2024
Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Michigan

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United Healthcare® Community Plan

Welcome

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

Click the following links to access different manuals:

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

Easily find information in this manual using the following steps:

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

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

Important information about the use of this manual

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

This manual will be amended as policies change.

Participation Agreement

In this manual, we refer to your Participation Agreement as “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 professional subject to this manual, including physicians, clinicians, facilities and ancillary care providers; except when indicated and all items are applicable to all types of health care providers subject to this guide
- “Community Plan” refers to UnitedHealthcare’s Medicaid plan
- “Your Agreement,” “Provider Agreement” or “Agreement” refers to your Participation Agreement with us
- “Us,” “we” or “our” refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this guide
- Any reference to “ID card” includes a physical or digital card

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Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com/MIcommunityplan	1-800-903-5253
Training	UHCprovider.com/training	
Provider Portal	UHCprovider.com, then Sign In using your One Healthcare ID or go to Provider Portal Self Services. New users: UHCprovider.com > New User and User Access	
CommunityCare Provider Portal Training	CommunityCare Provider Portal User Guide	
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 Michigan state goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits to the following members:

- Children, from birth through 18 years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act.
- Pregnant women, eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act.
- Children eligible for the Children's Health Insurance Program (MI Child).
- Categorically Needy — Blind and disabled children and adults not eligible for Medicare.
- Healthy Michigan Plan — Adults 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.

Michigan Department of Health and Human Services (MDHHS) will determine enrollment eligibility. It verifies which individuals must enroll, those that may voluntarily enroll and those excluded from enrollment. It will employ a population health management framework and contract with high-performing health plans in order to build a Medicaid managed care delivery system that maximizes the health status of beneficiaries, improves beneficiary experience and lowers cost. Through evidence- and value-based care delivery models, supported by health information technology/health information exchange and a robust quality strategy, MDHHS will support us in achieving these goals.

Services include inpatient and outpatient hospital services, physician services, laboratory and X-ray services, and home health services, among others. See our member handbook for a complete list of covered services at uhccp.com/mi.

If you have questions about the information in this manual or about our policies, go to UHCprovider.com or call Provider Services at **1-800-903-5253**.

Prior authorization disclaimer

Prior authorization requirements may exist and should be considered for any services or other items we offer. Please refer to the prior authorization list at UHCprovider.com/MICommunityPlan > Prior Authorization and Notification for authorization requirements.

How to join our network

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

All care providers offering services to Michigan Medicaid beneficiaries, including care providers participating in a managed care organization's (MCO) care provider network, are required to be screened and enrolled in the Michigan Medicaid program. The State of Michigan's Community Health Automated Medicaid Processing System (CHAMPS) is the state's web-based Medicaid enrollment and billing system. MDHHS will prohibit UnitedHealthcare Community Plan from making payments to all typical rendering, referring, ordering and attending care providers not enrolled in CHAMPS. This requirement applies to all individuals who provide services of any type to Medicaid beneficiaries, including health care providers, social services workers and pharmacies. For instructions on how to enroll in CHAMPS, log on to **michigan.gov**/medicaidproviders > **Provider Enrollment.**

Already in network and need to make a change?

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

Our approach to health care

Care Model

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

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

- Market-specific care management encompassing medical, behavioral and social care.
- An extended care team including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist.
- Options that engage members, connecting them to needed resources, care and services.
- Individualized and multidisciplinary care plans.
- Assistance with appointments with PCP and coordinating appointments. The Community Health Worker (CHW) 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 goals are to:

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

- Improve access to pharmacy.
- Identify and remove social and environmental barriers to care.
- Improve health outcomes, measured by improved Healthcare Effectiveness Data and Information Set (HEDIS®) and Centers for Medicare & Medicaid Services (CMS) Star Ratings metrics.
- Empower the member to manage their complex/chronic illness or problem and care transitions.
- Improve coordination of care through dedicated staff resources and to meet unique needs.
- Engage community care and care provider networks to help ensure access to affordable care and the appropriate use of services.

To refer your patient to the Care Model program, call Provider Services at **1-800-903-5253** or Member Services at **1-800-903-5253**, TTY **711**.

Compliance

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

Cultural resources

To 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**.

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 care provider profile and displayed within the directory.

Showcase your cultural competencies by keeping your data current through our **data attestation process**.

Translation/interpretation/auxiliary aide services

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

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

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

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

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

Care for members who are deaf or hard of hearing

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

UnitedHealthcare Community Plan provides the following:

Language interpretation line

We provide oral interpreter services Monday–Friday from 8 a.m.–8 p.m. ET.

To arrange for interpreter services, please call 1-877-842-3210 (TTY 711).

I Speak language assistance card

This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare members.

Materials for limited English-speaking members

We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

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

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual for medical care determinations. We also use the Michigan Association of Health Plan (MAHP) Bariatric Surgery Guidelines for gastric procedure decisions for weight management control, and National Comprehensive Cancer Network® (NCCN) guidelines for chemotherapy. Call **1-800-903-5253** to request a copy of the guidelines.

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

Application Programming Interface

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

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

Electronic Data Interchange

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

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

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

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

Getting started

- If you have a practice management or hospital information system, contact your software vendor for instructions on how to use EDI in your system.

- Contact clearinghouses to review which electronic transactions can interact with your software system.

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

Point of Care Assist

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

UHCprovider.com

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

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 as submitting prior authorization requests, checking claim status, submitting appeal requests, reviewing benefits and coverage limits, and finding copies of PRAs and letters in Document Library. All is available at no cost to you and without needing to pick up the phone.

To access the portal, you will need 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 portal tools:

- **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 authorizations and notifications** — 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 drugs by selecting the Prior Authorization dropdown in the UnitedHealthcare Provider Portal. You will be directed to Prior Authorization and Notification capability to complete your requests.
- **My Practice Profile** — View and update your care provider demographic data that UnitedHealthcare members see for your practice. For more information, go to UHCprovider.com/mpp.
- **Document Library** — Access reports and correspondence from many UnitedHealthcare plans for viewing, printing or download. For more information on the available correspondence, go to UHCprovider.com/documentlibrary.

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

Direct Connect

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

- Manage overpayments in a controlled process.
- Create a transparent view between care provider and payer.
- Avoid duplicate recoupment and returned checks.
- Decrease resolution 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 Provider Portal. On-site and online training is available.

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

Privileges

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

Provider Services

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

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

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

How to contact us

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

Topic	Contact	Information
Benefits	**UHCprovider.com/benefits** **1-800-903-5253**	Confirm a member's benefits and/or prior authorization.
Cardiology	For prior authorization or a current list of CPT codes that require prior authorization, visit **UHCprovider.com/cardiology** **1-800-903-5253**	Request prior authorization of the procedures and services outlined in this manual's prior authorization requirements.
Care Model (Care Management/ Disease Management)	1-800-903-5253	Refer high-risk members (e.g., asthma, diabetes, obesity).
Chiropractor Care	**myoptumhealthphysicalhealth.com** **1-800-873-4575**	We provide members older than 21 with up to six visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.
Claims	Use the Provider Portal at **UHCprovider.com/claims** **1-800-903-5253** Mailing address: **UnitedHealthcare Community Plan** Attn: Claims P.O. Box 30991 Salt Lake City, UT 84130-0991	Verify a medical claim status or get information about proper completion or submission of claims.
Claim Overpayments	See the Overpayment section for requirements before sending your request. Sign in to **UHCprovider.com/claims** to access the Provider Portal, then select the UnitedHealthcare Online app **1-800-903-5253** Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.

Topic	Contact	Information
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
Eligibility	To access eligibility information, go to **UHCprovider.com** then Sign In to the Provider Portal or go to **UHCprovider.com/eligibility**. **1-800-903-5253**	Confirm member eligibility.
Fraud, Waste and Abuse (Payment Integrity)	**michigan.gov/fraud** 1-800-903-5253 Office of Inspector General: 1-855-643-7283 Mailing address: **UnitedHealthcare Community Plan** Compliance Officer 3000 Town Center, Suite 1400 Southfield, MI 48075 or **Office of Inspector General** P.O. Box 30062 Lansing, MI 48909 **Payment Integrity Information:** **UHCprovider.com/MIcommunityplan** **Reporting:** **uhc.com/fraud** **1-800-455-4521 or 1-877-401-9430**	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Lab Services	1-800-445-4979	Joint Venture Hospital Laboratories (JVHL) is the preferred lab care provider.

Topic	Contact	Information
Medical Claim, Reconsideration and Appeal	Sign in to the Provider Portal at UHCprovider.com or go to **UHCprovider.com/claims** for more information. Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at the following address: Reconsiderations: UnitedHealthcare Community Plan P.O. Box 5240 Kingston, NY 12402-5240 Appeals: UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	**myuhc.com** **1-800-903-5253** **or 1-877-542-9239** / TTY 711 for help accessing member account *see "Website for Michigan Community Plan" for state's contact info.	Assist members with issues or concerns. Available 8:30 a.m. – 5:30 p.m. ET, Monday through Friday.
Mental/Behavioral Health & Substance Abuse	OptumHealth Behavioral Solutions **providerexpress.com** **1-800-888-2998** P.O. Box 30760 Salt Lake City, UT 84130-0760	Behavioral health eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. (PCP referral is not required.)
Michigan ENROLLS	**Medicaid.gov** MIEnrolls: 1-888-367-6557 or 1-800-975-7630	The Michigan Department of Health & Human Services (MDHHS) contracts with Michigan ENROLLS, an enrollment services contractor, to educate Medicaid enrollees about managed care and how to enroll, disenroll and change enrollment for these beneficiaries.

Topic	Contact	Information
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	1-800-368-1019 or 1-800-537-7697 TDD 711	Available 8 a.m. – 5 p.m. ET, Monday through Friday, except state-designated holidays.
Network Management Support	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page.	Self-service functionality to update or check credentialing information.
National Plan and Provider Enumeration System (NPPES)	**nppes.cms.hhs.gov** 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Obstetrics and Baby Care	Healthy First Steps® **uhchealthyfirststeps.com** **1-800-599-5985**	Refer pregnant members to this program.
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. ET, Monday through Friday; 6 a.m. – 6 p.m. ET, Saturday; and 9 a.m. – 6 p.m. ET, Sunday.
Pharmacy Services	**professionals.optumrx.com** **1-877-305-8952** (OptumRx)	OptumRx oversees and manages our network pharmacies.
Prior Authorization/ Notification for Pharmacy	UHCprovider.com > Prior Authorization > **Clinical Pharmacy and Specialty Drugs** **1-800-310-6826**	Request authorization for medications as required.
Prior Authorization Requests/Advance & Admission Notification	To notify us or request a medical prior authorization: **EDI:** Transactions 278 and 278N **Online Tool:** **UHCprovider.com/paan** **Phone:** Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications" or call 1-800-903-5253	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required. • Complete the notification or prior authorization process. • Upload medical notes or attachments. • Check request status Information and advance notification/prior authorization lists: Visit UHCprovider.com/MIcommunityplan > **Prior Authorization and Notification**
Provider Services	**UHCprovider.com/MIcommunityplan** **1-800-903-5253**	Available 7 a.m. – 5 p.m. ET, Monday through Friday.

Topic	Contact	Information
Technical Support	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. Website: **UHCprovider.com/en/contact-us/technical-assistance.html** **1-866-209-9320** for Optum support or **1-866-842-3278**, Option 1 for web support	Call if you have issues logging in the Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit Line	1-800-784-8669	Ask about services for quitting tobacco/smoking.
Transportation	ModivCare 1-877-892-3995	To arrange non-emergent transportation, please contact ModivCare at least 3 business days in advance.
Utilization Management	Provider Services **1-800-903-5253**	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. Request a copy of our UM guidelines or information about the program. For UM policies and protocols, go to: UHCprovider.com > Health Plans, Policies, Protocols and Guides > **For Community Plans**.
Vaccines for Children (VFC) program	517-335-8159	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 care providers with DHSS to bill for the administration of the vaccine.
Vision Services	**marchvisioncare.com** 1-800-903-5253	Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from MARCH® Vision Care.
Website for Michigan Community Plan (state website)	To reach Healthy Michigan Plan for member enrollment, call 1-844-445-7231/ TTY 711 More information about member enrollment, go to **michigan.gov/healthymiplan**	Access your state's specific community plan information on this website, including enrollment information.

