participation**
  Provider is enrolled as, or has applied to enroll as, a participating provider with the state program. UnitedHealthcare Community Plan may terminate provider from its state program provider network immediately upon notification from the state that provider cannot be enrolled or has been terminated from the state program, or the expiration of one 120 day period without enrollment of provider.
- **Licensure**
  Provider has all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to provider by UnitedHealthcare Community Plan under the Agreement and will maintain such necessary licenses, certifications, registrations and permits at all times throughout the term of the Agreement. If at any time during the term of the Agreement, provider is not in compliance with this section, provider shall discontinue providing services to customers. Additionally, payment will not be made for any items or covered services provided during any time period of noncompliance with this section.
- **Excluded individuals and entities**
  Provider nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the provider are: (a) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under executive order No. 12549 or under guidelines implementing executive order No. 12549; or b) excluded from participation in federal health care programs under either 42 U.S.C. §§ 1320a-7 or 1320a-7a. Provider acknowledges and agrees that payment will not be made for any items or covered services provided by an excluded individual or entity pursuant to 42 C.F.R. § 1001.1901(b).

3.3 Compliance with Law

Provider shall comply with all federal and State laws and regulations applicable to provider in performance of the Agreement, including but not limited to, the following:

- **Civil rights**
  Provider shall comply with Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972; Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act (see 42 CFR 438.3; 42 CFR 438.100(d)).
- **Lobbying**
  Provider certifies to the best of provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 C.F.R. § 93.100 et seq. that no federally appropriated funds have been paid or will be paid to any person by or on provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.
- **Medicaid laws and regulations**
  Provider agrees to abide by all federal and state Medicaid laws, regulations and state program requirements, including but not limited to:
  - **5 C.F.R. § 900.601 et seq., Administration of the Standards for a Merit System of Personnel Administration.**
  - **The following HHS Regulations in 45 C.F.R. subtitle A:**
    - 45 C.F.R. § 16.1 et seq., Procedures of the Departmental Appeals Board;
    - 45 C.F.R. § 75.1 et seq., Uniform Administrative Requirements, Cost Principles and Audit Requirements for HHS Awards;
    - 45 C.F.R. § 80.1 et seq., Nondiscrimination Under

 © 2024 UnitedHealthcare

Programs Receiving Federal Assistance Through the Department of Health and Human Services: Effectuation of Title VI of the Civil Rights Act of 1964;
- 45 C.F.R. § 81.1 et seq., Practice and Procedure for Hearings Under 45 C.F.R. §
- 80.1 et seq.;
- 45 C.F.R. § 84.1 et seq., Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting from Federal Financial Assistance.

- **Availability of services**
Provider will comply with 42 C.F.R. § 438.206 and any applicable state program regulations and requirements related to availability of services to customers including, but not limited to, meeting state program standards for timely access to care and services, taking into account the urgency of the need for services. Additionally, provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service beneficiaries, if provider serves only Medicaid beneficiaries. As applicable, provider will make covered services available 24 hours a day, 7 days a week when medically necessary. In addition, provider will provide physical access, reasonable accommodations and accessible equipment for customers with physical or mental disabilities.
- **Claims information**
Provider shall promptly submit to UnitedHealthcare Community Plan the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third-party liability payment before submitting claims to UnitedHealthcare Community Plan.
- **Continuity of care**
Provider shall cooperate with UnitedHealthcare Community Plan and provide customers with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event provider's participation with UnitedHealthcare Community Plan terminates during the course of a customer's treatment by provider, except in the case of adverse reasons on the part of provider.
- **Cultural competency and access**
Provider shall participate in UnitedHealthcare Community Plan's and the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex, and shall provide interpreter services in a customer's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to customers regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the customer's condition and ability to understand. Provider shall provide physical access, reasonable accommodations and accessible equipment for customers with physical or mental disabilities.
- **Data and reports**
Provider agrees to cooperate with and release to UnitedHealthcare Community Plan any information necessary for UnitedHealthcare Community Plan to comply with the state contract and federal and state law, to the extent applicable to provider in performance of the Agreement. Such information includes timely submission of reports including child health check-up reporting, EPSDT encounters and cancer screening encounters, if applicable, as well as complete and accurate encounter data in accordance with the requirements of UnitedHealthcare Community Plan and the state. By submitting data to UnitedHealthcare Community Plan, provider represents and attests to UnitedHealthcare Community Plan and the state that the data is accurate, complete and truthful, and upon UnitedHealthcare Community Plan's request provider shall certify in writing, that the data is accurate, complete, and truthful, based on provider's best knowledge, information and belief.
- **Fraud, waste and abuse**
Provider understands and agrees that each claim the provider submits to UnitedHealthcare Community Plan constitutes a certification that the provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the state or UnitedHealthcare Community Plan provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the provider bills a claim with a code that does not match the service provided. UnitedHealthcare

