2024
Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Minnesota

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United Healthcare® Community Plan

Welcome

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

Click the following links to access different manuals:

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

Easily find information in this care provider 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** at **1-877-440-9946** or find operational policy changes and other electronic transactions on our website at **UHCprovider.com**.

Using this care provider manual

If If there is a conflict between your Agreement and this care provider manual, use this care provider manual, unless your Agreement states you should utilize the Agreement, instead.

If there is a conflict between your Agreement, this care provider manual and applicable federal and state statutes and regulations and/or state contracts, the latter will control.

UnitedHealthcare Community Plan reserves the right to supplement this care provider manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This care provider manual will be amended as policies change.

Participation Agreement

Terms and definitions as used in this care provider manual:

- "Member" or "customer" refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement
- "You," "your" or "care provider" refers to any health care provider subject to this manual, including physicians, clinicians, facilities and ancillary care providers, except when indicated
- "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 care provider manual
- Any reference to "ID card" includes a physical or digital card

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

Table of Contents

Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	**1-877-440-9946**
Training	UHCprovider.com/training	**1-877-440-9946**
UnitedHealthcare Provider Portal	UHCprovider.com, then Sign In using your One Healthcare ID or go to UHCprovider.com/access	**1-866-842-3278** option 1
CommunityCare Provider Portal Training	UnitedHealthcare Provider Portal digital guide overview course	
Web Support	Chat with a live advocate 7 a.m.-7 p.m. CT from the UnitedHealthcare Provider Portal Contact Us page.	**1-866-842-3278** option 1
Resource Library	UHCprovider.com > Resources > Resource Library	

UnitedHealthcare Community Plan of Minnesota supports the state goals of increased access, improved health outcomes and reduced costs by offering the following Minnesota health care programs.

Medical Assistance

Medical Assistance (MA) is Minnesota's Medicaid program for people with low income.

MA is Minnesota's largest health care program and serves:

- Children, from birth through 18 years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act
- Pregnant women eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act
- Children eligible for the Children's Health Insurance Program (CHIP)
- 19–64 years old who are not eligible for another type of Medicaid and who meet certain income limits
- Medicaid-eligible families

MinnesotaCare

MinnesotaCare is a health care program for Minnesotans with low incomes.

Enrollees get health care services through a health plan. You can choose your health plan from those serving MinnesotaCare enrollees in your county.

MinnesotaCare is funded by a state tax on Minnesota hospitals and care providers, Basic Health Program funding and enrollee premiums and cost sharing.

Minnesota Senior Health Options/Minnesota Senior Care Plus

Minnesota Senior Health Options (MSHO) enrolls individuals who are:

- Eligible for Medical Assistance (MA) and enrolled in both Medicare Parts A and B
- Age 65 years old or older

MSHO includes all Medical Assistance and Medicare services in a single plan.

Minnesota Senior Care Plus (MSC+) provides Medical Assistance services only.

Special Needs Basic Care

Special Needs Basic Care (SNBC) enrolls individuals who are:

- Enrolled in MA and do not have a spend down at the time of SNBC enrollment
- Certified blind or disabled by the Social Security Administration (SSA) or the State Medical Review

Team (SMRT) or certified disabled by their county or tribal office for the Developmental Disabilities Waiver program
- Between 18–64 years old, with or without Medicare

SNBC members may be enrolled in an integrated plan that combines MA benefits with Medicare or in a plan that provides Medical Assistance services only.

If you have questions about the information in this manual or about our policies, go to UHCprovider.com or call **Provider Services** at **1-877-440-9946**.

How to join our network

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

Already in network and need to make a change?

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

Approach to health care

Population Health and Care Management Program

The Population Health and Care Management 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. Our Population Health and Care Management Program 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. This results in better quality of life, improved access to health care and reduced expenses. Our Population Health and Care Management Program 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.

Our Population Health and Care Management Program provides:

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

The goals of the Population Health and Care Management Program are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates

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

To refer your patient who is a UnitedHealthcare Community Plan member to Population Health and Care Management Program, call **Member Services** at **1-888-269-5410** TTY 711. You may also call **Provider Services** at **1-877-440-9946**.

Compliance

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

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. Linguistic and cultural barriers can negatively affect access to health care participation. You must support UnitedHealthcare Community Plan's Cultural Competency Program.

- **Cultural competency training and education:** Free continuing medical education (CME) and non-CME courses are available on our Cultural Competency page as well as other important resources. Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our data attestation process.

UnitedHealthcare Community Plan offers the following support services:

- **Language Interpretation Line:** We provide oral interpreter services 24 hours a day, 7 days a week to our members free of charge. More than 240 non-English languages and hearing impaired services are available. If a UnitedHealthcare Community Plan member needs interpreter services, they can call the phone number on their ID card.
  - If you need to call a professional interpreter during regular business hours, call **1-888-225-6056** and after hours, call **1-877-261-6608**
  - Enter the client ID 209677 (do not hit #) - press 1 for Spanish and 2 for all other languages
- 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 and also provide materials for visually impaired members

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

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual (we previously used MCG Guidelines) for medical care determinations.

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster. Learn the differences by viewing our Digital Solutions Comparison Guide.

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 API, EDI or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

Application Programming Interface (API)

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

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

Electronic Data Interchange

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

The benefit of using EDI is it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging into different payer

websites to manually request information. This is why EDI is usually care providers' and UnitedHealthcare Community Plan's first choice for electronic transactions.

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

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

Getting started

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

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

Point of Care Assist™

When made available by UnitedHealthcare, 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, quality programs and more.

UnitedHealthcare Provider Portal

This secure portal is accessible from **UHCprovider.com**. It allows you to access patient information such as eligibility and benefit information and digital ID cards. You can also perform administrative tasks such submitting prior authorization requests, checking claim status, submitting appeal requests, and find copies of PRAs and letters in Document Library. This is all 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.at **UHCprovider.com/eligibility**
- **Claims** — Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies at **UHCprovider.com/claims**
- **Prior authorization and notifications** — Submit notification and prior authorization requests.at **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 at 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
- Real-time reporting to track statuses of inventories in resolution process
- Provide control over financial resolution methods

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

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

Privileges

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

Provider Services

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

Provider Services 1-877-440-9946 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
Behavioral, Mental Health & Substance Abuse	Optum providerexpress.com **1-877-440-9946**	Eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	UHCprovider.com/benefits **1-877-440-9946**	Confirm a member's benefits and/or prior authorization.
Cardiology Prior Authorization	For prior authorization or a current list of CPT codes that require prior authorization, visit UHCprovider.com/cardiology **1-866-889-8054**	Request prior authorization of the procedures and services outlined in this manual's prior authorization requirements.
Chiropractor Care	myoptumhealthphysicalhealth.com **1-800-873-4575**	We provide members older than 21 with up to 6 visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.
Claims	Use the portal at UHCprovider.com/claims **1-877-440-9946** Mailing address: **UnitedHealthcare Community Plan** P.O. Box 5270 Kingston, NY 12402-5270 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 1355 S 4700 West, Suite 100 Salt Lake City, UT 84104	Verify a claim status or get information about proper completion or submission of claims.

Topic	Contact	Information
Claim Overpayments	See the Overpayment section for requirements before sending your request. Sign in to UHCprovider.com/claims to access the portal **1-877-440-9946** Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.
Dental	To find a dental provider, go to UHCprovider.com > Our Network > Dental Providers by State, Network or Location. uhcdental.com **1-866-547-0809**	Find a dental provider or go to the dental website for specific dental 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 or questions..
Eligibility	To access eligibility information, go to UHCprovider.com, then Sign In to the portal or go to UHCprovider.com/eligibility **1-877-440-9946**	Confirm member eligibility.
Fraud, waste and abuse (payment integrity)	Payment Integrity Information: UHCprovider.com/MNcommunityplan > Integrity of Claims, Reports, and Representations to the Government Reporting: uhc.com/fraud **1-800-455-4521** (NAVEX) or **1-877-401-9430**	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Laboratory services	UHCprovider.com > Our Network > Preferred Lab Network Labcorp 1-800-833-3984 Quest Diagnostics 1-866- 697-8378	Labcorp is network laboratory. Quest Diagnostics is a network laboratory.

Topic	Contact	Information
Medical claim, reconsideration and appeal	Sign in to the portal at UHCprovider.com or go to UHCprovider.com/claims **1-877-440-9946** Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5270 Kingston, NY 12402-5270 Appeals mailing address: **UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131-0364 MSHO/SNBC Integrated mailing address: **UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit** P.O. Box 6103, MS CA124-0187 Cypress, CA 90630-0023	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	myuhc.com **1-888-269-5410** / TTY 711 for help accessing member account	Assist members with issues or concerns. Available 7 a.m. – 7 p.m. CT Time, Monday through Friday.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	Language Line: **1-888-225-6056** (client ID 209677) TDD: 711	Available 8 a.m. – 5 p.m. CT Time, Monday through Friday, except state-designated holidays. • New Year's Day (January 1) • Martin Luther King's Birthday (3rd Monday in January) • Washington's and Lincoln's Birthdays (3rd Monday in February) • Memorial Day (last Monday in May) • Independence Day (July 4) • Labor Day (1st Monday in September) • Christopher Columbus Day (2nd Monday in October) • Veterans Day (November 11) • Thanksgiving (4th Thursday in November) • Christmas Day (December 25)
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).