Topic	Contact	Information
Vaccines for Children (VFC) program	1-517-335-8159	Care providers must participate in the VFC Program administered by the Department of Health and Senior Services (DHSS) and must use the free vaccine when administering vaccine to qualified eligible children. Providers must enroll as VFC providers with DHSS to bill for the administration of the vaccine.
Vision Services	marchvisioncare.com 1-800-903-5253	Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from MARCH® Vision Care.
Website for Michigan Community Plan (state website)	To reach Healthy Michigan Plan for member enrollment, call 1-844-445-7231/ TTY 711 More information about member enrollment, go to michigan.gov/healthymiplan	Access your state's specific community plan information on this website, including enrollment information.

Chapter 2: Care provider standards and policies

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com/MIcommunityplan	1-800-903-5253
Enterprise Voice Portal		1-877-842-3210
Eligibility	UHCprovider.com/eligibility	1-800-903-5253
Referrals	UHCprovider.com > Referrals	
Provider Directory	UHCprovider.com > Our Network > Find a Provider	

General care provider responsibilities

Non-discrimination

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

Communication between care providers and members

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

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

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

Provide official notice

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

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

You may use the Care Provider Demographic Information Update Form for demographic changes or to update NPI information for care providers in your office. This form is located at the Provider Portal at UHCprovider.com then Sign In > Provider 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 the Michigan Medicaid rate. Provider Services is available to help you and our members with the transition.

Provider termination

When intending to terminate your contractual relationship with UnitedHealthcare Community Plan, refer to your care provider contract for the required notification period before terminating with or without cause. Send notification to your provider advocate or contract manager, to:

UnitedHealthcare Community Plan
Attn: Network Management
3000 Town Center, Suite 1400
Southfield, MI 48075

If the affiliation between a PCP/group and UnitedHealthcare Community Plan terminates, the PCP must provide written termination notice to each member who has chosen them as their PCP, within 15 days of the PCP's awareness of the termination. We will notify and assign affected members to a new PCP.

If you are a specialist/specialist group and you/group initiate(s) the Agreement termination, you must notify affected UnitedHealthcare Community Plan members before the effective termination date. Affected UnitedHealthcare Community Plan members are those who have had at least 3 visits to you in a one year period, and/or who have a chronic condition such as COPD, ESRD or diabetes and whom you have seen at least 3 times in the previous 12-month period.

You should provide a written termination notice to members in an ongoing course of treatment with any other UnitedHealthcare Community Plan-affiliated care provider, within 15 days of your awareness of the affiliation termination between the care provider and UnitedHealthcare Community Plan. UnitedHealthcare Community Plan permits the member to continue an ongoing course of treatment with the terminating care provider if:

1. the member is in her second or third pregnancy trimester at the time of the care provider's termination, through postpartum care directly related to the pregnancy.
2. the member is determined to be terminally ill before a care provider's (knowledge of the) termination, and the care provider was treating the terminal illness before the termination date or knowledge of the termination.

By continuing treatment the terminating care provider agrees to accept UnitedHealthcare Community Plan reimbursement at applicable Medicaid rates as payment in full. The care provider also agrees to adhere to our quality standards, information submission and policies and procedures.

Please note: Non-contracted care providers are paid the published Medicaid Fee Screen rates applicable on the service date.

Arrange substitute coverage

If you cannot provide care and must find a substitute, arrange for care from other UnitedHealthcare Community Plan care providers and care professionals. You must have 24-hour on-call service for emergency and after-hours care, with back-up coverage arrangements as needed. You must notify your provider advocate of coverage arrangements.

For the most current listing 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 one year and have voluntarily stopped participation in our network.
2. Inactivate any tax identification numbers (TINs) with no claims submitted for one year. This is not a termination of the Provider Agreement. Call UnitedHealthcare Community Plan to reactivate a TIN.

Changing an existing TIN or adding a health care provider

Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the email address listed on the bottom of the form when updating a single care provider practitioner. Practices with 2 or more care provider practitioners, please use the Group/Organization Demographic Information Update form. The W-9 form and the Demographic Information Update Forms are available at UHCprovider.com > Sign In > My Practice Profile.

Otherwise, complete detailed information about the change, the effective date of the change and a W-9 on your office letterhead. Send this information to the email listed on the bottom of the Demographic Information Update Forms. For tax ID changes, please contact your provider advocate or contract manager.

Updating your practice or facility information

You can update your practice information through the Provider Portal application on UHCprovider.com. Go to UHCprovider.com then select Sign In. Or submit your change by:

- Completing the Care Provider Demographic Change Form and emailing it to the appropriate address listed on the bottom of the form.
- Calling our Enterprise Voice Portal at 1-877-842-3210.

After-hours care

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

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

Participate in quality initiatives

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

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for diseases and conditions. This is determined by United States government agencies and professional specialty societies. See Chapter 10 for more details on the initiatives.

Provide access to your records

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

Performance data

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

Comply with protocols

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

You must adhere to the Michigan (MDHHS) Medicaid Provider Manual.

You must agree that the Michigan Department of Health & Human Services - Office of Inspector General (MDHHS-OIG) has the authority to conduct postpayment evaluations of their claims paid by the health plan.

You must agree to follow the appeal process as outlined in Chapters 4 and 6 of the Administrative Procedures Act of 1969; MCL 24.271 to 24.287 and MCL 24.301 to 24.306 for post-payment evaluations conducted by MDHHS-OIG.

UnitedHealthcare Community Plan will immediately terminate individuals or entities excluded from MDHHS participation or other appropriate authorities.

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 the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

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

Follow medical record standards

Please reference **Chapter 9** for Medical Record Standards.

Inform members of advance directives

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

Your Agreement

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

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

If we have a concern about your Agreement, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions, you may 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 ma locate the Member's Handbook at **UHCCommunityPlan.com/MI**.

Also reference **Chapter 12** of this manual for information on provider claim reconsiderations, appeals, and grievances.

Appointment standards (Michigan DHHS Access and Availability Standards)

Comply with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- After-hours care phone number: 24 hours, 7 days a week
- Emergency services: available immediately 24 hours/day, 7 days a week
- Urgent care appointment: available within 48 hours
- Non-urgent or symptomatic care appointment: within seven business days of request
- Routine care appointment: within 30 business days of request

- Physical exam: within 180 calendar days
- EPSDT appointments: within 6 weeks
- New member appointment: within 30 calendar days
- Telephone access: average seconds to answer must be 30 seconds or less. The abandonment rate must be 5% or less.
- In-office waiting for appointments: take members to the exam room within 15 minutes of the scheduled appointment time
- Behavioral health routine care: available within 10 business days of request
- Behavioral health non-life threatening emergency: available within six hours of request
- Behavioral health urgent care: available within 48 hours of request
- Emergency dental services: available immediately 24 hours/day, 7 days a week
- Urgent dental care: available within 48 hours
- Routine dental care: within 21 business days of request
- Preventive dental services: within six weeks of request
- Initial dental appointment: within eight weeks of request

Specialty care

Specialists should arrange appointments for routine appointments within six weeks of request/referral and acute specialty care within 5 business days of request/referral.

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

Provider directory

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

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

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

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

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

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

For delegated providers, email your changes to **delprov@uhc.com**.

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

Care Provider attestation

Confirm your provider data every quarter through the 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 My Practice Profile in the Provider Portal 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 are providers who are not regularly available to provide covered services at an office or practice location should not e listed at that address.

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

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. Services requiring prior authorization must have a certification number from UnitedHealthcare Community Plan before services are rendered. You must call prior authorization service request(s) to us no less than 3 business days before the planned service date. Call us at **1-800-903-5253** if services will be performed within 48 hours of the prior authorization request.

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

- Verify eligibility using the Provider Portal at UHCprovider.com/eligibility or by calling Provider Services. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- Get prior authorization:
    1. To access the Prior Authorization app, go to UHCprovider.com, then click 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 the UnitedHealthcare Web Support at **1-866-842-3278**, option 3, 7 a.m. – 9 p.m. ET, Monday through Friday.

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 Michigan Department of Health and Human Services (DHHS) members may seek services from any participating care provider. The Michigan DHHS program requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

The PCP is responsible for supervising, coordinating and providing primary care; initiating referrals for specialty care; maintaining continuity of each member's health care; and maintaining the member's medical record, which includes documentation of all services provided by the PCP as well as any specialty or referral services for each assigned member. The PCP must provide 24 hours a day, seven days a week coverage and backup coverage when they are not available.

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

- General practice
- Internal medicine
- Family practice
- Pediatrics

NPs and PAs may enroll with the state as solo providers; however, to be considered a PCP, their supervising physician must be a PCP as well.

Members may change their assigned PCP by contacting Member Services at any time during the month. Customer Service is available 8:30 a.m. – 5:30 p.m., Monday through Friday.

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

Females have direct access (without a referral or authorization) to any OB/GYNs, for women's health care services.

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support, and benefit from the primary care case management system. The coverage will include availability of 24 hours a day, seven days a week. During non-office hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services or information given about accessing services or managing medical problems. **Recorded messages are not acceptable.**

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

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.
- Provide all well baby/well-child services.
- Coordinate each UnitedHealthcare Community Plan member's overall course of care.
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week.
- Document and communicate practice hours to members.
- 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, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide.
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment.
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer advanced cardiac and cardiovascular studies, as well as cardiac and pulmonary rehabilitation services to an UnitedHealthcare Community Plan specialist if you are not board-certified in Cardiology.
- Refer nerve conduction studies (NCVs) and electromyograms (EMGs) to an UnitedHealthcare Community Plan specialist if you are not board-certified in Neurology.
- Refer services requiring prior authorization to the Provider Services, UnitedHealthcare Community Plan Clinical, or Pharmacy Department as appropriate.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS® or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
- Complying with the Michigan DHHS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.

Children's Special Health Care Services (CSHCS)

PCPs willing to serve CSHCS members must meet the following qualifications:

a. Is willing to accept new CSHCS members with potentially complex health conditions.
b. Regularly serves children or youth with complex chronic health conditions.

c. Has a mechanism to identify children/youth with chronic health conditions.
d. Provides expanded appointments when children have complex needs and require more time.
e. Has experience coordinating care for children who see multiple professionals (pediatric specialists, physical therapists, behavioral health professionals, etc.).
f. Has a designated professional responsible for care coordination for children who see multiple professionals.
g. Provides services appropriate for youth transitioning into adulthood, including but not limited to; the use of a transition assessment tool and adoption of a transition policy that is publicly posted and specifies:
    i. the transition time frame.
    ii. transition approach.
    iii. legal changes that take place in privacy and consent at age 18.

When you sign your contract with us, you can choose to attest that you are a qualified CSHCS provider.

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

Members may choose a care provider who meets the PCP requirements and performs PCP-type services within a Rural Health Clinic or Federally Qualified Health Center as their PCP.

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

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.
- Perform diagnostic testing as medically necessary and within the specialist's scope of practice. Obtain additional authorization only if the service is on the plan's prior authorization list.
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care within 10 days after the service, or communicate immediately when medically necessary.
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP. Coordinate the referral process with the PCP if it is determined that a member needs additional specialist referrals.
- Maintain staff privileges at one UnitedHealthcare Community Plan participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the Michigan DHHS Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, seven days a week.

Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

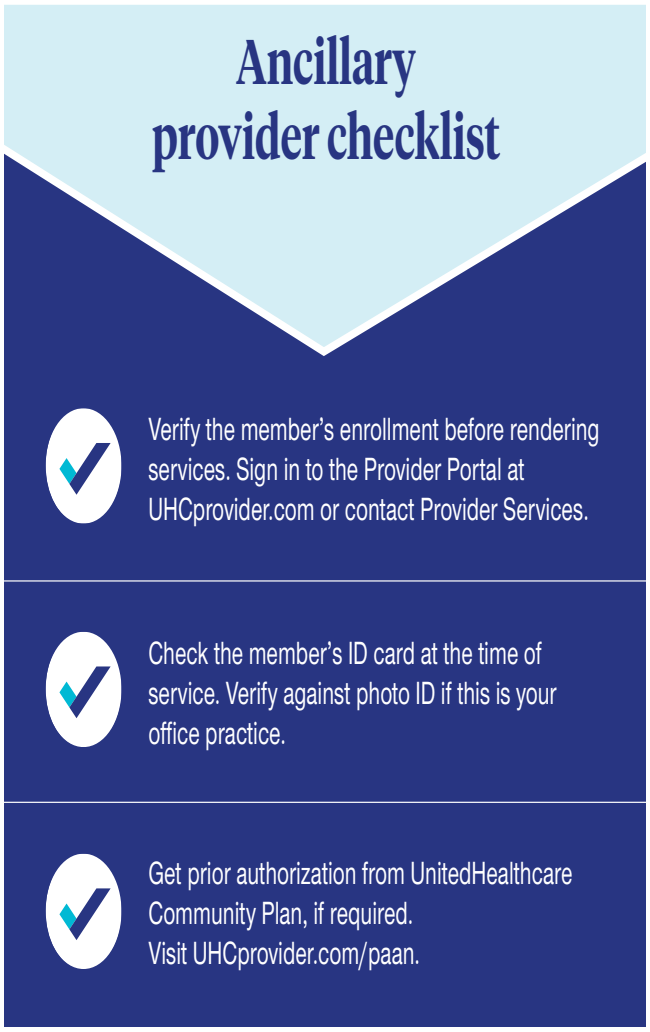
Specialists may use medical residents in all specialty care settings under the supervision of fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

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

Ancillary provider responsibilities

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

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



Chapter 3: Care provider office procedures and member benefits

Key contacts

Topic	Link	Phone Number
Member Benefits	UHCcommunityplan.com/mi	1-800-903-5253
Member Handbook	UHCcommunityplan.com/mi > Go to Plan Details, then Member Resources, View Available Resources	
Provider Services	UHCprovider.com/MIcommunityplan	1-800-903-5253
Prior Authorization	UHCprovider.com/paan	
DSNP	UHCprovider.com/MI > Medicare > Michigan Dual Complete Special Needs Plans	

To view member benefit coverage information, go to UHCcommunityplan.com/mi > select the applicable plan.

Assignment to PCP panel roster

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

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

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

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

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

Choosing a PCP

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

The Michigan Department of Health & Human Services (MDHHS) contracts with Michigan Enrolls, an enrollment services contractor, to enroll, disenroll and change a member's enrollment. Members requesting changes must contact Michigan Enrolls at 1-888-367-6557 or 1-800-975-7630.

Michigan Enrolls will reassign a member to UnitedHealthcare Community Plan if they were previously disenrolled due to no longer being Medicaid-eligible, and who are found eligible again within 3 months. We cannot request a member be disenrolled due to an adverse change in their health or because of a health condition.

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. Capitation reimbursement will be pro-rated for members changing their PCP mid-month. We allow members to change their PCP one time per month, unless there are extenuating circumstances.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

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

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

Member assignment

Assignment to UnitedHealthcare Community Plan

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

At enrollment time, each member receives a welcome kit instructing them how to obtain a member handbook. The handbook explains the member's health care rights and responsibilities through UnitedHealthcare Community Plan.

Medicaid members are locked into a health plan for 12 months. The Centers for Medicare & Medicaid Services (CMS) requires members to have the opportunity to change health plans once per year. The case number's last digit designates the member's open enrollment month. For example, if the case number ends in 2, the designated open enrollment month is every February.

When the designated open enrollment month occurs during the 90-day Medicaid Health Plan (MHP) change period, the member will not receive an open enrollment letter. The next open enrollment period for these members will be 12 months from the date of their last open enrollment letter, or in their designated month the following year, whichever date results in the member receiving a plan change notification letter at least once during each 12 month period.

If a member's case number changes they may have 2 open enrollment periods in a 12-month period. Open enrollment letters will be mailed during November and December each year to those that did not receive a change plans notice within the past 12-month period.

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

Immediate enrollment changes

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

Get eligibility information by calling Provider Services.

Unborn enrollment changes

Encourage your members to notify the Michigan DHHS when they know they are expecting. DHHS notifies MCOs daily of an unborn when Michigan Medicaid learns a woman associated with the MCO is expecting. Individuals attaining eligibility due to a pregnancy are usually guaranteed eligibility for comprehensive services through 60 days post-partum or post-loss of pregnancy.

The MCO or you may use the online change report through the Michigan website to report the baby's birth. With that information, DHHS verifies the birth through the mother. The MCO and/or the care provider's information is taken as a lead. To help speed up the process, the mother should notify DHHS when the baby is born.

Members may call **1-800-903-5253**.

Newborns may get UnitedHealthcare Community Plan-covered health services beginning on their date of birth. Newborns are automatically assigned to their mother's health plan at birth. Check eligibility daily until the mother has enrolled her baby in a managed care plan. Newborns are eligible for Medicaid coverage for their birth month, and may be eligible for up to 1 year or longer.

PCP selection

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

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

Member eligibility

UnitedHealthcare Community Plan serves members enrolled with Michigan DHHS, Michigan's Medicaid program. The Michigan DHHS determines program eligibility. An individual who becomes eligible for the Michigan DHHS program either chooses or is assigned to one of the Michigan DHHS-contracted health plans.

Member ID card

Our members receive 2 forms of Medicaid identification. The state of Michigan issues each member a plastic "MIhealth" Medicaid ID card. Each member receives their own UnitedHealthcare Community Plan ID card during the first week of enrollment. Coverage can change monthly.

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 cards against some form of photo ID, such as a driver's license, if this is your office practice.

Verify enrollment and eligibility by:

- Reviewing the member's "MIhealth" Medicaid ID card and UnitedHealthcare Community Plan ID card.
- Accessing UnitedHealthcare Community Plan's secure online provider portal, UHCprovider.com.
- Calling our automated eligibility system at **1-800-903-5253**. This option allows you to receive a fax confirmation.

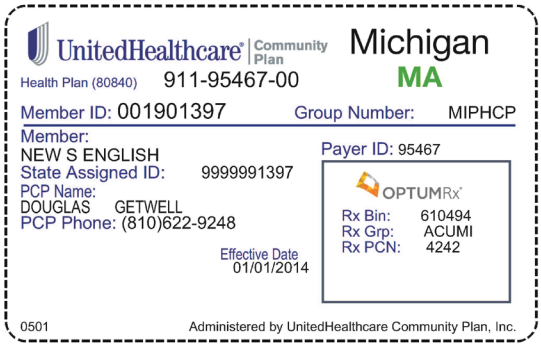
If a fraud, waste and abuse event arises from a care provider or a member, go to UHC.com/fraud. Or you may call the Fraud, Waste and Abuse Hotline.

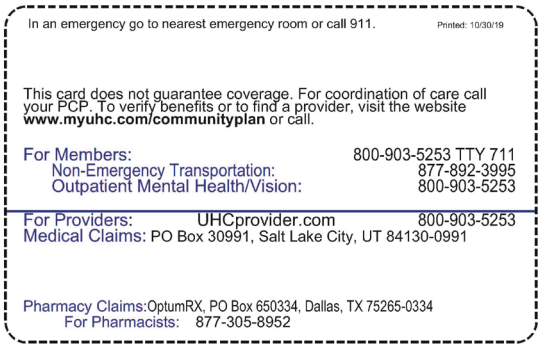
The member's ID card shows the PCP assignment on the front of the card , and "Medicaid" will show on the front lower right corner of the card. If a member does not bring their card, call Provider Services. Also document the call in the member's chart.

Member identification numbers

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

Sample health member ID card





PCP-initiated transfers

Non-compliance with treatment recommendations may not be adequate reason to transfer a member out of your practice. It is UnitedHealthcare Community Plan's responsibility to work with you to help coordinate care.

UnitedHealthcare Community Plan PCPs may request a member transfer for the following reasons:

- The member displays violent or life-threatening behavior involving physical acts of violence, physical or verbal threats of violence against you or your staff, threats or violence at your location, or when the member is determined to be an excessive menace to you or your staff.
- You and/or UnitedHealthcare Community Plan have documented evidence of fraud or misrepresentation involving alteration or theft of prescriptions, misrepresentations of UnitedHealthcare Community Plan membership or unauthorized use of benefits.
- Other non-compliance situations such as repeated failure to follow treatment plans, repeated use of non-contracted care providers, repeated ER use and other situations impeding care.
  - To transfer the member, contact UnitedHealthcare Community Plan by mail or call the Member Services number on the back of the member's card, with the specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, including prior warning notice(s) to the member that a continued behavior may result in a PCP transfer request, member name, date of birth, Medicaid number, current address, current phone number and the care provider's name. Send certified notification to the member, and mail the request and supporting documentation to:

    Mailing address:
    UnitedHealthcare Community Plan
    Attn: Health Services
    P.O. Box 30991
    Salt Lake City, UT 84130
  - UnitedHealthcare Community Plan prepares a summary within 5 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
  - If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
  - If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have 5 business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

Verifying member enrollment

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

- Provider Portal: access the Provider Portal through **UHCprovider.com/eligibility**
- **UnitedHealthcare Provider Services** is available from 7 a.m. - 5 p.m. CT, Monday through Friday.
- **Michigan Medicaid Eligibility System (MES)**

UnitedHealthcare Dual Complete (HMO D-SNP)

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

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

For information regarding UnitedHealthcare Dual Complete, please see the Medicare Products chapter of the Administrative Guide for Commercial, Medicare Advantage and D-SNP at **UHCprovider.com/guides**. For state-specific information, go to UHCprovider.com/MI > Medicare > **UnitedHealthcare Dual Complete Special Needs Plans**.

Chapter 4: Medical management

Key contacts

Topic	Link	Phone Number
Referrals	UHCprovider.com > Referrals	**1-800-903-5253**
Prior Authorization	UHCprovider.com/paan	
Pharmacy	professionals.optumrx.com	
Healthy First Steps	uhchealthyfirststeps.com	**1-800-599-5985**

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

Transition of care policy

UnitedHealthcare Community plan assists members transitioning to the health plan. As soon as they become an active member, they will have access to all the services we offer.

Members will be provided with access to services the entire time they are a part of UnitedHealthcare Community Plan.

If you need help transitioning care for your member, call **Provider Services** at **1-800-903-5253**.

To get a copy of our transition of care policy go to UHCprovider.com.

Ambulance services

Air ambulance

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

- Great distances or other obstacles keep members from reaching the destination
- Immediate admission is essential
- The pickup point is inaccessible by land
- Non-emergent air ambulance requires prior authorization

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

Emergency ambulance transportation

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

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

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

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

Non-emergency medical transportation

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

Non-emergent medical transportation requests are accepted between 8 a.m. and 5 p.m. ET.

Bus transportation will also be available if the member:

- Lives less than half a mile from a bus stop
- Has an appointment less than half a mile from the bus stop

Cardiology

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

You must obtain prior authorization for the following cardiology procedures:

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

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

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

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

Request prior authorization online or by phone:

- Online: UHCprovider.com/cardiology > Sign In
- Phone: **1-866-889-8054** from 7 a.m. – 7 p.m., Monday through Friday. Make sure the medical record is available.

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

Case management

Our Case Management Program coordinates health care services for our medically complex and high-risk members.

Case Management involves:

- Coordinating member's health care services, including home health care.
- Member and family education about the illness, maintaining wellness and preventing acute episodes
- Reducing exacerbations resulting in ER visits and hospital readmissions
- Care coordination is performed by case managers and outreach specialists

The Case Management process is most successful in achieving desired outcomes when medically complex and high-risk members are identified early and UnitedHealthcare Community Plan case managers, in collaboration with the member's health care providers, can initiate interventions as soon as possible.

If you have a UnitedHealthcare Community Plan member who may benefit from this program, please call us at **1-800-903-5253**.

Communicable diseases

You must report communicable diseases per the time frames specified by the Michigan Department of Health & Human Services (MDHHS).

How to report

Mail, call, or fax your local health department with the member demographics, diagnosis and onset date.