© 2024 UnitedHealthcare

Community Plan performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to United upon its request in order to determine appropriateness of coding. Further, when provider has received an overpayment, provider will return the overpayment to UnitedHealthcare Community Plan within 60 calendar days after the date on which the overpayment was identified, and to notify UnitedHealthcare Community Plan in writing of the reason for the overpayment.

- **Government audit and investigations**
  Provider acknowledges and agrees that the state, CMS, the Office of Inspector General, the Comptroller General and the U.S. Department of Health and Human Services and their designees or their authorized representatives shall at any time, have the right to inspect, audit or otherwise evaluate the quality, appropriateness and timeliness of services provided under the terms of the state contract and any other applicable rules, including the right to inspect and audit any records or documents of provider and its subcontractors, and the right to inspect the premises, physical facilities and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the state contract or from the date of completion of any audit, whichever is later. There shall be no restrictions on the right of the state or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the state contract and the reasonableness of their costs.
- **Hold harmless**
  Provider will accept, as payment in full, the amounts paid by UnitedHealthcare Community Plan to provider for covered services to customers, plus any deductible, coinsurance or copayment required to be paid by the customer, and will hold customers harmless in the event that UnitedHealthcare Community Plan cannot or will not pay for such covered services. If a service is not a covered services, prior to providing the service, provider shall inform the customer the service is not a covered service and have the customer acknowledge the information. If the customer still requests the service, provider shall obtain such acknowledgment in writing prior to rendering the service. If UnitedHealthcare Community Plan determines a customer was charged for covered services inappropriately, such payment may be recovered, as applicable. This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.
- **Marketing**
  Provider will comply with 42 C.F.R. § 438.104 and any applicable state program guidance and regulations related to marketing materials including, but not limited to, seeking approval from the Medicaid agency prior to distributing any marketing materials to customers.
- **Physician incentive plans**
  If provider participates in a physician incentive program ("PIP"), provider must comply with the requirements set forth in 42 C.F.R. §§ 422.208 and 422.210, including but not limited to the following:
  1. Provider will not make specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any customer and
  2. If the PIP places provider at substantial financial risk for services that provider does not furnish itself, provider must have stop-loss protection in accordance with 42 C.F.R. § 422.208(f)
- **Preventable conditions**
  No payment will be made by UnitedHealthcare Community Plan to a provider for provider preventable conditions, as identified in the state program. Provider shall identify and report to UnitedHealthcare Community Plan any provider preventable conditions in accordance with 42 C.F.R. §§ 434.6(a)(12)(i) and (ii) and 42 C.F.R. § 447.26(d).
- **Privacy and confidentiality**
  Provider shall safeguard customer privacy and confidentiality including, but not limited to, the privacy and confidentiality of any information that identifies a particular customer and shall comply with all federal and state laws and state program requirements regarding confidentiality and disclosure of medical records or other health and enrollment information.
- **Quality and utilization management**
  Provider agrees to cooperate with UnitedHealthcare Community Plan's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review and grievance procedures established by UnitedHealthcare Community Plan or as required under the state contract to ensure that customers have due process for their complaints, grievances, appeals, fair hearings or requests for