Topic	Contact	Information
Network management	**1-877-440-9946**	A team of provider relation advocates. Ask about contracting and care provider services.
Network management support	Chat with a live advocate 7 a.m.-7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page.	Self-service functionality for medical network care providers to update or check credentialing information.
NurseLine	**1-800-718-9066**	Available 24 hours a day, 7 days a week.
Obstetrics/pregnancy and baby care	Healthy First Steps Rewards **UHChealthyfirststeps.com**	For pregnant members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form. Refer members to UHChealthyfirststeps.com to sign up for Healthy First Steps Rewards.
One Healthcare ID support center	Email: **OptumSupport@optum.com** **1-855-819-5909**	Contact if you have issues with your ID. Available 7 a.m. – 9 p.m. CT Time, Monday through Friday; 6 a.m. – 6 p.m. CT Time, Saturday; and 9 a.m. – 6 p.m. CT Time, Sunday.

Topic	Contact	Information
Pharmacy prior authorization/ notification	Minnesota Care, Medical Assistance (MA) and Minnesota Senior Care Plus (MSC+), Special Needs Basic Care (SNBC): UHCprovider.com > Prior Authorization > **Clinical Pharmacy and Specialty Drugs** Medicaid: 1-800-310-6826 MSHO and SNBC: 1-800-711-4555	**Minnesota Care, Medical Assistance (MA), Minnesota Senior Care Plus (MSC+), Special Needs Basic Care and MN Senior Health Options (MSHO):** Request authorization for medications as required. Use the portal to access PreCheck MyScript. Request prior authorization and receive results and see which prescriptions require prior authorization, are not covered or preferred. Check coverage and price, including lower-cost alternatives. **MN Senior Health Options (MSHO) and Special Needs Base Care (SNBC) Integrated products:** Request authorization for medications as required. Use the portal to access PreCheck MyScript. Request prior authorization and receive results and see which prescriptions require prior authorization, are not covered or preferred. Check coverage and price, including lower-cost alternatives.
Pharmacy services	**professionals.optumrx.com** **1-877-305-8952** (OptumRx)	OptumRx oversees and manages our network pharmacies.
Population Health and Care Management Program	**UHCprovider.com/ MNcommunityplan** **1-877-440-9946**	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.

Topic	Contact	Information
Prior Authorization Requests/ Advanced & Admission Notification	To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N Online: **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 **1-877-440-9946**	Use Prior Authorization and Notification online to: • Determine if notification or prior authorization is required. • Complete the notification or prior authorization process. • Upload medical notes or attachments. • Check request status Information and advance notification/ prior authorization lists: **UHCprovider.com/ MNcommunityplan** >Prior Authorization and Notification
Provider Services	**UHCprovider.com/ MNcommunityplan** **1-877-440-9946**	Available 7 a.m. – 5 p.m. CT Time, Monday through Friday.
Radiology prior authorization	For prior authorization or a current list of CPT codes, visit **UHCprovider.com/radiology** **1-866-889-8054**	Request prior authorization of the procedures and services outlined in this manual's prior authorization requirements.
Referrals	UHCprovider.com > **Referrals** or use Referrals on the portal. Click Sign in at the top right corner of **UHCprovider.com**, then click Referrals. Provider Services **1-877-440-9946**	Submit new referral requests and check the status of referral submissions.
Reimbursement policy	**UHCprovider.com/ MNcommunityplan** > Policies and Protocols	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical support	Chat with a live advocate 7 a.m.-7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. **1-866-209-9320** for Optum support or **1-866-842-3278**, Option 1 for web support	Call if you have issues logging in to the portal, you cannot submit a form, etc.
Tobacco Free Quit Line	1-800-784-8669	Ask about services for quitting tobacco/smoking.

Topic	Contact	Information
Transportation (NEMT)	MTM 1-888-444-1519	To arrange non-emergent transportation, please contact MTM at least two business days in advance.
Utilization management	Provider Services **1-866-209-9320**	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. For UM policies and protocols, go to: UHCprovider.com > Resources > > Health Plans, Policies, Protocols and Guides > **For Community Plans** Request a copy of our UM guidelines or information about the program.
Vision services	**marchvisioncare.com** 1-844-516-2724	Contact MARCH Vision Care for information on benefits, lab order submissions, and demographic changes. This includes changes to addresses, phone numbers, office hours, network providers, and federal tax identification numbers. Attend a training session on **eyeSynergy**. This web portal gives you 24/7 access to eligibility, benefit, claim and lab order information.
Website for MN Community Plan	**UHCprovider.com/ MNcommunityplan** **1-866-942-3278**, option 1	Access your state-specific Community Plan information on this website.

Chapter 2: Care provider standards and policies

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	1-877-440-9946
Eligibility	UHCprovider.com/eligibility	
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.

Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This may include providing

service(s) for a reasonable time at our in-network rate. Provider Services is available to help you and our members with the transition.

Arrange substitute coverage

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

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

Administrative terminations for inactivity

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

1. End Agreements with care providers who have not submitted claims for UnitedHealthcare Community Plan members for 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.

Updating your practice or facility information

You can update your practice information through the portal on UHCprovider.com. Go to UHCprovider.com, then Sign In > Practice Management > My Practice Profile.

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

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

Provider participation and engagement in our quality and improvement activities is essential for a improved health care outcomes aligned with the states priorities and is contractually required.

Provide access to your records

Access to medical, financial or administrative records related to services provided to UnitedHealthcare Community Plan members is important to serving their needs. Per contract, we ask that all requests be met within 14 days. In some cases, we may request a even faster response, particularly for cases involving a member grievance/appeal, a regulatory requirement or if fraud or abuse is alleged. Records are to be maintained for a minimum of 6 years, and longer if required by applicable statutes and regulations.

Performance data

Performance data is important to providing our members with top quality care, and this is why the contract specifies that we be allowed to use provider performance data.

Comply with protocols

In accordance with the contract, you are required to comply with UnitedHealthcare Community Plan's and Payer's Protocols, including those contained in this manual.

You may view protocols at UHCprovider.com.

Office hours

In accordance with the contract, you are required to 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 investigate your complaint. If you disagree with the outcome, you may file for arbitration. If your concern relates to certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, follow the dispute procedures in your Agreement. After following those procedures, if one of us remains dissatisfied, you may file for arbitration.

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

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. You may locate the Member Handbook at **UHCcommunityplan.com/MN**. Also reference Chapter 12 of this manual for information on provider claim reconsiderations, appeals, and grievances.

Providing home care bill of rights to members

In the event of a termination of a home health agency due to sanction under Minnesota Statutes, §256B.064 or by a health plan action, home health care agencies should provide each impacted member with a copy of the home care bill of rights under Minnesota Statutes, §144A.44 at least 30 days before terminating services to a member.

This applies to Long Term Services and Supports as outlined under Minnesota Statutes, §256B.064.

Appointment standards (MN DHS 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 care: Immediately or referred to an emergency facility
- Urgent care appointment: within 24 hours
- Routine care appointment: within 45 calendar days
- Physical exam: within 180 calendar days
- EPSDT appointments: within 6 weeks
- New member appointment: within 30 calendar days
- In-office waiting for appointments: not to exceed one hour of the scheduled appointment time

Specialty care

Specialists should arrange appointments for routine appointments within 30 working days of request/referral.

Prenatal care

Prenatal care providers should arrange OB/GYN appointments based on clinical acuity. If an appointment is requested outside of routine prenatal appointment cadence, the expectation is:

- First and second trimester: within 7 calendar days of request
- Third trimester: within 3 days of request
- High-risk: within 3 calendar days of identification of high risk

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 6 months. We require you to confirm your information is accurate or provide us with applicable changes.

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

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

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

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

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

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

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

Care provider attestation

Confirm your provider data every 90 days through My Practice Profile in the portal. To access, go to UHCprovider.com and click Sign In in the top right corner then go to Practice Management > My Practice Profile.

When you submit demographic updates, list only those addresses where a member may make an appointment

and see the health care provider. On-call and substitute health care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address.

Prior authorization request

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

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

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

- Verify eligibility using the portal at UHCprovider.com/eligibility or by calling **Provider Services** at **1-877-440-9946**. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice
- Get prior authorization from the portal:
    1. To access the Prior Authorization and Notification tool, go to UHCprovider.com, then Sign In.
    2. Select the **Prior Authorization and Notification tool**.
    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 1, 7 a.m. – 9 p.m. CT Time, Monday through Friday.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

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

Requirements for PCP and specialists serving in PCP role

Specialists include internal medicine, pediatrics, or obstetrician/gynecology

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

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

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

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

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

Members may change their assigned PCP by contacting **Member Services 1-888-269-5410** at any time during the month. Customer service is available 7 a.m. - 7 p.m., Monday through Friday.

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

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

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support, and benefit from the primary care case management system. The coverage will include availability of 24 hours a day, 7 days a week. During non-office hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services. **Recorded messages are not acceptable.**

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

- Use lists supplied by the UnitedHealthcare Community Plan 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 for a one MD practice and at least 30 hours per week for a 2 or more MD practice
- Be available to members by telephone any time
- Tell members about appropriate use of emergency services
- Discuss available treatment options with members

Responsibilities of PCPs and specialists serving in PCP role

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

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this care provider manual
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment
- Treat UnitedHealthcare Community Plan members' general health care needs, using nationally recognized clinical practice guidelines
- Refer services requiring prior authorization to Provider Services, UnitedHealthcare Community Plan Clinical, or Pharmacy Department as appropriate
- Admit UnitedHealthcare Community Plan members to the hospital when necessary, coordinating 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 MN DHS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual

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

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

- **Rural Health Clinic:** The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be in rural, underserved areas.
- **Federally Qualified Health Center:** An FQHC is a center or clinic that provides primary care and other services.

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

PCP checklist

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

Specialist responsibilities

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

- Contact the PCP to coordinate the care/services
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer
- Verify the eligibility of the member before providing covered specialty care services
- Provide only those covered specialty care services, unless otherwise authorized
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care

- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP
- Maintain staff privileges at 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 MN DHS Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, 7 days a week. Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

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

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

Ancillary care 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-health care professionals. PCPs and specialists must use the UnitedHealthcare Community Plan ancillary network.