If you have a question, need a form or want information, contact:

Michigan Department of Community Health
Communicable Disease Epidemiology Division
201 Townsend St. 5th Floor
Lansing, MI 48913

Phone: 1-517-335-8165

Fax: 1-517-335-8121

After hour emergency calls only: 1-517-335-9030

Online:

- Michigan.gov/mdhhs: for more communicable disease information, resources and reporting
- Find a county health department and contact information at Michigan.gov/mdhhs

Discharge planning

Discharge planning helps ensure the member's home needs will be anticipated and met. The facility discharge planner should notify our Health Services department of issues that may affect discharge. This may include:

- Member's ability to care for self after discharge, including ability to understand instructions
- Member's home support system (family, chore worker)
- Member's home situation (house, apartment, shelter, street, stairs, etc.)
- Member's social situation (drug abuse, other abuse)
- Needed discharge equipment (or equipment already at home)
- Needed discharge services (Home Health, Infusion, SNF, Rehab)
- Previous non-compliance or failure to follow-up with you
- Discharge medications

Our Health Services department is available to assist you and/or the facility in making discharge arrangements and outpatient care plans, such as difficult placements or case management for catastrophic illnesses or injuries.

Prior authorization is required for some post-hospital outpatient services such as home health, home IV infusion, etc. Use our in-network care providers when available.

View prior authorization information and notification requirements at UHCprovider.com/MICommunityPlan > **Prior Authorization and Notification**.

Disease management programs

UnitedHealthcare Community Plan has disease management programs to meet the needs of our members with chronic illnesses, and to support your efforts for member self-management and optimal health status. These programs are based on nationally recognized and evidence-based clinical practice guidelines. There is no cost to our members to participate in these 4 programs:

- Asthma
- CHF
- COPD
- Diabetes

We automatically enroll members who have one of these diagnoses, but you may also refer a newly diagnosed member by calling **1-800-903-5253** and asking to speak with a Disease Management Nurse.

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 non-emergency services such as sprains/strains, stomachaches, earaches, fevers, cough, colds and sore throats.

Covered services include:

- Hospital emergency department room, ancillary and other care by in and out-of-network care providers.
- Medical and screening examinations consistent with Emergency Medical Treatment and Labor Act (EMTALA).
- 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 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.

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

Urgent care (non-emergent)

Urgent care services are covered.

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

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

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

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

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

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.

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

Family planning

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

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

Voluntary sterilization

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the DHHS Regulations for more information on sterilization.

Hearing services

Monaural and binaural hearing aids are covered, including fitting, follow-up care, batteries and repair. Bilateral cochlear implants, including implants, parts, accessories, batteries, charges and repairs are covered. Prior authorization requirements may apply. View prior authorization information and notification requirements at UHCprovider.com/MICommunityPlan > **Prior Authorization and Notification**.

Hospital admissions

Base hospital admissions on medical necessity and appropriateness of care. The hospital/admitting facility must verify that UnitedHealthcare Community Plan authorized an admission. Contact UnitedHealthcare Community Plan by calling **1-800-903-5253**, Monday – Friday, 8:30 a.m. – 5:30 p.m.

Elective admissions

UnitedHealthcare Community Plan must prior authorize all elective admissions. Inpatient and outpatient elective procedures require prior authorization if they are on the **Prior Authorization List**. Please call at least 72 hours before the procedure.

Admit non-emergent surgery patients on the day of surgery, unless pre-op days are medically necessary and authorized by our Health Services department in advance.

Perform diagnostic and laboratory tests before admission. Results and copies of pertinent medical records should accompany the member to the hospital.

Hospital admission notification by the PCP

When a member's condition requires hospitalization, the admitting care provider should obtain admission authorization by calling UnitedHealthcare Community Plan and providing the needed information.

You must observe the following utilization management inpatient admission requirements:

- The hospital or attending care provider must contact us for each admission.
- We inform you or the facility of the date we must receive clinical information (if applicable).

Hospital admission notification by the facility

The facility must verify member eligibility. Contact UnitedHealthcare Community Plan for inpatient admissions within 24 hours or the next business day.

- UnitedHealthcare Community Plan authorizes additional days when the facility contacts us by phone for concurrent review, before the exhaustion of the initial or approved length of stay.
- The facility must contact us with discharge information by phone to help ensure coordination of care between health care settings.
- The facility must notify us when a UnitedHealthcare Community Plan member is transferred to another facility.

Hospice

UnitedHealthcare Community Plan covers in-home hospice and short-stay inpatient hospice. Please refer to the prior authorization list at UHCprovider.com/MICommunityPlan > **Prior Authorization and Notification** for authorization requirements.

Laboratory

Joint Venture Hospital Laboratories (JVHL) is the preferred lab provider. Contact JVHL directly.

Process outpatient laboratory services through a UnitedHealthcare Community Plan contracted care provider.

Contact JVHL at 1-800-445-4979 for assistance in arranging services with a JVHL or UnitedHealthcare Community Plan hospital provider.

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

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

See the Billing and Submission chapter for more information.

Maternity/pregnancy/well-child care

Pregnancy notification risk screening

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

Access the digital Notification of Pregnancy through the Provider Portal at **UHCprovider.com**. You may also call Call Healthy First Steps at **1-800-599-5985.**

Healthy First Steps strives to:

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

- Encourage members to stop smoking with our Quit for Life tobacco program
- Help identify and build the mother's support system including referrals to community resources and pregnancy support programs.

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

Pregnancy/maternity

You must bill antepartum care, delivery and postpartum care visits separately using the following codes:

Antepartum Visits: all prenatal visit dates, along with LMP or EDD/EDC, must be included with the claim.

- 59425—Antepartum care only, 4–6 visits OR
- 59426—Antepartum care only, 7 or more visits

*HEDIS® & ACOG Guidelines state the first prenatal care visit must be completed in the first trimester or the first 42 days the member is enrolled in a health plan.

Postpartum Visit: 59430 – postpartum care only (required 7-84 days from delivery)

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.

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

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

Notify UnitedHealthcare Community Plan immediately of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program. You must notify UnitedHealthcare Community Plan if a member's pregnancy is determined to be high risk.

To notify UnitedHealthcare Community Plan of pregnancies, call Provider Services.

A UnitedHealthcare Community Plan member does not need a referral from her PCP for OB/GYN care.

Maternity admissions

All maternity admissions require notification. Days in excess of 48 hours for vaginal deliveries and 96 hours for C-section require clinical information and medical necessity review. ER labor checks do not require prior authorization. A labor check is a stay for maternity purposes of less than six hours.

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

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

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

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

- Date and time of delivery.
- Gender.
- Birth weight.
- Gestational age.
- Baby name.
- Method of delivery.
- Apgar scores and discharge date, if known.

Non-routine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires prior authorization. Infants remaining in the hospital after mother's discharge require separate notification and will be subject to medical necessity review.

Newborn enrollment

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

Bright Futures assessment

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

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

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

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

Hysterectomies

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

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

Find the form on the Michigan Department of Social Services website at michigan.gov/.

See “Sterilization consent form” section on next page for more information. Exception: Michigan DHHS 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.

Before claim submission, mail the completed consent form and UnitedHealthcare Community Plan’s Consent Submission Form to:

UnitedHealthcare Community Plan
P.O. Box 30991
Salt Lake City, UT 84130-0991

Reimbursement is made upon completion of documentation requirements and UnitedHealthcare Community Plan review. The member may not be billed if consent forms are not submitted.

Pregnancy termination services

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

Allowable pregnancy termination services do not require a referral from the member’s PCP.

Prior authorization is required for abortions, regardless if the member uses an in-network or out-of-network care provider.

Sterilization and hysterectomy procedures

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

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

Sterilization informed consent

A member has only given informed consent if the Michigan 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

Obtain an informed consent to sterilization form through the state of Michigan Medical Services Administration by calling 1-800-292-2550. Before claim submission, mail the UnitedHealthcare Community Plan's Consent Submission Form to:

UnitedHealthcare Community Plan
P.O. Box 30991
Salt Lake City, UT 84130-0991

Use the consent form for sterilization:

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

However, do not sign and date the form until after you perform the procedure.

You may also find the form on the Michigan Department of Social Services website at michigan.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.

Maternal Infant Health Program (MIHP)

The MIHP program promotes healthy pregnancies, infant growth and development, while seeking to reduce maternal and infant mortality. Pregnant Medicaid members can qualify for MIHP at any time during their pregnancy, while newborns may qualify at birth.

MIHP services intend to supplement regular prenatal/infant care and assist health care providers in managing the mother and baby's health and wellbeing. These

services provide assistance to help support families' basic needs, prenatal and parenting education, and referrals to community resources.

Screen all pregnant members to determine if they qualify for MIHP. Members must meet certain criteria to qualify for services.

For more information and program documents, go to the Michigan MIHP website at michigan.gov/mihp.

Neonatal intensive care unit (NICU) case management

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

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

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

Inhaled nitric oxide

Use the NRS guideline for Inhaled Nitric Oxide (iNO) therapy at UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > Clinical Guidelines.

Pharmacy programs

Preferred Drug List

We provide UnitedHealthcare Community Plan's formulary, or Preferred Drug List (PDL), to assist in the selection of cost-effective therapies. Prescription benefit includes some over-the-counter (OTC) products. Find covered OTC products in the complete PDL.

We communicate PDL updates through prescriber mailings and monthly website updates. Obtain the UnitedHealthcare Community Plan PDL by contacting your provider advocate or view the UnitedHealthcare Community Plan PDL.

Pharmacy PDL

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

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

If a member requires a non-preferred medication, call the Pharmacy Provider Services at **1-800-310-6826** or use the online Prior Authorization and Notification tool on the Provider Portal at UHCprovider.com.

Find the PDL and Pharmacy Prior Notification Request form at UHCprovider.com/priorauth.

We communicate PDL updates through prescriber mailings and monthly website updates. Obtain the UnitedHealthcare Community Plan PDL by contacting your provider advocate or view the UnitedHealthcare Community Plan PDL.

Requests to add medications to the PDL

Send PDL suggestions to the UnitedHealthcare Community Plan Director of Pharmacy at:

Attn: Director of Pharmacy Services
UnitedHealthcare Community Plan Unison Plaza
1001 Brinton Road
Pittsburgh, PA 15221

Provide adequate clinical documentation, such as clinical necessity, as well as therapeutic advantages over current PDL products. UnitedHealthcare Community

Plan's Pharmacy and Therapeutics Committee will review submitted suggestions at the subsequent P&T meeting.

Prescription guidelines and pharmacy authorizations

Prescriptions may cover up to a maximum 30-day medication supply. Refills are permitted as medically necessary, but will only be dispensed if the member is UnitedHealthcare Community Plan eligible. All medications (prescription and OTC) require a valid prescription from the prescribing care provider. The member must first have tried and failed listed PDL agent(s) before authorization being reviewed for non-PDL agents.

Health care providers may request a pharmacy prior authorization (PA) or a medical exception for a non-PDL medication. Find pharmacy prior authorization forms on our website. Submit prior authorization or exception requests to Pharmacy Services by completing and calling **1-800-310-6826**.

Upon approval, Pharmacy Services places a system override to allow the claim to pay online at the UnitedHealthcare Community Plan participating pharmacy. If the requested medication criteria is not met, Pharmacy Services sends a notification to the requesting care provider, which will include member appeal rights.

Pharmacy appeal requests

UnitedHealthcare Community Plan decisions may be appealed by the member or the member's health care provider on behalf of the member, if the member has given the care provider power of attorney. Mail appeal requests to UnitedHealthcare Community Plan at:

UnitedHealthcare Community Plan
Grievance and Appeals Department
P.O. Box 30991
Salt Lake City, UT 84130-0991

Specialty pharmacy medications

The Specialty Pharmacy Management Program provides high-quality, cost-effective care for our members.

A specialty pharmacy medication is a high-cost drug that generally has one or more of the following characteristics:

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

Specialty pharmacy medications are available through our specialty pharmacy network.

For more information about Specialty Pharmacy Medications, go to UHCprovider.com > Prior Authorization and Notification > **Clinical Pharmacy and Specialty Drugs**.

Screening, Brief Interventions, and Referral to Treatment (SBIRT) services

SBIRT services are covered when:

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

What is included in SBIRT?