 © 2024 UnitedHealthcare

external review of adverse decisions made by UnitedHealthcare Community Plan or provider. Provider shall adhere to the quality assurance and utilization review standards of the state program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

- **Records**
  As required under state or federal law or the state contract, provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to customers. Medical records and supporting management systems shall include all pertinent information related to the medical management of each customer. Other records shall be maintained as necessary to clearly reflect all actions taken by provider related to services provided under the state contract. Provider shall retain all records including, as applicable, grievance and appeal records and any other records related to data, information and documentation for a period of not less than 10 years from the close of the Agreement or such other period as required by law. Provider acknowledges and agrees that the state, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to customers. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the state contract for state or federal fraud investigators.
- **Stark Law and the Anti-Kickback Statute**
  Provider shall not make inappropriate referrals for designated health services to health care entities with which provider or a member of provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals (see, 42 U.S.C. 1395nn; 42 U.S.C. 1320a-7b; 42 C.F.R. § 411.350).

3.4 Requirements for specific provider types

The following provisions apply to certain provider types as indicated:

- **Advance directives**
  When applicable, provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices and HMOs as specified in 42 C.F.R. §§ 417.436(d), 422.128 and 438.3(i).
- **Clinical Laboratory Improvements Act (CLIA) certification or waiver**
  As applicable, if provider performs any laboratory tests on human specimens for the purpose of diagnosis and/ or treatment, provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by UnitedHealthcare Community Plan. A state authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to state law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.
- **Electronic visit verification (EVV)**
  Provider shall cooperate with state requirements for electronic visit verification for personal care services and home health services, as applicable.
- **Long-term services and supports (LTSS) providers**
  Any LTSS Covered Services under the state contract that could be authorized through a waiver under section 1915(c) of the Social Security Act (the "Act") or a state program amendment authorized through sections 1915(i) or 1915(k) of the act must be delivered in settings consistent with 42 C.F.R. § 441.301(c)(4).

3.5 Termination

In the event of termination of the Agreement, provider shall promptly supply to UnitedHealthcare Community Plan all information necessary for the reimbursement of any outstanding Medicaid claims.

Section 4 - UnitedHealthcare Community Plan requirements

4.1 Prompt payment

UnitedHealthcare Community Plan shall pay provider pursuant to the state contract and applicable state and federal law and regulations, including but not limited to 42 C.F.R. § 447.46. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or state third party liability law and the

 © 2024 UnitedHealthcare

terms of the state contract. Unless UnitedHealthcare Community Plan otherwise requests assistance from provider, UnitedHealthcare Community Plan will be responsible for third party collections in accordance with the terms of the state contract.

4.2 Provider discrimination prohibition

UnitedHealthcare Community Plan will not discriminate in the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. In addition, UnitedHealthcare Community Plan will not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. This provision shall not be construed as prohibiting UnitedHealthcare Community Plan from limiting a provider's participation to the extent necessary to meet the needs of customers. This provision also is not intended and shall not interfere with measures established by UnitedHealthcare Community Plan that are designed to maintain quality of care practice standards and control costs.

4.3 Provider-customer communications

UnitedHealthcare Community Plan may not prohibit, or otherwise restrict, provider when acting within the lawful scope of practice, from advising or advocating on behalf of a customer for the following: (i) the customer's health status, medical care or treatment options, including any alternative treatment that may be self-administered; (ii) any information the customer needs in order to decide among all relevant treatment options; (iii) the risks, benefits and consequences of treatment or non-treatment; or (iv) the customer's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.

UnitedHealthcare Community Plan also shall not prohibit a provider from advocating on behalf of a customer in any grievance system, utilization review process or individual authorization process to obtain necessary health care services.

Section 5 - Other requirements

5.1 Compliance with state contract

All tasks performed under the agreement shall be performed in accordance with the requirements of the applicable state contract. The provisions of the state contract applicable to provider are incorporated into the Agreement by reference. Nothing in the Agreement relieves UnitedHealthcare Community Plan of its responsibility under the state contract. If any provision of the Agreement is in conflict with provisions of the state contract, the terms of the state contract shall control and the terms of the Agreement in conflict with those of the state contract will be considered waived.