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

Ancillary provider checklist

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

Chapter 3: Care provider office procedures

Key contacts

Topic	Link	Phone Number
Member Benefits	UHCcommunityplan.com/MN	1-888-269-5410
Member Handbook	UHCcommunityplan.com/MN Go to Plan Details, then Member Resources, View Available Resource	
Provider Services	UHCprovider.com	1-877-440-9946
Prior Authorization	UHCprovider.com/paan	1-877-440-9946
DSNP	UHCprovider.com/MN > Medicare > Dual Complete Special Needs Plan	1-877-440-9946

Assignment to PCP panel roster

Once a member is assigned a PCP, view the panel rosters electronically on the 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 > UnitedHealthcare Provider Portal digital guide overview course

Choosing a PCP

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

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

Deductibles/copayments

There are no copays for the following members:

- Children, pregnant women, individuals expected to reside more than 30 days in an institution and individuals in hospice in MA
- Members residing in a nursing facility or institution.
- Members in hospice
- MinnesotaCare Children who are younger than 21 years
- Pregnant women enrolled in MinnesotaCare are exempt from cost-sharing

- American Indians who receive services from an Indian care provider or through Indian Health Services (IHS) Contract Health Services (CHS) referral from an IHS facility
- American Indians enrolled in a federally recognized tribe pay no MinnesotaCare cost-sharing at any care provider
- MSHO members (but still may have to pay Medicare Part D copays)
- SNBC members (but still may have to pay Medicare Part D copays)

There are no copays for the following services:

- For testing items and services, COVID-19 diagnosis and treatment through the last day of the quarter in which the federal public health emergency ends
- Preventive services including:
  - Services with a rating of A or B from the United States Preventive Services Task Force, which includes tobacco use counseling and interventions (smoking cessation) services
  - Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
  - Women's preventive services and screenings
- Substance use disorder treatment services
- Mental health services

Medically necessary service

UnitedHealthcare Community Plan pays for covered services that are medically necessary.

Medically necessary health care services or supplies are:

- Appropriate according to accepted standards of medicine
- Necessary to meet members' health needs
- Cost-efficient

Member assignment

Assignment to UnitedHealthcare Community Plan

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

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

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

Selecting UnitedHealthcare Community Plan MSHO and SNBC Plans

Eligible individuals select a Managed Care Organizations (MCO) to receive their MSHO and SNBC benefits.

Automatic enrollment of newborns

A newborn born to a mother who enrolled in MA is automatically enrolled as of the date of birth. To avoid delays in claims processing and payment, have the payer assignment of newborns checked daily.

Get eligibility information by calling **Provider Services** at **1-877-440-9946**

Unborn enrollment changes

Encourage your members to notify the MN DHS when they know they are expecting. DHS notifies MCOs daily of an unborn when MN Medicaid learns a woman associated with the MCO is expecting. The MCO or you may use the online change report through the MN website to report the baby's birth. With that information, DHS 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 DHS when the baby is born.

Members may call state of MN at 1-800-366-5411 or go to **benefits.gov/benefit/1286**.

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

PCP selection

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

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

Member eligibility

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

Member ID card

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

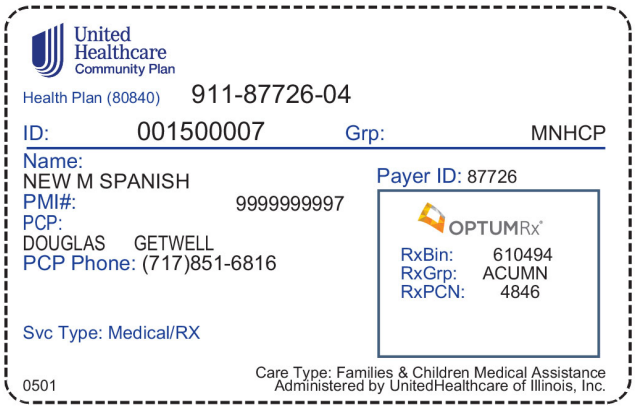
If a fraud, waste and abuse event arises from a care provider or a member, go to **uhc.com/fraud** to report it. Or you may call the **Fraud, Waste, and Abuse Hotline**.

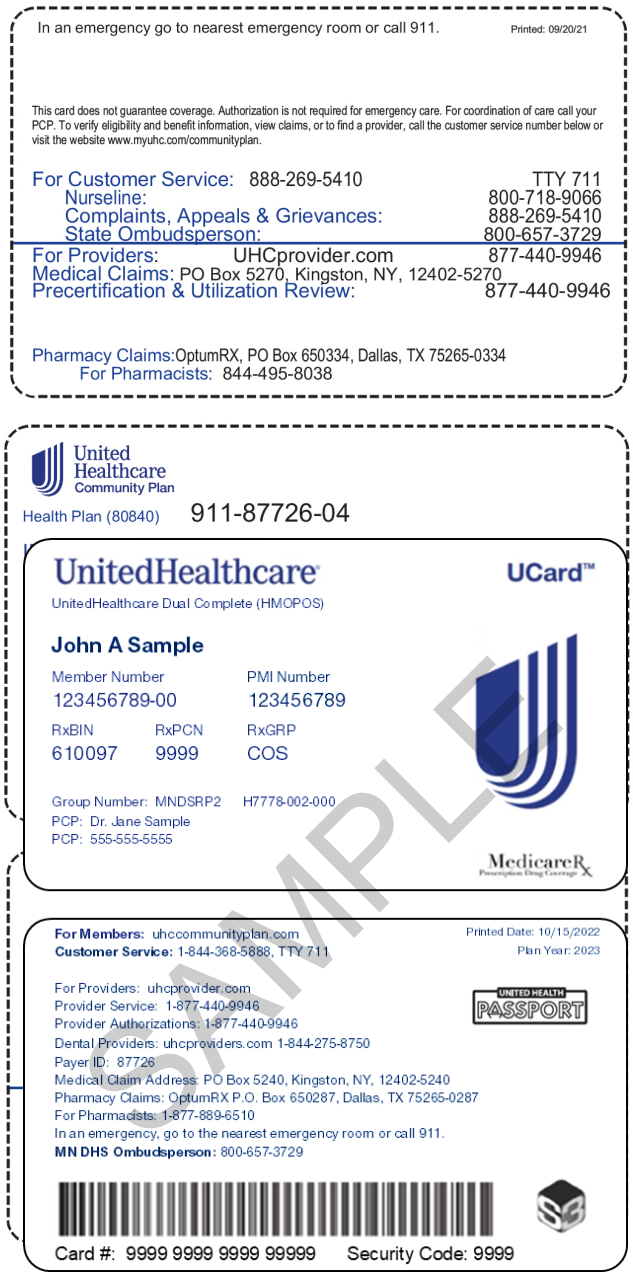
The member's ID card also shows the PCP assignment on the front of the card. If a member does not bring their card, call **Provider Services** at **1-877-440-9946**. Also document the call in the member's chart.

Member identification numbers

Each member receives a 9-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. The MN DHS Medicaid Number is also on the member ID card.

Sample health member ID card





Verifying member enrollment

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

- UnitedHealthcare Provider Portal: access the portal through **UHCprovider.com/eligibility**
- **UnitedHealthcare Provider Services** is available from 8 a.m. - 5 p.m. Central Time, Monday through Friday at **1-877-440-9946**
- **Minnesota Health Care Programs (MHCP)**

Chapter 4: Member benefits and medical management

Key contacts

Topic	Link	Phone Number
Referrals	UHCprovider.com > Referrals	**1-877-440-9946**
Prior Authorization	**UHCprovider.com/paan**	
Pharmacy	**professionals.optumrx.com**	
Dental	**UHCprovider.com**	**1-866-547-0809**
Healthy First Steps	**UHChealthyfirststeps.com**	**1-800-599-5985**
Transportation		1-888-444-1519

Benefits

Go to **UHCcommunityplan.com/MN** or UHCprovider.com > **Eligibility** for more information.

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

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.

MSHO members pay no copays for MA-covered services, prescriptions and over-the-counter drugs (but still have to pay Medicare Part D copays).

For authorization, go to **UHCprovider.com/paan** or call **Provider Services** at **1-877-440-9946**.

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:

- Have their physical or mental health placed in serious jeopardy
- Suffer continuation of severe pain
- Incur serious impairment to bodily function
- Suffer serious dysfunction of any bodily organ or part
- Death

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

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

Non-emergent ambulance transportation

It is required that you bill UnitedHealthcare for Basic Life Support (BLS) HCPC code A0428 when providing services.

Non-emergency medical transportation (NEMT) wheelchair van

It is required to bill UnitedHealthcare code A0130 when providing services Non-emergency medical transportation wheelchair van.

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
- 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

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

Request prior authorization online or by phone.

- Online: **UHCprovider.com/cardiology.** Select the Go to Prior Authorization and Notification
- Phone: **1-866-889-8054** Monday through Friday 7 a.m. – 7 p.m. CT Time

Make sure the medical record is available.

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

Dental services

A Dental Provider Manual is available for detailed coverage information.

Facility services require a prior authorization.

The following services are covered for all members:

- Routine
- Diagnostic
- Periodontics
- Preventive
- Prosthodontics (limited)
- Restorative
- Oral and maxillofacial surgery
- Endodontics

Refer to the Dental Provider Manual at **uhcdental.com** for applicable exclusions and limitations and covered services. Standard ADA coding guidelines apply to all claims.

For more details, go to: **UHCprovider.com**

To find a dental provider, go to UHCprovider.com > Our Network > Find a Provider > **Dental Providers by State, Network or Location**.