Screening: With just a few questions on a questionnaire or in an interview, you can identify members who have alcohol or other drug (substance) use problems and determine how severe those problems already are. 3 of the most widely used screening tools are the Alcohol Use Disorders Identification Test (AUDIT), the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and the Drug Abuse Screening Test (DAST).

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

Referral to treatment: Refer members whose screening indicates a severe problem or dependence s to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder.

This includes coordinating with the Alcohol and Drug Program in the County where the member resides for treatment.

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

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

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

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

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

Medication-assisted treatment

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

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

To find a medical MAT provider in Michigan:

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

If you have questions about MAT, please call Provider Services at **1-800-903-5253**, enter your Tax Identification Number (TIN) then say 'Representative', and 'Representative' a second time, then 'Something Else' to speak to a representative.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

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

For behavioral health and substance use disorder authorizations, please contact OptumHealth Behavioral Solutions.

Prior authorization information

UnitedHealthcare Community Plan can add or delete required prior authorization procedures. We will post updates on UHCprovider.com/MICommunityPlan > **Prior Authorization and Notification**.

- Services requiring prior authorization must have a certification number from UnitedHealthcare Community Plan before you render services
- For services requiring prior authorization, specialists and PCPs must request authorization no less than 3 business days before the planned service date
- If services will be performed within 48 hours of the prior authorization request, you must call the request in to us at **1-800-903-5253**
- If requesting prior authorization services by telephone, you will receive a certification number based on clinical information supporting the request at the time of call
- If requesting prior authorization services by telephone, you will receive a reference number for requests that have to be pended for clinical review. For requests that can be approved immediately, a prior authorization number will be provided at the time of call.

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

Concurrent review guidelines

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

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

Concurrent review details

Concurrent Review is notification within 24 hours or 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 a record review.

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

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

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

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

- Prevent, diagnose, alleviate or cure a physical or mental illness or condition
- Maintain health
- Prevent the onset of an illness, condition or disability
- Prevent or treat a condition that endangers life, causes suffering or pain or results in illness or infirmity
- Prevent the deterioration of a condition
- Promote daily activities; remember the member's functional capacity and capabilities appropriate for individuals of the same age
- Prevent or treat a condition that threatens to cause or worsen a handicap, physical deformity, or malfunction; there is no other equally effective, more conservative or substantially less costly treatment available to the member
- Not experimental treatments

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**.

Preventive health and clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs.

Visit **UHCprovider.com/cpg** to view the guidelines. They are an important resource to guide clinical decision-making.

Pain management

UnitedHealthcare Community Plan of Michigan uses the "Michigan Guidelines for the Use of Controlled Substances for the Treatment of Pain" guidelines and conducts medical record review to monitor compliance. These guidelines address the medical management of pain and effective and appropriate pain relief. View these guidelines on the Michigan Department of Health & Human Services website at **michigan.gov** or contact your provider advocate to obtain a hard copy.

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 do not require a hard copy referral form when you are referring a UnitedHealthcare Community Plan member to another participating UnitedHealthcare Community Plan care provider. Non-participating UnitedHealthcare Community Plan care providers must contact us at **1-800-903-5253** to obtain prior approval. Either the specialist or the referring PCP can contact us for prior approval. It is the responsibility of the specialist to:

- Verify member eligibility prior to rendering the service
- Communicate outcomes to the referring PCP to help ensure coordination of care
- 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.

General referral information

- Pediatric members may self-refer to any UnitedHealthcare Community Plan participating pediatrician
- Female members may self-refer to any UnitedHealthcare Community Plan contracted OB/GYN for well woman care
- Direct glucometer referrals to the designated UnitedHealthcare Community Plan pharmacy vendor with a prescription
- Refer advanced cardiac and cardiovascular studies, as well as cardiac and pulmonary rehabilitation services to an UnitedHealthcare Community Plan specialist if you are not board-certified in Cardiology
- Refer nerve conduction studies (NCVs) and electromyograms (EMGs) to an UnitedHealthcare Community Plan specialist if you are not board-certified in Neurology

Reimbursement

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

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

UnitedHealthcare Community Plan will not reimburse:

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

Second opinion benefit

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the Michigan DHHS. 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. 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 provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact UnitedHealthcare Community Plan at **1-800-903-5253.**
- 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 requiring prior authorization

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

Direct access services – Native Americans

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

Seek prior authorization within the following time frames

- **Emergency or Urgent Facility Admission:** 1 business day
- **Inpatient Admissions; After Ambulatory Surgery:** 1 business day
- **Non-Emergency Admissions and/or Outpatient Services (except maternity):** at least 14 business days beforehand; if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time

Utilization management guidelines

Call **1-800-903-5253** to discuss the guidelines and utilization management.

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

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 non-covered services. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal.

See Appeals in **Chapter 12** for more details.

Vision services

UnitedHealthcare Community Plan uses MARCH® Vision Care for vision services. Members may self-refer to participating MARCH Vision Care optometrists for covered vision services. Find the MARCH Vision Care Provider Directory online at **marchvisioncare.com**.

- Diabetic members may obtain a retinal eye exam annually
- Help ensure your assigned members with diabetes obtain a dilated eye exam annually
- We contract with ophthalmologists for management of non-routine eye diseases and conditions; PCPs may refer members for these services and care.
- Submit claims to MARCH Vision Care, not to UnitedHealthcare Community Plan

Optometry care providers must verify member eligibility and benefit coverage by contacting MARCH Vision Care at 1-800-903-5253 or online at **marchvisioncare.com**.

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

Key contacts

Topic	Link	Phone Number
EPSDT	brightfutures.aap.org	1-517-484-3013
Vaccines for Children	michigan.gov/vfc	1-517-335-8159

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 to age 21, including pregnant women. EPSDT screening includes immunizations, hearing, vision, speech screening and nutritional assessments; dental screening; and growth and development tracking.

For complete details about diagnoses codes as well as full and partial screening, examination, and immunization requirements, go to the EPSDT schedule. Find care provider resources and information on EPSDT/Well Child Exam forms, billing codes, Developmental Screening tools, Immunization Tools and Resources for Women, Infants & Children (WIC) at ihp.msu.edu.

To find the Healthy Child Forms, go to: brightfutures.aap.org.
Find details on how to fill out the Healthy Child form at: toolkits.solutions.aap.org.

Addressing a child's developmental delays – Early On

Early On® Michigan offers early intervention services for infants and toddlers, birth to 3 years of age, with developmental delays and/or disabilities, and their families.

If you think your infant or toddler may have a developmental delay, contact Early On at 1-800-Early-On or visit 1800earlyon.org to learn more.

Full screening

Perform a full screen. Include:

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

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

Interperiodic screens

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

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

Lead screening/treatment

The state of Michigan requires all Medicaid-eligible children be tested for lead at 12 and 24 months of age, or between 36 and 72 months if not tested previously. Call Provider Services if you find a child has a lead blood level over 10ug/dL. Children with elevated blood lead levels will be offered enrollment in a care coordination program.

UnitedHealthcare Community Plan provides 3 convenient methods for obtaining specimens in the provider office, to help ensure greater member compliance. These are:

- MedTox filter paper kits: we offer these kits at no charge to our care providers. This method uses 2 drops of fingerstick blood to obtain a blood lead screen. Once collected, send the samples to the MedTox laboratory in prepaid envelopes through U.S. mail. MedTox faxes results to care provider offices and reports results electronically to MDHHS within 48 hours (usually) of MedTox laboratory sample receipt. Find more information about provided supplies at **MedTox.com** or call MedTox at 1-877-725-7241.
- The Michigan Department of Community Health filter paper kit: Call MDHHS at 1-517-335-9867 to obtain free filter paper blood lead collection kits or other lead collection supplies. The MDHHS Bureau of Laboratories accepts micro tube samples and also offers the option to obtain and submit filter paper blood lead samples of Medicaid-eligible children for state lab processing.

Find more information on lead testing, filter paper and the proper sample collection technique on the MDHHS website at **michigan.gov**.

Labs must submit a copy of the blood lead level results to the Michigan Lead Registry. More information on lead testing and lead poisoning can be found on the Michigan Department of Community Health site at **michigan.gov**.

Vaccines for Children program (VFC)

The Vaccines for Children program provides immunizations. Michigan Medicaid requires you to register with the federal VFC program to obtain free vaccines for Michigan Medicaid members. 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. State of Michigan Division of Communicable Disease and Immunizations: 1-517-335-8159.

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

- Eligible for Medicaid
- American Indian or Alaska Native, as defined by the Indian Health Services Act
- Uninsured
- Underinsured (these children have health insurance, but the benefit plan does not cover immunizations

Children in this category may not only receive vaccinations from a federally qualified health center or rural health clinic; they cannot receive vaccinations from a private health care provider using a VFC-supplied vaccine).

Michigan Childhood Immunization Registry (MCIR)

You are required by law to report to MCIR each immunization provided to a child born after Dec. 31, 1993. MCIR is an electronic database for care provider immunization data. You may only use this data for immunization purposes and blood lead results. You may use MCIR to access a child's record to determine the completeness of their immunizations.

An optional Vaccine Inventory Module can assist you with vaccine inventory management and generate reports for VFC program documentation.

You can access MCIR by modem, direct line, or a fax-back system. For more information, visit the MCIR website at **mcir.org**.

Chapter 6: Value-added services

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com/MIcommunityplan	**1-800-903-5253**
Healthy First Steps	uhchealthyfirststeps.com	**1-800-599-5985**
Value Added Services	UHCcommunityplan.com/MI >View Plan Details	**1-800-903-5253**

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call **Provider Services** at **1-800-903-5253** unless otherwise noted.

Adult pain management/ chiropractic services

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

We provide members with up to 18 visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.

Use the following steps to access the fee schedules online:

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

For more information on chiropractic care, go to myoptumhealthphysicalhealth.com.

Chronic condition management

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

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

Identification – The health plan uses claims data (e.g., hospital admissions, ER visits, and 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.

Healthy First Steps Rewards

Healthy First Steps (HFS) is a specialized case management program designed to provide assistance to all pregnant members, those experiencing an uncomplicated pregnancy, as well as additional medical, behavioral, and social risks. The goal is improving birth outcomes and lowering Neonatal Intensive Care Unit (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. Members get reminders of upcoming appointments and record completed visits.

How You Can Help

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

Mobile Apps

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

- **Health4Me** enables users to review health benefits, access claims information and locate in-network providers.

Quit For Life

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

State-funded programs

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

For more information about WIC, go to wiccp.state.mi.us/clientPortal/WebForms/PublicPages/WICClinics.aspx.

Chapter 7: Mental health and substance use

Key contacts

Topic	Link	Phone Number
Behavioral Health/Provider Express	providerexpress.com	**1-800-888-2998**
Provider Services	UHCprovider.com/MIcommunityplan	**1-800-903-5253**

OptumHealth Behavioral Solutions (OBH) provides UnitedHealthcare Community Plan members with unlimited outpatient mental health visits for members with mild to moderate mental health diagnoses. The remainder of the mental health and substance use disorder benefit is carved out to the state of Michigan.

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

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

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

How to join our behavioral health network

Credentialing information is available at providerexpress.com > Clinical Resources > Guidelines/Policies & Manuals > Credentialing Plans > Optum.

Chronic mental health conditions and substance abuse

Refer a member with a chronic condition meeting the MSA criteria for Serious and Persistent Mental Health Illness (SPMI-adults) or Severe Emotional Disturbance (SED children) to the Community Mental Health (CMH) agency in the member's county of residence.

The Substance Abuse Coordinating Agency in the member's county of residence is responsible for substance abuse treatment.

Please visit Michigan.gov for county contact numbers for SPMI and substance abuse referrals.

Eligibility

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

Authorizations

Prior authorization is required for out-of-network care providers. Get prior authorization by going to UHCprovider.com/priorauth or calling **Provider Services** at **1-800-903-5253**.

Collaboration with other care providers

Coordination of care

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

- Is prescribed medication,

- Has coexisting medical/psychiatric symptoms, or
- Has been hospitalized for a medical or psychiatric condition

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

Portal access

Website: **UHCprovider.com**

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

View the Prior Authorization list, find forms and access the care provider manual. Or call the **Provider Services** at **1-800-903-5253** to verify eligibility and benefit information (available 8:30 a.m. - 5:30 p.m., ET, Monday through Friday).