5.2 Monitoring

UnitedHealthcare Community Plan shall perform ongoing monitoring (announced or unannounced) of services rendered by provider under the Agreement and shall perform periodic formal reviews of provider according to a schedule established by the state, consistent with industry standards or state managed care organization laws and regulations or requirements under the state contract. As a result of such monitoring activities, UnitedHealthcare Community Plan shall identify to provider any deficiencies or areas for improvement mandated under the state contract and provider and UnitedHealthcare Community Plan shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by UnitedHealthcare Community Plan and/or required by the state program.

5.3 No Exclusivity

Nothing in the Agreement or this appendix shall be construed as prohibiting or penalizing provider for contracting with a managed care organization other than UnitedHealthcare Community Plan or as prohibiting or penalizing UnitedHealthcare Community Plan for contracting with other providers.

5.4 Delegation

Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties.

5.5 Regulatory amendment

UnitedHealthcare Community Plan may unilaterally amend this appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities including, but not limited to, Medicaid agency. Unless such laws, regulations or regulatory authority(ies) direct otherwise, the signature

© 2024 UnitedHealthcare

of provider will not be required in order for the amendment to take effect.

Section 6 - State specific requirements

6.1 Medically necessary or medical necessity

In addition to Section 3.1(iii) and as required by the state contract, medically necessary or medical necessity means ODM requirements as stated in OAC Chapter 5160.

6.2 HealthChek

The parties agree to comply with all HealthChek requirements as specified in OAC Chapter 5160.

6.3 Timely filing

UnitedHealthcare Community Plan must accept claims for 365 calendar days from the date of service, as described in Ohio Admin. Code 5160-1-19. In addition, UnitedHealthcare Community Plan must follow the overpaid claims and timely filing exceptions described in the rule.

6.4 Health information exchanges

As applicable, provider must provide admission, discharge and transfer (ADT) data to Ohio's HIEs.

© 2024 UnitedHealthcare

Glossary

AABD

Assistance to the aged, blind and disabled.

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 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.

Acute inpatient care

Care provided to members sufficiently ill or disabled requiring:

- 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
- Constant availability of licensed nursing personnel
- Constant availability of medical supervision by attending care provider or other medical staff

Advance directive

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

Adverse benefit determination

1. For a resident of a rural area, the denial of a member's request to exercise their right, to obtain services outside the network
2. The denial, in whole or in part, of payment for a service
3. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities
4. The denial or limited authorization of a requested service, including determinations based on the type of level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit
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. The failure to provide services in a timely manner, as defined by the state
7. The reduction, suspension or termination of a previously authorized service

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 care 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 to 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 care 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 PCP.

© 2024 UnitedHealthcare

Centers for Medicare & Medicaid Services

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

Children's Health Insurance Program

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

Clean claim

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

Centers for Medicare and Medicaid Services CMS

CMS – the federal regulatory agency for these programs

Contracted health professionals

Primary care providers, specialists, medical facilities, allied health professionals and ancillary service providers under contract with UnitedHealthcare Community Plan. These care providers deliver specific covered services to members. They represent those individuals and entities used through the UnitedHealthcare Community Plan prior authorization and referral policies and procedures.

Coordination of benefits

COB – A process of figuring out which of 2 or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

Covered services

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

Credentialing

The verification of applicable licenses, certifications and experience. This process assures care provider status is extended only to professional, competent care providers who continually meet UnitedHealthcare Community Plan qualifications, standards and requirements.

Current procedural terminology (CPT®) codes

A code assigned to a task or service a care provider does for a member. Every medical task or service has its own CPT code. These codes are used by the insurer to know how much they need to pay the physician. CPT codes are created and published by the American
Medical Association.

Delivery system

The mechanism by which health care is delivered to a member. Examples include hospitals, care provider offices and home health care.

Disallow amount

Medical charges for which the network care provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member.