Durable medical equipment

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

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

See our Coverage Determination Guidelines at UHCprovider.com > Resources > Health Plans, Policies,

Protocols and Guides > For Community Plan > 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 emergency room use. A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fevers, coughs, colds, sore throats.

Covered services include:

- Hospital emergency department room, ancillary and other care by in and out-of-network care providers
- Medical examination
- Stabilization services
- Access to designated Level I and Level II trauma centers or hospitals meeting the same levels of care for emergency services
- Emergency transportation
- Emergency dental services, limited to broken or dislocated jaw, severe teeth damage, and cyst removal

Access to emergency and urgent care services must be available to members 24 hours, 7 days a week.

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

Emergency room care

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

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

After the member has received emergency care, the hospital must seek approval within one hour for pre-approval for more care to make sure the member remains stable. If the hospital needs to appeal the decision or if does not receive a decision within 1 hour and/or they need to speak with a peer (medical director), call **1-800-955-7615**. The treating care provider may continue with care until the health plan's medical care provider is reached, or when one of these guidelines is met:

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

Depending on the need, the member may be treated in the ER, in an inpatient hospital room, or in another setting. 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** at **1-877-440-9946**.

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 Prior Authorization and Notification on the portal at UHCprovider.com/paan, EDI 278N transaction at UHCprovider.com/edi, or call **Provider Services** at **1-877-440-9946**.

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** at **1-877-440-9946** (UM Department, etc.)

The criteria are available in writing upon request or by calling **Provider Services** at **1-877-440-9946**.

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

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

Family planning

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

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

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

Non-covered items include:

- Reversal of voluntary sterilization
- Hysterectomies for sterilization
- In-vitro fertilization, including:
  - GIFT (gamete intrafallopian transfer)
  - ZIFT (zygote intrafallopian transfer)
  - Embryo transport
- Infertility services, if given to achieve pregnancy **Note:** Diagnosis of infertility is covered. Treatment is not.
  - Morning-after pill - contact MN Department of Health Services to verify state coverage

Parenting/child birth education programs

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

Voluntary sterilization

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the DHS Regulations for more information on sterilization.

Care coordination/ health education

Our care coordination program is led by our qualified, full-time care coordinators. You are encouraged to collaborate with us to ensure care coordination services

are provided to members. This program is a proactive approach to help members manage specific conditions and support them as they take responsibility for their health.

The program goals are to:

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

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

Identification for care management

Our program uses proactive risk stratification and the Health Risk Assessment to identify a member for care management services. If you identify a member needing care management services, you can refer into the program through **Provider Services** at **1-877-440-9946.**

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Long-Term Support Services program

All members enrolled in the Elderly Waiver (EW) program are immediately assigned a care coordinator in our Long-Term Support Services (LTSS) program for comprehensive assessment, coordination of physical and behavioral health needs and authorization of Home and Community Based Services (HCBS).

The EW program is a federal Medicaid waiver program that funds home and community-based services for people 65 years old and older who are eligible for MA, require the level of care provided in a nursing home and choose to live in the community. This is available through Minnesota Senior Care Plus (MSC+) or Minnesota Senior Health Options (MSHO) plans.

Home and Community Based Services for Elderly Waiver:

- Adult companion services
- Adult day services
- Adult day services bath
- Case management/care coordination
- Case management aide
- Chore services
- Consumer directed community supports (CDCS)
- Customized living (including 24-hour customized living)
- Environmental accessibility adaptations
- Extended home health services
- Extended personal care assistance
- Extended home care nursing (LPN and RN)
- Family adult day services (FADS)
- Family caregiver services (includes training and education, coaching and counseling with assessment and memory care)
- Foster care for adults
- Home-delivered meals
- Homemaker
- Individual community living supports
- Personal emergency response systems (PERS)
- Respite
- Specialized equipment and supplies
- Transitional services
- Transportation (non-medical)

Members who are enrolled in MSC+ and MSHO plans who are residing within a nursing facility will receive assessment and care coordination by our LTSS case managers. These case managers will also support a member's transition to the community by coordinating services, which include housing support, as appropriate.

Waiver programs

All members enrolled in the following waiver programs are supported by our Coordinator of the Coordinators and receive HCBS services through the county:

- Brain Injury (BI)
- Community Alternative Care (CAC)
- Community Access for Disability Inclusion (CADI)
- Development Disabilities (DD)

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

Gender dysphoria services

Treatment including, but not limited to, hormone therapy, surgery and behavioral health services for gender dysphoria is a covered benefit as deemed medically necessary based on the most recent, published medical standards by nationally recognized medical experts in the transgender health field. Select services, such as surgery, may require prior authorization.

Health home programs

The Behavioral Health Home (BHH), Health Care Home (HCH) and Certified Community Behavioral Health Clinic (CCBHC) programs help improve total health and wellbeing of members by coordinating care, increasing quality and empowering individuals to take ownership of their care. These programs reduce Medicaid inpatient and behavioral hospital admissions and avoidable emergency room visits, connect members to social determinants of health services and provide services beyond those typically offered by healthcare professionals, including:

- Comprehensive care management
- Care coordination
- Health promotion
- Individual and family support
- Community services referrals
- Preventive services referrals

We assign each BHH/HCH/CCBHC care provider a clinical practice consultant (CPC) to assist in addressing barriers to care, offer information on health plan resources for members and provide population health data during regular Joint Operations Committee meetings. In addition, CPCs deliver actionable data such as transition of care alerts, gaps in care information and trended health data to better position BHH/HCH/CCBHC practices in meeting timely care needs. Every care provider also has a provider advocate to address claims questions or concerns.

A member cannot be enrolled in both a HCH and a BHH program at the same time as these services are considered duplicative. If you have questions or need assistance in helping a member select the program that would be best for them, please contact your assigned CPC.

For Minnesota Health Care Homes, the following **training** has been made available to train providers further on the HCH program as well as the portal.

BHH services are covered for Minnesota Medical Assistance (Medicaid) members but are not a covered benefit for MinnesotaCare members.

Call **Provider Services** at **1-877-440-9946** for more information.

Hearing services

Monaural and binaural hearing aids are covered,

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

Hospice

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

Home hospice

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

Respite hospice

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

Inpatient hospice

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

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

Laboratory

Labcorp and/or Quest Diagnostics are network laboratories. Contact **Labcorp** or **Quest** directly.

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

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

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

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

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.

Healthy First Steps Pregnancy Notification Form at **UHCprovider.com**, then Sign In

for the UnitedHealthcare Provider Portal. **1-800-599-5985**

- 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

Bill the initial pregnancy visit as a separate office visit. You may bill global days if the mother has been a UnitedHealthcare Community Plan member for 3 or more consecutive months or had 7 or more prenatal visits.

Medicaid does not consider ultrasounds medically necessary if they are done only to determine the fetal sex or provide parents with a photograph of the fetus. We allow the first 3 obstetrical ultrasounds per pregnancy. The fourth and subsequent obstetrical ultrasound procedures will only be allowed for identified high-risk members. High-risk member claims must include the corresponding diagnosis code.

For prior authorization maternity care, including out-of-plan and continuity of care, call **1-877-440-9946** (**Provider Services**) or go to or go to **UHCprovider.com/paan.** For more information about prior authorization requirements, go to UHCprovider.com/MNcommunityplan > **Prior Authorization and Notification**

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

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

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

A UnitedHealthcare Community Plan member does not need a referral from her PCP for OB-GYN care. Perinatal home care services are available for UnitedHealthcare Community Plan members when medically necessary.

Maternity admissions

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

Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, Prior Authorization and Notification at **UHCprovider.com/paan**, or by calling **Provider Services** at **1-877-440-9946.**

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

- Date of admission
- Member's name and Medicaid ID number
- Obstetrician's name, phone number, care provider ID

- Facility name (care provider ID)
- Vaginal or cesarean delivery

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

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

Non-routine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires prior authorization. Infants remaining in the hospital after the mother's discharge require separate notification and will be subject to medical necessity review. Midwifes (CNMs) must be a licensed registered nurse recognized by the Board of Nurse Examiners as Advanced Practice Nurses (APNs) in nurse-midwifery and certified by the American College of Nurse-Midwives.

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

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

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

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

Post maternity care

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

Newborn enrollment

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

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

Home care and all prior authorization services

The discharge planner ordering home care should call **Provider Services** at **1-877-440-9946** to arrange for home care.

Hysterectomies

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

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

Find the form on the MN Department of Human Services mn.gov/dhs.

See "Sterilization consent form" section for more information.

Exception: MN DHS does not require informed consent if:

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

sterility.

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

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

Pregnancy termination services

UnitedHealthcare Community Plan does not provide coverage for abortion services or make coverage decisions for our members.

All induced abortion and abortion-related services should be billed to Minnesota DHS as Medical Assistance & MinnesotaCare members are eligible for induced abortions and abortion-related services coverage under the following conditions:

MEDICAL ASSISTANCE

- The member suffers from a physical disorder, physical injury or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would, as certified by a physician, place the member in danger of death unless the abortion is performed
- Pregnancy resulted from rape
- Pregnancy resulted from incest
- Other health or therapeutic reasons

MINNESOTACARE (MNCare)

- Pregnancy resulted from rape
- Pregnancy resulted from incest
- For prevention of substantial and irreversible impairment of a major bodily function
- Continuation of the pregnancy would endanger the member's life

Members enrolled in MNCare and seeking an abortion for other health or therapeutic reasons must apply for, and be covered by, Medical Assistance prior to the procedure.

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

Sterilization consent form

Use the consent form for sterilization:

- **Complete all applicable sections of the form.** Complete all applicable sections of the consent form before submitting it with the billing form. The MN 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 MN Department of Social Services website https://mn.gov/dhs/.