Website: **providerexpress.com**

Update your practice information, review guidelines and policies, and view the national Optum Network Manual. Or call **Provider Services** at **1-800-903-5253**.

Claims

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

Monitoring audits

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

Addressing the opioid epidemic

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

Brief summary of framework

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

Increasing education and awareness of opioids

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

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

Prescribing opioids

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

Pharmacy lock-in

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

Expanding MAT 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 services, such as counseling, cognitive behavioral therapies, and recovery support, to provide a comprehensive approach to OUD. We expand MAT access and help ensure we have an adequate member MAT network.

To find a behavioral health MAT provider in Michigan:

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.

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

Chapter 8: Member rights and responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	UHCcommunityplan.com/mi	1-800-903-5253
Member Handbook	UHCcommunityplan.com/mi > Community Plan > Member benefits	

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 PHI

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

Amendment of PHI

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

Accounting of disclosures

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

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

Right to request restrictions

Members have the right to ask you 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 could endanger them. Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Member rights and responsibilities

The following information is in the Member Handbook at the following link under the Member Information tab: UHCcommunityplan.com/MI > UnitedHealthcare Community Plan.

Native American access to care

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

Member rights

Members may:

- 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
- Receive information about health services and how to obtain them
- Know the qualifications of their health care provider
- Give their consent for treatment unless unable to do so because life or health is in immediate danger
- Discuss any and all treatment options with you
- Refuse treatment directly or through an advance directive
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do
- Receive medically necessary services covered by their benefit plan
- Receive information about in-network care providers and practitioners, and choose a care provider from our network
- 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
- Request a fair hearing or have an external review
- 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. Expect that their medical records and communications will be treated in a confidential manner as required by law.
- 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. If not available in-network, the member must go through the prior authorization process for an out-of-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
- See any in-network OB/GYN for well woman exams or obstetrical care without a referral from their PCP
- See any in-network pediatrician without a PCP referral if they are younger than 18 years old
- Ask for information about our care provider payment arrangements, and if they may affect referral use and other needed services
- Get a copy of these rights and responsibilities or have them explained if they have questions

Member responsibilities

Members should:

- Understand their benefits so they can get the most value from them
- Show you their Medicaid member ID card
- Inform us of other health insurance coverage
- Always carry their member ID card and 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
- Tell you their complete health history, and about any changes in their health
- 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
- Report emergency treatment to you within 48 hours. Report an emergency stay at a hospital soon after
- 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
- Know the name(s) of their medication(s), what they are for and how to use them
- Tell us if they move or change phone numbers
- Respect the rights of other UnitedHealthcare Community Plan members, doctors and staf.

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

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

Chapter 9: Medical records

Medical record charting standards

You are required to keep complete and orderly medical records, which fosters efficient and quality member care. You must establish and enforce policies and procedures for saving, storing, securing, protecting and retrieving medical records if using a computerized medical records system. 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.

Topic	Contact
Procedural Elements	**Medical records are readable*** • Sign and date all entries. • Member name/identification number is on each page of the record. • Document language or cultural needs. • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member's first language is something other than English. • Procedure for monitoring and handling missed appointments is in place. • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions. • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions.*
History	An initial history (for members seen 3 or more times) and physical is performed. It should include: • **Medical and surgical history*** • A family history that includes relevant medical history of parents and/or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance abuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults • Screenings of/for: - Recommended preventive health screenings/tests - Depression - High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit - Medicare members for functional status assessment and pain - Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

Topic	Contact
Problem Evaluation and Management	Documentation for each visit includes: • Appropriate vital signs (Measurement of height, weight, and BMI annually) - **Chief complaint*** - **Physical assessment*** - **Diagnosis*** - **Treatment plan*** • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines. • Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT). • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets. • Treatment plans are consistent with evidence-based care and with findings/diagnosis: - Time frame for follow-up visit as appropriate - Appropriate use of referrals/consults, studies, tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review. • There is evidence of care provider follow-up of abnormal results. • Unresolved issues from a previous visit are followed up on the subsequent visit. • There is evidence of coordination with behavioral health care provider. • Education, including lifestyle counseling, is documented. • Member input and/or understanding of treatment plan and options is documented. • Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented.

***Critical element**

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). Clearly and easily identify any agents causing a negative response.
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen 3 or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record.
- Tobacco habits, alcohol use and substance abuse (12 years and older).
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one.
- History of physical examination (including subjective and objective findings).
- Unresolved problems from previous visit(s) addressed in subsequent visits; Diagnosis and treatment plans consistent with finding.
- Lab and other studies as appropriate.
- Member education, counseling and/or coordination of care with other care providers.
- Notes regarding the date of return visit or other follow-up.
- Consultations, lab, imaging and special studies initialed by PCP to indicate review.
- Consultation and abnormal studies including follow-up plans.
- Document "no shows" or missed appointments along with follow-up efforts to reschedule the appointment.

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)

If 85% of the records we sample vary significantly from established standards, we will work with you and your staff to help ensure medical record documentation and record keeping practices comply with requirements.

Chapter 10: Quality management program and compliance information

Key contacts

Topic	Link	Phone Number
Credentialing	Medical: Network Management Support Team Chat with a live advocate 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 providers that meets adequacy standards
- Striving for improvement of member health care and services
- Monitoring and enhance patient safety
- Tracking member and provider satisfaction and take actions as appropriate

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

Cooperation with quality-improvement activities

You must comply with all quality-improvement activities. These include:

- Providing requested timely medical records.
- Cooperating with quality-of-care (QOC) 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.

Quality Improvement Program

UnitedHealthcare Community Plan considers all QI activities privileged and confidential, consistent with state and federal laws. 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.)

You are not required to obtain prior consent from members to share medical records with us. State law MCL 400.111b(7) permits state-contracted qualified health plans to obtain a Medicaid member's medical records for quality of care and utilization management purposes. Any other medical record disclosure by you

to an outside party should be consistent with applicable laws.

Corrective action plans

We may ask you to submit a corrective action plan if you are not in compliance with UnitedHealthcare Community Plan standards or do not cooperate with quality improvement initiatives. Required corrective actions may include changes in policies, practices or providing written verification of compliance with standards.

The Quality Improvement department reviews all corrective action plans and is available to assist you in developing and implementing plans. You may appeal findings or corrective action plan requests through written correspondence to the UnitedHealthcare Community Plan CMO.

QOC case referral

If you suspect a quality concern, report the incidence to the UnitedHealthcare Community Plan Quality Management department, which will investigate concerns with strict confidentiality. Report concerns to the Quality Management department by:

- Phone: 1-800-903-5253
- In writing to:

  UnitedHealthcare Community Plan
  Quality Management Department
  3000 Town Center, Suite 1400
  Southfield, MI 48075

Care provider satisfaction

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

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

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

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

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable Michigan 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 Drug Enforcement Administration (DEA) certificate
- Current professional liability insurance

Current board certification is not a requirement for network participation, but is a requirement for designation in the UnitedHealth Premium designation program.

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

Based on state policy, all network care providers, or any person with a 5% or more direct or indirect ownership interest in the provider, must consent to criminal background checks, including fingerprinting, as a condition of participation. MDHHS will conduct criminal background checks and will require submission of fingerprints from care providers designated as "high" categorical risk when directed by CMS.

View the Credentialing and Recredentialing Plan at UHCprovider.com > Resources > Resource Library > **Join Our Network & Credentialing**.

Facility criteria

UnitedHealthcare Community Plan credentials hospitals, free standing surgical centers, SNFs and home healthcare agencies. Criteria vary based on the facility type. General criteria for contracting with a hospital and/or ancillary site is:

- Accreditation, certification or compliance with UnitedHealthcare Community Plan established standards
- In good standing with federal and state regulatory agencies
- Current state license, if applicable
- Appropriate insurance coverage
- On-site facility review, if not accredited

Credentialing and recredentialing process

UnitedHealthcare Community Plan's credentialing and recredentialing process determines whether you are a good fit for the UnitedHealthcare Community Plan care provider network. You must go through the credentialing and recredentialing process before you may treat our members.

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

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

Excluded from this process are practitioners who:

- Practice only in an inpatient setting,
- Hospitalists employed only by the facility; and/or
- NPs and PAs who practice under a credentialed UnitedHealthcare Community Plan care provider.

UnitedHealthcare Community Plan does not make credentialing and recredentialing decisions based on race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes.

The National Credentialing Center (NCC) completes these reviews. Find applications on the Council for Affordable Quality Healthcare (CAQH) website.

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

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

Performance review

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

Applicant rights and notification

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

You also have the right to receive the status of your credentialing application, please 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.

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

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 aims to improve the efficiency and effectiveness of the United States health care system. While the Act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have had the greatest impact on how the health care industry works. UnitedHealthcare Community Plan is a "covered entity" under these regulations. So are all health care providers who conduct business electronically.

Transactions and code sets

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

Unique identifier

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

National Provider Identifier

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

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

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

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

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

Ethics and integrity

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

Compliance program

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

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

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

Reporting and auditing

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

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

To facilitate the reporting process of questionable incidents involving members or care providers, call our **Fraud, 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 about the UnitedHealthcare Community Plan Fraud, Waste and Abuse program.

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

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

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the state of Michigan 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 Michigan Department of Health and Human Services.

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be signed and dated and kept for at least 10 years from the close of the Michigan program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. The Michigan Public Health Code Act 368 of 1978, Section 333.16213 requires you to retain medical records for a minimum of seven years from the service date. 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 within 60 days.

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

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

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

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

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

Delegating and subcontracting

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

Office site quality

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

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

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

Criteria for site visits

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

The following table describes the QOC criteria and thresholds.

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

Chapter 11: Billing and submission

Key contacts

Topic	Link	Phone Number
Claims	UHCprovider.com/claims	**1-800-903-5253**
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	1-800-465-3203
EDI	UHCprovider.com/EDI	**1-800-210-8315**
Payment Policies	UHCprovider.com/en/policies-protocols/comm-plan-medicaid-policies/reimbursement-community-state-policies.html	

Our claims process

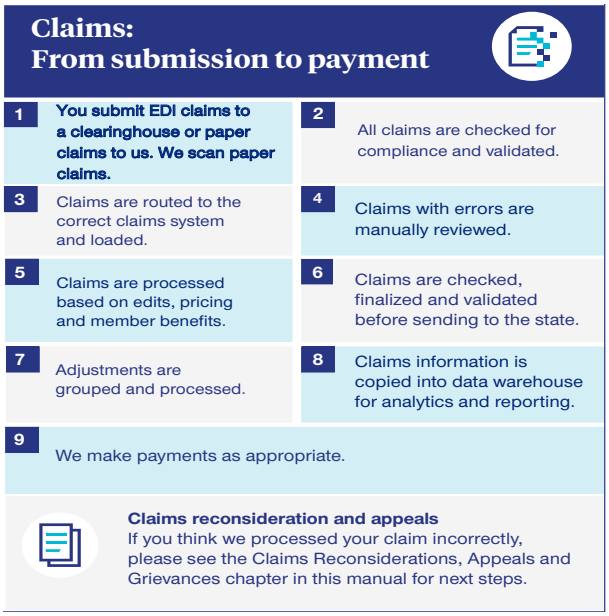
For claims, billing and payment questions, go to UHCprovider.com.

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

National Provider Identifier

HIPAA requires you have a unique NPI. The NPI identifies you in all standard transactions.Your clean claims must include your NPI and federal TIN.

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 by calling **Provider Services** at **1-800-903-5253**



General billing guidelines

We only consider reimbursing claims if you met billing and coverage requirements. Submitting a referral does not guarantee we will pay you. Payment depends on the member's coverage on the date(s) of service, medical necessity, plan rules about limitations and exclusions, and UnitedHealthcare Community Plan policies. We don't reimburse excessive, inappropriate or non-covered charges. To comply with applicable standards, policies and law, we may adjust previous payments for services and audit claims. We may seek reimbursement for overpayments or offset future payments as allowed by law. Non-contracted care providers are paid the published Medicaid Fee Screen rates applicable on the service date.