Examples are:

- The difference between billed charges and in-network rates
- Charges for bundled or unbundled services as detected by Correct Coding Initiative edits

Discharge planning

Screening eligible candidates for continuing care following treatment in an acute care facility. It involves care planning, scheduling, arranging and steps that move a member from 1 level of care to another.

Disenrollment

The discontinuance of a member's eligibility to receive covered services from a contractor

Dispute

- **Care provider claim reconsideration** – step 1 when a care provider disagrees with the payment of a service, supply or procedure
- **Care provider appeal** – step 2 when a care provider disagrees with the payment of a service, supply or procedure

Durable medical equipment

DME – Equipment and supplies ordered by a care provider for everyday and extended use, for medical reasons other than convenience or comfort. DME may include oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Periodic Screening Diagnosis and Treatment Program

EPSDT – a package of services in a preventive (well-child) exam covered by Medicaid as defined in Social Security Act Section 1905 (R). Covered services

 © 2024 UnitedHealthcare

include a complete health history and developmental assessment; an unclothed physical exam; immunizations; laboratory tests; health education; and screenings for vision, dental, substance use disorder, mental health and hearing. They also include any medically necessary services found during the preventive exam.

Electronic date interchange

EDI – the electronic exchange of information between 2 or more organizations

Electronic funds transfer

EFT – the electronic exchange of funds between 2 or more organizations

Electronic medical record

EMR – an electronic version of a member's health record and the care they have received

Eligibility determination

Deciding whether an applicant meets the requirements for federal or state eligibility

Emergency care

The provision of medically necessary services required for immediate attention to review or stabilize a medical emergency

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 care 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

Health Insurance Portability and Accountability Act

HIPPA –a federal law that provides data privacy protection and security provisions for safeguarding health information

© 2024 UnitedHealthcare

Home health care (home health services)

Health care services and supplies provided in the home, under physician's orders. Services may be provided by nurses, therapists, social workers or other licensed care providers. Home health care usually does not include help with nonmedical tasks, such as cooking, cleaning or driving.

In-network care provider

A care provider who has a written Agreement with UnitedHealthcare Community Plan to provide services to members under the terms of their Agreement

Medicaid

A federal health insurance program for low-income families and children, eligible pregnant members, people with disabilities and other adults. The federal government pays for part of Medicaid and sets guidelines for the program. States pay for part of Medicaid and have choices in how they design their program. Medicaid varies by state and may have a different name in your state.

Medical emergency

An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention you could reasonably expect 1 of the following to result:

- Their health would be put in danger
- They would have serious problems with their bodily functions
- They would have serious damage to any part or organ of their body

Medically necessary

Medically necessary health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine

Member

An individual who is eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement

National Provider Identifier

NPI – Required by CMS for all care providers who bill, prescribe or refer for health care services and is used on all electronic transactions. It is a single unique care provider identifier assigned to a care provider for life that replaces all other care provider identifiers. It does NOT replace your DEA number.

Out-of-area care

Care received by a UnitedHealthcare Community Plan member when they are outside of their geographic territory

Preventive health care

Health care emphasizing priorities for prevention, early detection and early treatment of conditions. It generally includes routine/physical examination and immunization.

Primary care provider

PCP – a physician, including an M.D. or D.O., nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the plan who provides, coordinates or helps members access a range of health care services

Prior authorization (notification)

The process where care providers seek approval prior to rendering health care services, drugs or DME as required by UnitedHealthcare Community Plan policy

Provider Group

A partnership, association, corporation or other group of care providers.

Quality management (QM)

A methodology that professional health personnel use to achieve desired medical standards and practices. The formal program includes activities to help improve and maintain quality service and care and involve multiple organizational components and committees.

Rural health clinic

A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics may receive enhanced payments for services provided to enrolled members.

Service area

The geographic area served by UnitedHealthcare Community Plan, designated and approved by Ohio Department of Medicaid.

© 2024 UnitedHealthcare

Specialist

A care provider licensed in the state of 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 nonphysician 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

Temporary Assistance to Needy Families

TANF – 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, 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.

© 2024 UnitedHealthcare