Have 3 copies of the consent form:

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

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

Minnesota Care, Medical Assistance (MA), Minnesota Senior Care Plus (MSC+) and Special Needs Basic Care (SNBC) Non-integrated

Pharmacy preferred drug list

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

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

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

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

Pharmacy prior authorization

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

To request pharmacy prior authorization, call Pharmacy Prior Authorization at **1-800-310-6826**. We provide notification for prior authorization requests within 24 hours of request receipt.

Specialty pharmacy medications

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

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

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

Medication Therapy Management (MTM) program

UnitedHealthcare Community Plan of Minnesota will align with the state Medication Therapy Management Services (MTMS) program.

Pharmacists:

- Must be enrolled with the state as MTM care providers to be in our MTM program
- Bill CPT codes under medical claims platform as a care provider

Facilities will be listed as "billing provider" on claim.

You are expected to bill UnitedHealthcare Community Plan by specific, HIPAA-compliant MTM CPT codes based on the service provided. New care provider enrollment follows our plan's network enrollment process.

MN Senior Health Options (MSHO) and Special Needs Base Care (SNBC)

Pharmacy preferred drug list

UnitedHealthcare Community Plan determines and maintains its list of covered medications. This list applies to all UnitedHealthcare Community Plan of Minnesota enrollees. We cover drugs listed on our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or network mail order pharmacy service and other coverage rules are followed. We have additional coverage requirements or limits for certain prescription drugs. If an enrollee requires a non-formulary medication, call the Pharmacy Prior Authorization at **1-800-711-4555** or use the online Prior Authorization and Notification tool in the provider portal. We will notify the enrollee of formulary changes at least 60 days before the effective date. If a drug is removed from our formulary because it has been recalled from the market, we will not give a 60-day notice before removing the drug from our formulary. Instead, we will remove the drug from our formulary immediately and notify enrollees about the change as soon as possible.

Pharmacy prior authorization

The rules apply to drugs and to those affected by a clinical prior authorization edit. To request pharmacy prior authorization, call Pharmacy Prior Authorization at 1-800-711-4555. We review expedited requests within 24 hours and standard requests within 72 hours.

Specialty pharmacy medications

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

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

Radiology

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

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

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

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

- ER
- Observation unit
- Urgent care
- Inpatient stay

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

Request prior authorization online or by phone at:

- Online: **UHCprovider.com/Radiology** and see Prior Authorization and Notification
- Phone: **1-866-889-8054** from 7 a.m. – 7 p.m., Monday through Friday. Make sure the medical record is available

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

Restricted Recipient Program (RRP)

The Minnesota Restricted Recipient Program (MRRP) is a program for Minnesota Health Care Program (MHCP) recipients, developed and operated under the direction of the Minnesota DHS for recipients who have used health care services at a frequency or amount that is not medically necessary and/or who have used health care services resulting in unnecessary costs to MHCP. Upon identification by either DHS, the MCO or a provider in the community, recipients are reviewed to determine if criteria for program enrollment is met as defined by MN State Statute, administrative rule 9505.2165 subpart 2 part B.

- MHCP recipients under restriction who change plans remain under restriction with the new MHCP plan until they have satisfied the time period of the restriction and meet criteria for discharge
- All restricted recipients have designated providers that must provide all services, including a primary care provider, clinic, hospital (including emergency room) and pharmacy
- The designated primary care provider manages referrals to non-designated providers
- Initial placement in the restricted recipient program lasts for a period of 24 months.
- An additional 36-month restriction may be imposed following the initial restriction period if the recipient has not maintained compliance with program rules, based on a review of service utilization and claims

Restricted Recipient Program Coordinators (RRPC) work with a recipient throughout the restriction period to assist with provider selection, coordinate care and services and assist recipients in meeting their individual health care needs in a cost-effective manner.

Provider involvement

- The designated primary care provider is responsible to oversee the recipient's health care in a holistic manner
- UHC's RRP only accepts specialty provider referrals that were submitted within 90 days of the service being rendered
- The designated primary care provider authorizes referrals to other providers, as medically necessary. This includes a delegate primary care provider or a specialty provider that can prescribe medication. A referral is not needed for substance use disorder treatment or family planning services.
- The designated primary care provider may authorize some or all the other providers in the primary care clinic to see and prescribe for the recipient if the primary care provider is not available

Prescription monitoring

All prescriptions for restricted recipients must be written by their designated primary care provider or by a provider whom the recipient has been referred to by the primary care provider and filled at the recipient's designated participating pharmacy.

Forms for this program, including a primary care physician referral form, can be found on our **UHCCP Provider Website** > Restricted Recipient Program.

Referral guide and claims payment

Providers should check **MN-ITS**, the Minnesota Department of Human Services billing and eligibility system before providing care to a patient. If care is provided to a restricted recipient by someone other than

the designated providers, or a provider referred by the designated primary care provider, the claim may not be paid.

Referrals **REQUIRED** from Designated PCP	No Referral Needed from Designated PCP
The designated PCP must submit a referral before a restricted recipient receives services from a provider that is not one of the enrollees' designated providers. All restricted enrollees will have a designated: • PCP • Clinic • Hospital • Pharmacy Referrals are required from designated PCP for: • Hospital services not provided in the designated hospital - **Note:** Only one referral necessary for all services during an inpatient stay • Emergency department services provided by a non-designated hospital, except for services that meet the definition of "Emergency" in the Rule - "Emergency" means a condition, including labor and delivery, that if not immediately diagnosed and treated could cause a person serious physical or mental disability, continuation of severe pain or death • Behavioral health services provided by a psychiatrist, clinical nurse specialists or any mental health provider ordering medications • Pain clinic providers, including anesthesiologists • Urgent care	Restricted recipients may directly access the services listed below without needing a restricted recipient referral: • Emergency services at the designated hospital, including physician services • Long- term care facilities • Annual routine eye exam by optometrist and one pair of glasses • Services performed by an audiologist and hearing aids • Behavioral health therapists or counselors and psychologists • Routine dental services, except for services by oral surgeons - *Note: Prescriptions written by dentists require special handling*. • PCA and Assessment for PCA services • PT/OT, speech therapy, respiratory therapy • Home care services • Radiology, imaging services (X-ray, CT, MRI, ultrasound, etc.) • DME and supplies • Laboratory services • Chiropractor • Dietitian • Antibiotic infusions • Rule 25 Assessment/substance abuse disorder treatment services

For more information about the program, call the UnitedHealthcare RRP at **1-888-413-0945** (Monday–Friday, 8 a.m. – 4:30 p.m. CT) or email **mn_rrp@uhc.com**.

Screening, brief interventions, and referral to treatment (SBIRT)

What is SBIRT?

SBIRT is a comprehensive, integrated public health approach to the delivery of early intervention and treatment services for persons with substance use disorders as well as those who are at risk of developing these disorders.

SBIRT screening quickly assesses the severity of substance use and identifies the appropriate level of treatment. You can identify members who have alcohol or other 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 focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. 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 provides those identified as needing more extensive treatment with access to specialty care. Referring members, whose screening indicates a severe problem or dependences, to a licensed and certified behavioral health agency allows the member to receive a full 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.

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**.

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.

Medication-assisted treatment

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

To prescribe Buprenorphine, you must have a current registration with the United States Drug Enforcement Agency (DEA) and be authorized to prescribe buprenorphine in the state.

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 provider on **UHCprovider.com**.

To find a medical MAT provider in MN:

1. Go to **UHCprovider.com**
2. Select "Our Network," then "Find a Provider."
3. Select "Search for Doctors, Clinics, or Facilities by Plan Type"
4. Click on "Behavioral Health 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 **1-877-440-9946** and enter your TIN. Say "Representative," and "Representative" a second time. Then say "Something Else" to speak to a representative.

Tuberculosis (TB) screening and treatment; Direct Observation Therapy (DOT)

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

Responsibilities

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

Vision

Vision services are covered by March Vision Care. Please see the Reference Guide at **marchvisioncare.com** for information such as compliance, electronic payment information, safety resources and training or call 1-844-916-2724.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

- Patient name and ID number
- Ordering health care professional name and TIN/NPI
- Rendering health care professional and TIN/NPI
- ICD Clinical Modification (CM)
- Anticipated date(s) of service
- 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 **Optum** at **1-877-440-9946**.

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

Concurrent review guidelines

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

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

Concurrent review details

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

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

planning including primary and secondary diagnosis, clinical information, care plan, admission order, member status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information by access to Electronic Medical Records (EMR).

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

UnitedHealthcare Community Plan uses InterQual (formally MCG Care 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, skilled nursing facilities, home health care and ambulatory facilities.

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

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

We don't consider experimental treatments medically necessary.

Determination process

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

Evidence-based clinical guidelines

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

Medical and drug policies and coverage determination guidelines

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

Referral guidelines

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

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

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

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

Reimbursement

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

- Determine if the member is eligible on the date of service by using the portal on **UHCprovider.com** then Sign In, contacting UnitedHealthcare Community Plan's **Provider Services** Department, or the MN 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 MN DHS. 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 **1-877-440-9946**.
- 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

The MCO is exempt from second surgical opinion procedures for Greater MN.

For a list of MA covered services, go to **Medical Assistance coverage**.
For a list of Minnesota Care covered services, go to **MinnesotaCare coverage**.