Fee schedule

UnitedHealthcare Community Plan routinely updates fee schedules in response to changes published by the state of Michigan, such as fee amount changes. We will use reasonable efforts to implement the fee schedule changes in our system within 30 days after the final publication, and make them effective in our system on the effective date of the change as designed by the state.

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). Always use the state DCN when billing claims.

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.

Claims must be computer-generated or typed. Hand writing, white-out and/or correction tape are not acceptable on the claim form. We return claims submitted with these items.

Clean claims and submission requirements

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

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

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

Submit any services completed by NPs or PAs who are part of a collaborative agreement. Use their tax ID and NPI, and we will process the claims just like other physicians.

Care provider coding

UnitedHealthcare Community Plan complies with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) state standards based on claims data and chart review. Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to find an ICD-10 code. You must code to the highest level of specificity. Include at least 1 diagnosis code, and up to 4, in order of priority (primary, secondary condition, etc.) to describe the service reason.

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.
- Our payer ID is 87726.
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don’t successfully transmit.
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for HCFA 1500 and UB-04 forms.

For more information, see EDI Claims.

EDI companion documents

UnitedHealthcare Community Plan’s companion documents are intended to share information within Implementation Guides (IG) adopted by HIPAA. The companion documents identify the data content requested when it is electronically transmitted. UnitedHealthcare Community Plan uses companion documents to:

- Clarify data content that meets the needs of the health plan’s business purposes when the IG allows multiple choices.
- Provide values the health plan will return in outbound transactions.
- Outline which situational elements the health plan requires.

The companion document provides general information and specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements.

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

Clearinghouse and status reports

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

For clearinghouse options, use our Electronic Data Exchange (EDI) at UHCprovider.com > Resources > Resource Library > EDI Clearinghouse Options.

e-Business support

Call **Provider Services** at **1-800-903-5253** for help with online billing, claims, Electronic Remittance Advices (ERAs), 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/EDI.

Electronic payment solution: OptumPay

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

Why choose ACH/direct deposit?

- Direct deposit puts payment directly into your bank account
- Easy and fast way to get paid

- Improved financial control; no paper checks or remittance information to lose or misplace
- Ability to track information on online portal

What does this mean to you?

- If your practice/healthcare organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a Virtual Card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to UHCprovider.com/payment.
- If your practice/healthcare organization is already enrolled and receiving your claim payments through AHC/direct deposit from Optum Pay or receiving Virtual Cards there is no action you need to take.
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Vault.
- 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.

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on UHCprovider.com/EDI.

Claim submissions must use data elements consistent with the Medical Service Administration's CMS Uniform Billing Guidelines. These guidelines can be found in the Michigan Medicaid Provider Manual. 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:

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

Capitated services

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period. We pay you whether that person seeks care.

Capitation payment arrangements apply to participating physicians and health care 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, and
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 providers are performing on behalf of UnitedHealthcare Community Plan.

A capitation payment report is included with the capitation payment made to capitated care providers. The capitation payment is prorated on a daily basis and computed from the member's effective date of eligibility with the PCP. Newborns are prorated from their date of birth. If a member changes PCPs at any time during a month, each PCP will receive capitation for each day the member was assigned to them.

Please contact your provider advocate for more information or questions.

Form reminders

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

- Send the referring provider's NPI and name on outpatient claims when this care provider is not the attending provider
- Include the attending provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims
- Behavioral health care providers can bill using multiple site-specific NPIs

Subrogation and coordination of benefit

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

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

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

Global days

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

For reimbursement, we follow CMS guidelines and the National Physician Fee Schedule (NPFS) Relative Value File to determine global days values. To learn more about billing for global days and their values, read our global days policy on UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > **Reimbursement Policies for Community Plan** > Global Days Policy, Professional - Reimbursement Policy - UnitedHealthcare Community Plan.

Correct Coding Initiative

UnitedHealthcare Community Plan performs coding edit procedures based on the Correct Coding Initiative (CCI) and other nationally recognized sources.

Comprehensive and component code combination edits apply when a code pair(s) appears to be related. These edits can be further broken down to explain the bundling rationale. Some of the most common causes for denials in this category are:

- Separate procedures: Only report these codes when performed independently
- Most extensive procedures: You can perform some procedures with different complexities. Only report the most extensive service
- With/without services: Don't report combinations where one code includes and the other excludes certain services
- Medical practice standards: Services part of a larger procedure are bundled
- Laboratory panels: Don't report individual components of panels or multichannel tests separately

Clinical laboratory improvements amendments

Submit your laboratory claims with the Clinical Laboratory Improvements Amendments (CLIA) number. In box 23 of the CMS 1500 claim form, enter the 10-digit CLIA certification number for laboratory services billed by an entity performing CLIA-covered procedures.

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. For more information about the CLIA number, contact the CMS CLIA Central Office at 1-410-786-3531 or go to 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 transplants

The Department of Health and Human Services covers medically necessary, non-experimental transplants. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation.

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.

Billing codes

- Non-specific CPT or HCPCS codes will be rejected as “unclean”, including most codes ending in 99 and others such as A4649, E1399, J3490, and J7799. Submit supporting documentation as a claim attachment if these codes must be used for delivered services.
- For surgical services using the above non-specific codes, submit operative notes to UnitedHealthcare Community Plan’s Medical Director for review
- Non-specific Durable Medical Equipment (DME) codes require a manufacturer’s invoice to determine pricing. If the invoice is not submitted we will deny the claim for required documentation.
- We will pay not otherwise classified (NOC) codes at 20% of billed charges, unless you and the health plan mutually agree to other payment terms before rendering the service. Ask to negotiate a rate through the authorization intake process.

Please refer to your contract or contact your provider advocate for more information about using appropriate billing codes.

Medical necessity

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

Place of Service codes

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

Asking about a claim

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

Provider Services

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

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

Allow Provider Services 45 days to solve your concern.

UnitedHealthcare Community Plan Provider Portal

You can view your online transactions with the Provider Portal by signing in at **UHCprovider.com** with your One Healthcare ID. This portal offers you with online support

any time. If you are not already registered, you may do so on the website.

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

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

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

Find Provider Portal training on **UHCprovider.com/training**.

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

Resolving claim issues

To resolve claim issues, contact **Provider Services** at **1-800-903-5253**, use the Provider Portal or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 30991
Salt Lake City, UT 94130-0991

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

For paper claims

Submit a screen shot from your accounting software that shows when you submitted the claim. The screen shot must show the correct:

- Member name
- Date of service
- Claim date submission (within the timely filing period)

Timely filing

Timely filing issues may occur if members give the wrong insurance information when you treat them.

This results in receiving:

- A denial/rejection letter from another carrier
- Another carrier's explanation of benefits
- A letter from another insurance carrier or employer group saying that the member either has no coverage or had their coverage terminated before the date of service

All of the above must include documentation the claim is for the correct member and the correct date of service. A submission report alone is not considered proof of timely filing for electronic claims. They must be accompanied by an acceptance report.The date on the other carrier's payment correspondence starts the timely filing period for submission to UnitedHealthcare Community Plan.

To be timely, you must receive the claim within the timely filing period from the date on the other carrier's correspondence. If we receive the claim after the timely filing period, it will not meet the criteria.If a claim is rejected, and corrections are not received within 90 days from date of service or close of business from the primary carrier, the claim is considered late billed. It will be denied timely filing.

Timely filing limits can vary based on state requirements and contracts. If you don't know your timely filing limit, refer to your Provider Agreement.

Balance billing

Do not balance bill members 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 are able to balance bill the member for non-covered services if the member provides written consent prior to getting the service. If you have questions, please contact your provider advocate.

Third-party resources

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

Chapter 12: Claim reconsiderations, appeals and grievances

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider agreement.

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

For member appeals and grievance information, go to **uhccp.com/mi** and view the member handbook.

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?	Digital submission and address	Online form for fax 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 normally receive a duplicate claim rejection on your resubmission.	Care Provider	UnitedHealthcare Community Plan P.O. Box 30991 Salt Lake City, UT 84130-0991	UHC provider.com/claims	**1-800-903-5253**	Use the Claims Management or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	Re-submit corrected claims within 12 months from service date	30 business days
Care Provider Claim Reconsideration (step 1 of claim dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care Provider	Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations, see the Reconsiderations and Appeals interactive guide For those care providers exempted from this requirement, requests may be submitted at the following address: UnitedHealthcare Community Plan P.O. Box 5240 Kingston, NY 12402-5240	UHC provider.com/claims	**1-800-903-5253**	Use the Claims Management or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	Must receive within 365 calendar days of the claim processing date	30 business days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

Situation	Definition	Who may submit?	Digital submission and address	Online form for fax 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 Formal Appeal (step 2 of claim dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care Provider	Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations, see the Reconsiderations and Appeals interactive guide For those care providers exempted from this requirement, requests may be submitted at the following address: UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364	UHCproviders.com/claims	**1-800-903-5253**	Use the Claims Management or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	Level 1 appeal: within 180 calendar days of the reconsideration decision letter Level 2 appeal: within 60 calendar days from the level 1 appeal decision letter	30 business days
Care Provider Grievance	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member	Care Provider	UnitedHealthcare Community Plan P.O. Box 30991 Salt Lake City, UT 84130-0991		**1-800-903-5253**	Use the Claims Management or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	120 business days	30 business days
Member Appeal	A request to change an adverse benefit determination that we made.	*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 30991 Salt Lake City, UT 84130-0991	UHCproviders.com/claims *AOR Consent Form on this site for member appeals	**1-800-903-5253**		60 calendar business days	Urgent appeals - 72 hours Standard appeals - 30 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 30991 Salt Lake City, UT 84130-0991		**1-800-903-5253**		N/A	90 calendar days

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 provider agreements than described in the standard process.

Denial

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

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

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

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

Other top reasons for denial include:

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

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

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

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

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

Claim correction

What is it?

You may need to update information on a claim you've already submitted. A corrected claim replaces a previously processed or denied claim submitted in error.

When to use:

Submit a corrected claim to fix or void one that has already processed. Submit corrected claims within 1 year of the service date if the original claim was received within the care provider's filing limit.

How to use:

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

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

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

For those care providers exempted from this requirement, requests may be submitted at the following address:

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.

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

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 30991
Salt Lake City, UT 84130-0991

Claim reconsideration (step 1 of dispute)

What is it?

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

When to use:

Reconsiderations can be done repeatedly, but should include new information each time. Submit a claim reconsideration when you think a claim has not been properly processed. Submit claim reconsiderations within 12 months from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) as required by law (or your Participation Agreement).

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

How to use:

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

- **Electronically:** Use the Claim Reconsideration application on the **Provider Portal**. Include electronic attachments. You may also check your status using the **Provider Portal**.
- **Phone:** Call **Provider Services** at **1-800-903-5253** or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.
- Most care providers in your state must submit reconsideration requests electronically.
  - For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide**
  - For those care providers exempted from this requirement, requests may be submitted at the following address:
- **Mail:** Submit the Claim Reconsideration Request Form to:

  UnitedHealthcare Community Plan
  P.O. Box 30991
  Salt Lake City, UT 84130-0991
  - This form is 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** at **1-800-903-5253** 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. If you have questions, call **Provider Services** at **1-800-903-5253**.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Valid proof of timely filing documentation (reconsideration)

What is it?

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

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

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

How to use:

Submit a reconsideration request electronically, phone or mail with the following information:

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

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 or within 60 days. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer we recoup the funds from your next payment, call **Provider Services** at **1-800-903-5253**.

If you prefer to mail a refund, send an Overpayment Return Check or the Overpayment Refund/Notification form.

Also send a letter with the check. Include the following:

- Name and contact information for the person authorized to sign checks or approve financial decisions
- Member identification number
- Date of service
- Original claim number (if known)
- Date of payment
- Amount paid
- Amount of overpayment
- Overpayment reason
- Check number

Where to send:

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

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

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

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

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

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

Sample overpayment report

***The information provided is sample data only for illustrative purposes.
Please populate and return with the data relevant to your claims that have been overpaid.**

Member ID	Date of Service	Original Claim #	Date of Payment	Paid Amount	Amount of Overpayment	Reason for Overpayment
11111	01/01/14	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 one time formal review of a processed claim that was partially paid or denied.