Services that are not state plan services

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

- Circumcision, unless medically necessary
- Cosmetic procedures or treatments, unless necessary as the result of injury, illness or disease, or for the treatment or repair of birth anomalie.
- Drugs covered under the Medicare Prescription Drug Program for members who are eligible for Medicare
- Detoxification, unless medically necessary
- Experimental or investigative services
- Fertility drugs or procedures when specifically used to enhance fertility
  - Also not covered: in vitro fertilization, artificial insemination and reversal of a voluntary sterilization
- Incarceration
- IEP and IFSP services, except for evaluations that are medical in nature and result in IFSPs or IEPs, or determine the need for continued services
- Incidental services
- Out of Country Care
- Room and Board
- Services Provided at Federal Institutions
- Infertility services

Services requiring prior authorization

Retrospective Review	Within 30 calendar days of receiving all pertinent clinical information	Within 2 determi

scheduled admission time

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

Utilization management guidelines

Call **1-877-440-9946** 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.

Chapter 5: Child & teen check-ups

Key contacts

Topic	Link	Phone Number
Child & teen checkups	https://mn.gov/dhs/	Care providers 1-651-431-2700 or 1-800-366-5411 Members 1-651-431-2670 or 1-800-657-3739
Vaccines for children	health.state.mn.us/people/immunize/hcp/mnvfc/index.html	1-651-201-5414

The Child & Teen Checkups (C&TC) benefit provides comprehensive and preventive health care services for children younger than age 21 who are enrolled in Medicaid.

Follow the C&TC schedule for all eligible UnitedHealthcare Community Plan members to age 21, including pregnant women. C&TC 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 C&TC schedule.

To find the C&TC, go to: mn.gov/dhs.

Find details on the C&TC Schedule of Age-Related Screening Standards at edocs.dhs.state.mn.us.

Development disability services and coordination with regional centers

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

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

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

First Steps program

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

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

How to refer - call 1-866-693-4769 to complete a referral and visit **HelpMeGrowMN.org** for a free evaluation. Or go to **wilder.org** for more information.

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

Full screening

Perform a full screen. Include:

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

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

Interperiodic screens

Interperiodic screens are medically necessary screens outside the standard schedule that do not require the full screen. Use this screen to start expanded 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

Call **Provider Services** at **1-877-440-9946** 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.

Targeted case management

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

Identification – The 5 target populations include:

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

Referral – Refer eligible members to a regional center or local governmental health program, as appropriate, for TCM services. To refer, contact your local CMHC. If you're not sure who your local CMHC is, call Behavioral Health **Member Services** at **1-877-440-9946**.

Continuity of Care – UnitedHealthcare Community Plan is responsible for coordinating the member's health care with the TCM care provider. We also determine medical necessity for covered services that are recommended by the TCM care provider.

Vaccines for children program (VFC)

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

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

Contact **VFC** or **MnVFC** if you have questions. Phone: 1-651-201-5414

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

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

Chapter 6: Value-added services

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	**1-877-440-9946**
Healthy First Steps Rewards	UHChealthyfirststeps.com	**1-800-599-5985**
Value Add Services	UHCcommunityplan.com/MN > View plan details	**1-877-440-9946**

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 **1-877-440-9946** unless otherwise noted.

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 **Provider Services** at **1-877-440-9946** .

Doctor Chat— virtual visits

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

Healthy First Steps Rewards

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

Members self-enroll on a smartphone or computer. They can go to UHChealthyfirststeps.com and click on "Register" or call **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 in Healthy First Steps Rewards.

Infant/child car seats

Available during pregnancy and up to 8 weeks postpartum

Available through Healthy First Steps Rewards, UHChealthyfirststeps.com and click on "Register" or call **Member Services 1-888-269-5410** to inquire about this benefit.

Mobile apps

Apps are available at no charge to our members. **UnitedHealthcare® app** enables users to:

- Review health benefits
- Access claims information
- Locate in-network care providers

Mom's Meals

Healthy eating after hospitalization: Prepared meals (through our partner Mom's Meals) are delivered to the homes of members recently discharged from the hospital, including birthing people.

NurseLine

NurseLine **1-800-718-9066** is available at no cost to our members 24 hours a day, 7 days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the emergency room or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **1-800-718-9066** to reach a nurse.

On My Way (OMW)

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

Question, Persuade and Refer (QPR) Training

QPR is an emergency mental health intervention that teaches lay and professional gatekeepers to recognize and respond positively to someone exhibiting suicide warning signs and behaviors. It is evidence-based practice recognized by SAMHSA.

Seeking Safety

Seeking Safety is a modern evidence-based-integrated, present-focused and manual-based model that helps individuals dealing with trauma/PTSD and substance abuse establish safety in their lives. Seeking Safety provides opportunities for individuals to discover connections between the 2 disorders and develop new coping skills to manage the overwhelming impulses and emotions associated with these co-occurring disorders. This is uniquely facilitated by peers for peers in our markets to bring to their communities. Seeking Safety applies 25 coping skills to help attain and maintain safety in relationships, thinking, behaviors and emotions.

Self Care by AbleTo

Self Care by AbleTo is an app that contains tools and resources to help with self-management of symptoms of stress and worry. It is free to members and their domestic family members.

To access Self Care, members visit Ableto.com/begin to create an account. They can download the AbleTo app on the Apple App Store or Google Play Store using the same information used when creating the account.

State-funded programs

The state also has programs, such as WIC to help with nutritional needs for low income families.

For more information about WIC, call 1-800-657-3942 or go to **health.state.mn.us/people/wic**.

SUD recovery coaching

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

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

Traditional healing services

Eligible members will receive a $250 annual reimbursement for traditional healer services (a generalist or specialty), as well as purchase of ceremonial supplies or food for the ceremony as recommended by the healer.

Ask member to call **Member Services** at **1-888-269-5410** to inquire about reimbursement eligibility.

Transportation to social services

Providing public transportation for UnitedHealthcare Community Plan of Minnesota members to social services locations including AA/NA/support group meetings, Boys & Girls Club, childcare for medical appointments, employment counseling, food resource locations, pre-and post-natal education including lactation consultation, SDOH-related federal, state, or county and legal appointments, SSI/PMD appointments, weight control meetings, WIC appointments, YMCA and more. To schedule a member's trip to one of these locations, contact MTM at 1-888-444-1519. Social services trips fall outside the state parameters for covered NEMT benefit. If a member needs a mode of transportation other than public transportation, the member may receive another mode based on a provider's request for a different mode or other guidelines set by UnitedHealthcare Community Plan of Minnesota.

UHC Latino

Our award-winning Spanish-language **site** provides more than 600 pages of health and wellness information and reminders on important health topics.

White Bison

White Bison offers sobriety, recovery, addiction prevention and wellness/Wellbriety learning resources to the Native American/Alaska Native community nationwide. Many non-Native people also use White Bison's healing resource products, attend its learning circles and volunteer their services. White Bison is a National Association for Alcoholism and Drug Abuse Counselors (NAADAC) approved provider (#64009) and a Combined Federal Campaign (CFC) member (#11364).

Youth Club Membership

We will cover the annual membership for the Boys & Girls Club for qualified members younger than age 19. Call **Member Services** at **1-888-269-5410** to inquire about this benefit.

Chapter 7: Mental health and substance use

Key contacts

Topic	Link	Phone Number
Behavioral Health Provider Express and Provider Services	providerexpress.com	1-877-440-9946

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

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

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

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

To request an ID number, contact the MN Department of Human Services website at mn.gov/dhs/general-public/about-dhs/contact-us/

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

Covered services

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

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

For member resources, go to providerexpress.com > Clinical Resources > Live and Work Well (LAWW) clinician center > Mind & Body > Recovery and Resiliency. This page includes tools to help members address mental health and substance use issues.

Benefits covered by **United Healthcare Community Plan Dual Special Needs**, **MinnesotaCare** and **Medical Assistance** include:

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

  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)
  - Child-parent psychotherapy
  - Functional family therapy
  - Electroconvulsive therapy
  - Telemental health
- Rehabilitation services

Additional benefits covered/funded only by **MinnesotaCare and Medical Assistance** include:

- Multi-systemic therapy)
- Day treatment
- Dual-disorder residential
- Intermediate residential (SUD)
- Short-term residential
- Community support
- Psychiatric residential rehabilitation
- Secure residential rehabilitation
- Adult Mental Health Targeted Case Management (AMH-TCM)*
- Children's Mental Health Targeted Case Management (CMH-TCM)*

*The state acknowledges that AMH-TCM and CMH-TCM providers may provide services to enrollees for multiple MCOs and FFS, and agrees to monitor caseload ratios and will provide feedback to the MCO regarding the caseload ratios of all contracted case management providers.

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 portal at UHCprovider.com>Sign In.

Authorizations

Members may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care. Help ensure prior authorizations are in place before rendering non-emergent services. Get prior authorization by going to **UHCprovider.com/priorauth**, calling **1-877-440-9946**.

Collaboration with other care providers

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.

Health home programs

Please see the **Health home programs** section in the Medical Management chapter to learn more about BHH, HCH, and CCBHC)programs. Please be aware these services are covered under the **Minnesota Medicaid Families and Children** benefit.

Portal access

Website: **UHCprovider.com**

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

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

Website: **providerexpress.com**

Update your practice information, review guidelines and policies, and view the national BH Network Manual or call **1-877-440-9946**.

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

Increasing education 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 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.

Expanding medication assisted treatment access and capacity

Evidence-based MAT treatment is central to OUD treatment. MAT takes a chronic condition approach

and incorporates medication use in addition to other 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 MN:

1. Go to **UHCprovider.com**,
2. Select “Our Network,” then “Find a Provider.”
3. Select “Search for Doctors, Clinics, or Facilities by Plan Type”
4. Click on ““Medicaid Plans.” Then select applicable state, then applicable plan.
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 Chapter 4.

For information about the **Medication Therapy Management Program**, see the Medical Management chapter.

Chapter 8: Member rights and responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	UHCcommunityplan.com/MN	**1-888-269-5410**
Member Handbook	UHCcommunityplan.com/MN > Community Plan > Member benefits	**1-888-269-5410**

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

Privacy regulations

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

Access to 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/MN.

Native American access to care

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

Member rights

Members have the right to:

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

Member responsibilities

Members should:

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

Our member rights and responsibilities help uphold the

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

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

Chapter 9: Medical records

Medical record charting standards

You are required to keep complete and orderly medical records in paper or electronic format, which fosters efficient and quality member care. You are subject to our periodic quality medical record review. The review could include any of the following items to determine compliance:

Topic	Contact
Confidentiality of Record	Office policies and procedures exist for: • Privacy of the member medical record • Initial and periodic training of office staff about medical record privacy • Release of information • Record retention • Availability of medical record if housed in a different office location • Process for notifying United Healthcare Community Plan upon becoming aware of a patient safety issue or concern • Coordination of care between medical and behavioral care providers
Record Organization and Documentation	• Have a policy that provides medical records upon request. Urgent situations require you to provide records within 48 hours • Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing Medical records • Release only to entities as designated consistent with federal requirements • Keep in a secure area accessible only to authorized personnel

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 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**

Member copies

A member or their representative is entitled to one free copy of their medical record. Additional copies may be available at the member's cost. Medical records are generally kept for a minimum of 5 years unless federal requirement mandate a longer time frame (i.e., immunization and tuberculosis records required for lifetime).

Medical record review

Medical record reviews may be conducted on an ad hoc basis. The review check for records that contain an initial health assessment and baseline comprehensive medical history, which is conducted and documented prior to the patient's second visit followed by ongoing physical assessment and additional information listed below. Per the contract, a passing rate for the reviews is 85%. This assessment should also include:

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

Member hospitalization records should include, as appropriate:

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

Chapter 10: Quality management program and compliance information

Key contacts

Topic	Link	Phone Number
Credentialing	Medical: Network Management Resource Team Chat with a live advocate 7 a.m.-7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. Chiropractic: **myoptumhealthphysicalhealth.com**	

What is the quality improvement program?

UnitedHealthcare Community Plan's comprehensive Quality Improvement Program (QIP) 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 are highly valued and can offer input through representation on our Provider Advisory and Disparities Committee and your provider services representative/provider advocate.

Cooperation with quality-improvement activities

Your participation in all quality improvement activities is highly valued and specified in the contract. Activities include:

- Providing requested timely medical records
- Cooperating with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans
- Participating in quality audits, such as site visits and medical record standards reviews, and taking part in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review
- Providing requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by secure email.
- Completing practitioner appointment access and availability surveys.

Your cooperation and compliance to the contract for the following will help us to together, better serve your patients:

- 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)

Care provider satisfaction

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

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

Our main concern with the survey is objectivity. That's why UnitedHealthcare Community Plan engages independent market research firm to analyze and report findings.

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

Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. You are encouraged to visit the following website to view the guidelines, as they are an important resource to guide clinical decision-making.

UHCprovider.com/cpg

Credentialing standards

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

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

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

Credentialing and recredentialing process

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

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

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

Excluded from this process are practitioners who:

- Practice only in an inpatient setting
- Hospitalists employed only by the facility

Health facilities

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

- State and federal licensing and regulatory requirements and an NPI number
- Have a current unrestricted license to operate
- Have been reviewed and approved by an accrediting body
- Have malpractice coverage/liability insurance that meets contract minimums

- Agree to a site visit if not accredited by the Joint Commission (JC) or another recognized accrediting agency
- Have no Medicare/Medicaid sanctions

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

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

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.

All care providers are notified of initial credentialing decisions within 60 calendar days of the Credentialing Committee's decision or as required by state law. However, we are generally able to notify care providers within 14 days of the Credentialing Committee's decision. For recredentialing, we notify care providers of the decision within 60 calendar days (or as required by state law) if the Credentialing Committee determines they are no longer eligible to participate in our network. We send written notice of recredentialing approvals to care providers as required by state law.

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, 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.

Care provider participation

You must meet the credentialing and recredentialing standards and be eligible to enroll with the Minnesota Medicaid program. As a condition of network participation, you must be enrolled with the state as a Minnesota Health Care Programs (MHCP) provider.

Failure to meet recredentialing requirements

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

Monitoring of network care providers

We monitor sanction activity from state licensing boards, CMS, Office of Inspector General (OIG) and other regulatory bodies. If we find a care provider has a sanction that results in loss of license or material restriction, we terminate them from our network.

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/Evidence of Coverage 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 care providers who conduct business electronically.

Covered entities must use appropriate safeguards and comply with Security and Privacy laws under 45 CFR 164 with respect to electronic PHI to prevent use or disclosure of PHI by employees, subcontractors and agents.

Transactions and code sets

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

Unique identifier

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

National Provider Identifier

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

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

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.

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

Security

Covered entities must meet basic security measures:

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

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

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

Office site quality

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

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	**1-877-440-9946**
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	1-800-465-3203
EDI	UHCprovider.com/edi	**1-800-210-8315**

Our claims process

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

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

Claims: From submission to payment

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

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

National Provider Identifier

HIPAA requires you have a unique NPI. The NPI identifies you in all standard transactions.

If you have not applied for a NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan. Call **Provider Services** at **1-877-440-9946**.

Your clean claims must include your NPI and federal TIN.

General billing guidelines

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

Fee schedule

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 PMI (Preferred Master Identification) number. UnitedHealthcare Community Plan prefers you bill with the UnitedHealthcare Community Plan member ID.

Acceptable claim forms

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

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

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

Clean claims and submission requirements

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

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

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

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

Care provider coding

UnitedHealthcare Community Plan complies with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) state standards based on claims data and chart review. Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to find an ICD-9 or ICD-10 code.

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

Electronic claims submission and billing

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

- All claims are set up as "commercial" through the clearinghouse
- Our payer ID is 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 EDI at UHCprovider.com > Resources > Resource Library > Electronic Data Interchange > **EDI Clearinghouse Options**.

e-Business support

Call **Provider Services** at **1-877-440-9946** for help with online billing, claims, Electronic Remittance Advices (ERAs), and Electronic Funds Transfers (EFTs).

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

To find more information about EDI online, go to **UHCprovider.com/EDI**.

Electronic payment solution: Optum Pay™

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

Why choose ACH/direct deposit?

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

What does this mean to you?

- If your practice/healthcare organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a Virtual Card will be automatically sent in place of paper checks.
- **To sign up** for the ACH/direct deposit option, go to **UHCprovider.com/payment**
- If your practice/healthcare organization is already enrolled and receiving your claim payments through ACH/direct deposit from Optum Pay™ or receiving

Virtual Cards there is no action you need to take

- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Library
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

Completing the CMS 1500 claim form

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

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

Completing the UB-04 form

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

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

Capitated services

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

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

1. Who have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare Community Plan for such member, 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.

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

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

MHCP Provider Resource Center

Hours: 8 a.m. to 4:15 p.m. CT (closed from 12:00 to 12:45 p.m. for lunch) Monday through Friday

Voice: 1-651-431-2700 or 1-800-366-5411

To reach a resource center representative with questions about billing, MN–ITS transactions, coverage policy and payment, Press 0, then one of the following:

- Press 1 to enter an NPI
- Press 2 to enter a UMPI
- Press 3 if you are not currently an enrolled provider, then select the option for your provider type from the following:
  - Option 1: Nursing facilities, dental, transportation, outpatient mental health, eyeglasses, contacts and eye exams
  - Option 2: Pharmacy, equipment and supplies, hearing aids and chiropractic
  - Option 3: Rehab therapy, hospice, lab, physician, hospital, IEP, family planning services
  - Option 4: Home care, waiver services, chemical dependency services

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

Subrogation and coordination of benefit

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

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

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

Hospital and clinic method of billing professional services

Hospital and clinics must bill for professional services bill on a CMS 1500. The servicing provider's name is placed in box 31, and the servicing provider's group NPI number is placed in box 33a.

Global days

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

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

Correct Coding Initiative

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

Comprehensive and component codes

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

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

Clinical laboratory improvements amendments

Submit your laboratory claims with the Clinical Laboratory Improvements Amendments (CLIA) number. In box 23 of the CMS 1500 claim form, enter the 10-digit 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 obstetrical services

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

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

Billing guidelines for transplants

The UnitedHealthcare Community Plan covers medically necessary, non-experimental transplants, including the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation.

Gather all required referrals and evaluations to complete the pre-transplant evaluation process once the member is a possible candidate.

Ambulance claims (emergency)

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

Claims submission for personal care assistance services

This section is applicable to Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+).

UnitedHealthcare enters into contracts with home care agencies that provide Personal Care Assistance (PCA) Services to eligible UnitedHealthcare Community Plan of Minnesota (UHCCP MN) members under the Minnesota Health Care Programs (MHCP).

Home care agencies that provide PCA services must ensure the individual rendering PCAs, and are affiliated to the contracted agency prior to the individual providing services to UHCCP MN members. The home care agencies and the individual PCAs must be enrolled with the Minnesota Department of Human Services (DHS) to be included in the provider enrollment file (PECD File) submitted to the health plan by DHS for record and for claims processing. The individual PCA providers receives an identification number called an UMPI. An UMPI is a 10-digit Unique Minnesota Provider Identifier that MHCP assigns to the individual provider at the time of your enrollment.

Home care agencies are required to submit the individual rendering PCA provider information (UMPI) on the claim form to comply with Minnesota Statutes, section 62J.536. Claims that are submitted without a valid rendering provider UMPI will be denied. An agency can submit replacement claims with the individual rendering PCA added to the claim. To meet timely filing requirements the replacement claims must be submitted within the 6 months filing window from the last claim processing date.