When to use:

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

- Submit a level 1 appeal within 180 days from the reconsideration decision letter date. You may request a level 2 appeal if you are dissatisfied with a level 1 appeal decision denial. Appeal rights are included in appeal determination letters.
- Submit a level 2 appeal within 60 days from the level 1 appeal notice. You must include additional information or documentation that could affect the level 1 decision. We will not accept a letter requesting a review of the information submitted with the level 1 appeal.

How to use/file:

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 the Claims Management or Claims on the **Provider Portal**. Click Sign in to the Provider Portal in the top right corner of **UHCprovider.com**, then click Claims. You may upload attachments. Include confirmation that UnitedHealthcare Community Plan or one of its affiliates received and accepted your claim.
- Most care providers in your state must submit reconsideration requests electronically.
  - For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide**
  - For those care providers exempted from this requirement, requests may be submitted at the following address:
- **Mail:** Send the appeal to:

  UnitedHealthcare Community Plan
  Attn: Appeals and Grievances Unit
  P.O. Box 30991
  Salt Lake City, UT 84130-0991

Discussion with care provider reviewer

Contact us at **1-800-903-5253** to discuss an adverse determination with an UnitedHealthcare Community Plan care provider or care provider reviewer, depending on the case type.

Questions about your appeal or need a status update?

Call **Provider Services** at **1-800-903-5253**. 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.

- **Phone:** Call **Provider Services** at **1-800-903-5253**
- Most care providers in your state must submit reconsideration requests electronically.
  - For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide**
  - For those care providers exempted from this requirement, requests may be submitted at the following address:
- **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. See Member Appeals and Grievances Definitions and Procedures.

Member appeals and grievances

For information regarding member appeals and grievances, refer the member to the UnitedHealthcare Community Plan Member Handbook at **UHCCommunityPlan.com/MI**.

State fair hearings

For information regarding member state fair hearings, refer the member to the UnitedHealthcare Community Plan Member Handbook at **UHCCommunityPlan.com/MI**.

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 (FWA) cases to law enforcement, regulatory and administrative agencies according to state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its Anti-Fraud, Waste and Abuse Program. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

An important aspect of the Compliance Program is reviewing our operation's high- risk areas. Then

we implement reviews and audits to help ensure compliance with law, regulations and contracts. You are contractually obligated to cooperate with the company and government authorities.

Exclusion checks

Before hiring or contracting with employees, UnitedHealthcare Community Plan of Michigan participating providers must review federal (HHS-OIG and GSA) and state exclusion lists, as applicable. This includes the hiring of temporary workers, volunteers, the CEO, senior administrators or managers, and sub delegates who are involved in or are responsible for the administration or delivery of UnitedHealthcare Community Plan benefits.

You need to:

- Ensure potential employees are not excluded from participating in federal health care programs. For more information or access to the publicly accessible excluded party online databases, use the following links:
  - Health and Human Services — Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) at oig.hhs.gov
  - General Services Administration (GSA) System for Award Management at SAM.gov
- Review the exclusion lists monthly and disclose to us any exclusion or other event that makes an individual ineligible to perform work directly or indirectly on federal health care programs
- Maintain a record of exclusion checks for 10 years. We, or CMS, may request exclusion checks documentation to verify completion

Standards of conduct awareness

You must provide a copy of your own code of conduct, or the UnitedHealth Group's Code of Conduct (at unitedhealthgroup.com > About > Ethics & Integrity > UnitedHealth Group's Code of Conduct).

You must maintain distribution standards records (i.e. in an email, website portal or contract) for 10 years. We, or CMS, may request documentation to verify compliance.

FWA and general compliance training

You should provide and administer FWA and general compliance training to employees and contractors.

Distinction between and examples of FWA

Please refer to the Glossary at the end of this manual for definitions of fraud, waste or abuse.

FWA examples include, but are not limited to the following:

- **Back filling:** Billing for part of the global fee before the claim is received for the actual global code
- **Billing for services not rendered:** Billing for services or supplies that were not provided to the membe.
- **Double billing:** Billing more than once for the same service
- **Falsified documents:** Submitting falsified or altered claims, or supporting claims with falsified or altered medical records and/or supporting documentation
- **Misrepresentation:** Misrepresenting the diagnoses and/or services provided to obtain higher payment or payment for non-covered services
- **Patient brokering:** Using "brokers" who offer money to subscribers for the use of their ID cards
- **Unbundling:** Billing each component of a service when one comprehensive code is available
- **Up-coding:** Billing at a higher level of service than was actually provided
- **Waiver of copay:** Choosing not to collect copayments or deductibles as part of the payment Agreement

Prevention and detection

We help prevent and detect potential FWA through many sources, including:

- UnitedHealthcare Payment Integrity functions
- Optum companies within UnitedHealth Group
- Health care providers
- Health plan members
- Federal and state regulators and task forces
- News media
- Professional anti-fraud and compliance associations
- CMS websites: sam.gov/SAM/

False Claims Act information

UnitedHealthcare Community Plan of Michigan participating providers must comply with federal and state False Claims Acts. The federal False Claims Act prohibits you from knowingly presenting or causing the presentation of a fraudulent claim payment. The Act also protects reporters from retaliation, including harassment, demotion and wrongful termination. In addition to the federal False Claims Act, the state of Michigan has enacted a Michigan Medicaid False Claims Act to discourage fraud against state government programs.

Citation: False Claims Acts (31 U.S.C. §§ 3729-3733).

Corrective action plans

We evaluate the appropriateness of paid claims as part of our payment integrity responsibility. We may initiate a formal corrective action plan if you do not comply with our billing guidelines or performance standards. We monitor the plan to confirm that it is in place and address any billing/performance problems.

Penalties for submitting fraudulent or abusive claims

All violations of company policies, contractual obligations, or laws, including the False Claims Act, will be taken seriously. Submitting fraudulent or abusive claims may result in discipline, up to and including legal action and suspension from UnitedHealthcare Community Plan of Michigan.

Health care provider self-disclosures

UnitedHealthcare Community Plan of Michigan participating health care providers, suppliers, or other individuals or entities subject to civil monetary penalties can use the Provider Self Disclosure Protocol to voluntarily disclose self-discovered evidence of potential fraud. Self-disclosure gives you the opportunity to avoid the costs and disruptions of a government-directed investigation and civil or administrative litigation. For more information visit the United States Department of Health & Human Services online at oig.hhs.gov.

Reporting potential FWA to us

UnitedHealthcare Community Plan has a legal responsibility to report incidents to CMS and the Office of Health Services Inspector General. If you suspect fraud, waste or abuse of the Medicaid program, call or send correspondence to either of the following:

UnitedHealthcare Community Plan
Compliance Officer
3000 Town Center, Suite 1400
Southfield, MI 48075

1-800-903-5253

Office of Inspector General
P.O. Box 30062
Lansing, MI 48909
1-855-643-7283
michigan.gov/fraud

Find out how we follow federal and state regulations around false claims at UHCprovider.com/MIcommunityplan

Chapter 13: Care provider communications and outreach

Key contacts

Topic	Link	Phone Number
Provider Education	UHCprovider.com > Resources > Resource Library	1-800-903-5253
News and Bulletins	UHCprovider.com > Resources > News	
Provider Manuals	UHCprovider.com/guides	

Communication with care providers

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

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

- UHCprovider.com: This public website is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs:
- UHCprovider.com/MIcommunityplan: The UnitedHealthcare Community Plan of Michigan page has state-specific resources, guidance and rules.
- **Michigan health plans**: UHCprovider.com/MI is the fastest way to review all of the health plans UnitedHealthcare offers in Michigan. To review plan information for another state, use the drop-down menu at UHCprovider.com > Resources > Health Plans. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **Policies and protocols**: UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans library includes UnitedHealthcare Community Plan policies and protocols.
- **Social Media:** Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics.
  - Facebook
  - Instagram
  - LinkedIn
  - YouTube
  - X (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 UnitedHealthcare CommunityCare Provider Portal user guide for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News:** Bookmark UHCprovider.com > Resources > News. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans. You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your practice and 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.

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 education and training

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

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

Email communication – required contact information

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

Submit your email address in one of the following ways:

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

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** at **1-800-903-5253** and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting **Provider Services**.

Find the following forms on the state's website at Michigan.gov:

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

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. It also includes recipient practices that result in unnecessary cost, as defined by 42 CFR 455.2.

Abuse (of member)
Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault.

Acute Inpatient Care
Care provided to members sufficiently ill or disabled requiring:

- Constant availability of medical supervision by attending care provider or other medical staff
- Constant availability of licensed nursing personnel
- Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

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

Adverse Benefit Determination

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

Ambulatory Care
Health care services that do not involve spending the night in the hospital. Also called "outpatient care". Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility
A state facility that is licensed, equipped and operated to provide surgeries and obstetrical deliveries. Members can leave the facility the same day surgery or delivery occurs.

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

Appeal
A member request that their health insurer or plan review an adverse benefit determination.

Authorization
Approval obtained by care providers from UnitedHealthcare Community Plan for a service before the service is rendered. Used interchangeably with "preauthorization" or "prior authorization."

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

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

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

Centers for Medicare & Medicaid Services (CMS)
A federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and SCHIP programs.

CHIP
Children's Health Insurance Program.

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

CMS
Centers for Medicare and Medicaid Services, the federal regulatory agency for these programs.

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

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

Disallow Amount (Amt)
Medical charges for which the network provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member. Examples are:

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

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

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

Dispute
Provider claim reconsideration: Step 1 when a provider disagrees with the payment of a service, supply, or procedure.

Provider appeal: Step 2 when a provider disagrees with the payment of a service, supply, or procedure.

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

Early Periodic Screening Diagnosis and Treatment Program (EPSDT)
A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA Section 1905 (R). Covered services include a complete health history and developmental assessment; an unclothed physical exam; immunizations; laboratory tests; health education; and screenings for vision, dental, substance abuse, mental health and hearing. They also include any medically necessary services found during the preventive exam.

Electronic Data Interchange (EDI)
The electronic exchange of information between 2 or more organizations.

Electronic Funds Transfer (EFT)
The electronic exchange of funds between 2 or more organizations.

Electronic Medical Record (EMR)
An electronic version of a member's health record and the care they have received.

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

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

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 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
An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or another person. This includes any act constituting fraud under applicable federal or state law (42 CFR § 455.2).

Grievance
Unhappiness about the plan and/or care provider regarding any matter including quality of care or service concerns. Does not include adverse benefit determination (see appeals/dispute).

Grievances may include, but are not limited to, the quality of care or services provided, and relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes an member's right to dispute an extension of time proposed to make an authorization decision.

Healthcare Effectiveness Data and Information Set (HEDIS)
A rating system developed by NCQA that helps health insurance companies, employers, and consumers learn about the value of their health plan(s) and how it compares to other plans.

HIPAA
Health Insurance Portability and Accountability Act. A federal law that provides data privacy protection and security provisions for safeguarding health information.

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

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

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

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

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

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

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

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

Out-Of-Area Care
Care received by a UnitedHealthcare Community Plan member when they are outside of their geographic territory.

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

Primary Care Provider (PCP)
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or PA, as allowed under state law and the terms of the plan who provides, coordinates or helps members access a range of health care services.

Prior Authorization (Notification)
The process where health care providers seek approval prior to rendering health care services, drugs or DME as required by UnitedHealthcare Community Plan policy.

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

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

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

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by Michigan DHHS.

Specialist
A care provider licensed in the state of Michigan and has completed a residency or fellowship focusing on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a care provider who has special training in a specific area of health care.

State Fair Hearing
An administrative hearing requested if the member does not agree with a Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

TANF
Temporary Assistance to Needy Families. A state program that gives cash assistance to low-income families with children.

Third-Party Liability (TPL)
A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan pays claims for covered benefits and pursues refunds from the third party when liability is determined.

Timely Filing
When UnitedHealthcare Community Plan puts a time limit on submitting claims.

Title XIX
Section of Social Security Act describing the Medicaid program coverage for eligible persons.

UnitedHealthcare Community Plan
An affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, 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.

Waste
The overutilization of services or practices resulting in unnecessary costs. Waste also refers to useless consumption or expenditure without adequate return.