Home care agencies must maintain documentation of PCA services rendered to comply with Minnesota Statutes, §256B.4912.

National drug code

Claims must include:

- National Drug Code (NDC) and unit of measurement for the drug billed
- HCPCS/CPT code and units of service for the drug billed
- Actual metric decimal quantity administered.

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

Medical necessity

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

Place of Service codes

Go to CMS.gov for Place of Service codes.

Asking about a claim

You can ask about claims through UnitedHealthcare Community Plan **Provider Services** at **1-877-440-9946** 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

UnitedHealthcare Community Plan Provider Portal

You can view your online transactions with the 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 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

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

Find portal training at UHCprovider.com/training.

Portal training course is available using the UnitedHealthcare CommunityCare Provider Portal user guide.

Resolving claim issues

To resolve claim issues, contact **Provider Services** at **1-877-440-9946**, use the portal, or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402-5270

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

Timely filing

Timely filing issues may occur if members give the wrong insurance information when you treat them. This results in receiving:

- A denial/rejection letter from another carrier
- Another carrier's 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, we 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.

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)

The general rule for claims submission is 6 months from the date of service, with the exception of newborn claims that have 12 months from the newborn's date of birth.

If a claim is rejected, and corrections are not received within 6 months 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.

If you don't know who your provider advocate is, email mn_provider_relations@uhc.com. A provider advocate will get back to you.

Third-party resources

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

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. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

For claims, billing and payment questions, go to **UHCprovider.com**. We no longer use fax numbers. Please use our online options or call **Provider Services** at **1-877-440-9946**.

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

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

SITUATION	DEFINITION	WHO MAY SUBMIT?	SUBMISSION ADDRESS	ONLINE FORM OR MAIL	CONTACT PHONE NUMBER	WEBSITE (Care Provider 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 5270 Kingston, NY 12402-5270	UHC provider.com/claims	**1-877-440-9946**	Use the Claims Management or Claims on the portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	Submit replacement claims within 6 months of the date of incorrect payment, or within 12 months from the date of service, whichever is greater.	30 business days
Care Provider Claim Reconsideration	Resubmitting a corrected claim with the appropriate corrected claim indicator.	Care Provider	UnitedHealthcare Community Plan P.O. Box 5270 Kingston, NY 12402-5270	NA	**1-877-440-9946**	Use the Claims Management or Claims on the portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	Submit replacement claims 6 months of the date of incorrect payment, or within 12 months from the date of service, whichever is greater.	30 calendar days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
SITUATION	**DEFINITION**	**WHO MAY SUBMIT?**	**SUBMISSION ADDRESS**	**ONLINE FORM OR MAIL**	**CONTACT PHONE NUMBER**	**WEBSITE (Care Provider Only) for Online Submissions**	**Care Provider FILING TIME FRAME**	**UnitedHealthcare Community Plan RESPONSE TIME FRAME**
Care Provider Claim Formal Appeal	A second review in which you did not agree with the outcome of the reconsideration.	Care Provider	UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364 **MSHO/SNBC Integrated Plans:** UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit P.O. Box 6103 MS CA 124-0187 Cypress, CA 90630-002	NA	**1-877-440-9946** **MSHO/SNBC Integrated Plans 1-888-867-5511 (TTY 711)**	Use the Claims Management or Claims on the portal. Click Sign in on the top right corner of **UHCprovider.com**, then click Claims.	60 calendar days from denial receipt	Resolution of appeal within 30 calendar days of receipt.
Care Provider Grievance **Note:** This does *not* apply to the MSHO or SNBC Integrated Plans.	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member	Care Provider	UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364	NA	**1-877-440-9946**	Use the Claims Management or Claims on the portal. Click Sign in on the top right corner of **UHCprovider.com**, then click Claims.	60 calendar days from incidence	30 calendar days from grievance receipt
Member Appeal	A request to change an adverse benefit determination that we made.	*Member *Member's authorized representative (such as friend or family member) with written member consent *Care provider on behalf of a member with member's written consent	UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364 **MSHO/SNBC Integrated:** UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit P.O. Box 6103 MS CA124-0187 Cypress, CA 90630-0023	**UHCprovider.com/claims** *AOR Consent Form on this site for member appeals	**1-877-440-9946** **MSHO/SNBC Integrated:** **1-844-368-5888 (TTY 711)**	NA	60 calendar days from date of denial.	Urgent appeals We will resolve within 72 hours Resolution of non-urgent appeal within 30 calendar days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
SITUATION	**DEFINITION**	**WHO MAY SUBMIT?**	**SUBMISSION ADDRESS**	**ONLINE FORM OR MAIL**	**CONTACT PHONE NUMBER**	**WEBSITE (Care Provider Only) for Online Submissions**	**Care Provider FILING TIME FRAME**	**UnitedHealthcare Community Plan RESPONSE TIME FRAME**
Member Grievance	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	*Member *Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent	UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364 **MSHO/SNBC Integrated:** UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit P.O. Box 6103 MS CA124-0187 Cypress, CA 90630-0023	NA	**1-877-440-9946** **MSHO/SNBC Integrated:** **1-844-368-5888 (TTY 711)**	NA	Grievance can be filed at any time.	Resolution will be within 30 calendar days for written submitted grievance or 10 days for orally submitted grievance.

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.

How to use:

Use the claims reconsideration application on the portal. To access the portal, sign in to **UHCprovider.com** using your One Healthcare ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Mailing address:

UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402-5270

Additional information:

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

Resubmitting a claim

What is it?

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

When to use it:

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

Common reasons for rejected claims:

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

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

How to use:

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

UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402-5270

Claim reconsideration (step one of dispute)

What is it?

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

When to use:

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

For administrative denials:

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

For medical necessity denials:

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

How to use:

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

Electronically: Use the Claim Reconsideration application on the portal. Include electronic attachments. You may also check your status using the portal.

- Phone: Call **Provider Services** at **1-877-440-9946** or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.
- **Mail:** Submit the Claim Reconsideration Request Form to:

  UnitedHealthcare Community Plan
  P.O. Box 5270
  Kingston, NY 12402-5270

  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 **1-877-440-9946** if you can't verify a claim is on file
- Do not resubmit validated claims on file unless submitting a corrected claim
- File adjustment requests and claims disputes within contractual time requirements
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

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 by phone, or mail with the following information:

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

Additional information:

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

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your contract. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer we recoup the funds from your next payment, call **Provider Services** at **1-877-440-9946**.

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:

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

If you prefer we recoup the funds from your next payment, call **Provider Services** at **1-877-440-9946**.

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 time frame as listed in your contract.

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

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

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 one, use the claim appeal process.

How to use:

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

- **Electronic claims:** Use the Claims tool on the portal. Click Sign in on the top right corner of UHCprovider.com > Claims & Payment > Look up a claim. You may upload attachments.
- **Mail:** Send the appeal to:

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

- For MSHO/SNBC Integrated Plans, mail to:

  UnitedHealthcare Community Plan
  Attn: Appeals and Grievances Unit
  P.O. Box 6103
  MS CA124-0187
  Cypress, CA 90630-0023

Questions about your appeal or need a status update?
Call **Provider Services** at **1-877-440-9946** for questions about your appeal or if you need a status update. If you filed your appeal online, you should receive a confirmation email or feedback through the secure portal.

Care provider grievance

Applies to Medicaid-only products. Does not apply to MSHO/SNBC Integrated plans.

What is it?

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

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:

Electronic submission of provider appeals and grievances are available through Claims on the portal. To file verbally or in writing:

- **Phone:** Call **Provider Services** at **1-877-440-9946**
- **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 definitions and procedures

UnitedHealthcare Community Plan uses the CMS definitions for appeals and grievances.

Member appeals

What is it?

An appeal is a formal way to share dissatisfaction with an adverse or partially adverse benefit determination.

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

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

When to use:

You may act on the member's behalf with their written consent. You may provide medical records and supporting documentation as appropriate. Punitive action is not taken against providers who assist members in filing appeals.

Where to send:

You or the member may call or mail the information within 60 calendar days from the date of the adverse benefit determination.

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

Toll-free: **1-800-587-5187** (TTY **711**)

For MSHO/SNBC Integrated Plans:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 6103
MS CA124-0187
Cypress, CA 90630-0023

Toll-free: **1-844-368-5888** (TTY 711)

How to use:

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

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

We resolve a standard appeal 30 calendar days from the day we receive it.

We resolve an expedited appeal 72 hours from when we receive it.

We may extend the response up to 14 calendar days if the following conditions apply:

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

If submitting the appeal by mail, you must complete an Appointment of Representative form (CMS Form 1696) or an equivalent document. Copy of the online form is at UHCprovider.com.

Member grievance

What is it?

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

When to use:

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

Where to send:

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

Mailing address:

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

Toll-free: **1-800-587-5187** (TTY **711**)

For MSHO/SNBC Integrated Plans:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 6103
MS CA124-0187
Cypress, CA 90630-0023

Toll-free: **1-844-368-5888** (TTY 711)

We will resolve grievances submitted orally within 10 days and in writing within 30 days.

Second level of appeals

Second level appeals are dependent upon the benefit denial that was upheld or partially upheld through the Health Plan appeal (1st level).

Independent review entity

What is it?

The independent review entity (IRE) is the second level of the Medicare appeals process. The IRE will apply to Medicare-only benefits and benefits covered by both Medicare and Medicaid.

When to use:

Regulations require that case files automatically be forwarded to the IRE as follows:

- UnitedHealthcare fails to provide an appeal decision within the time frame specified
- The appeal decision upholds or partially upholds the initial denial

How to use:

No action needs to be taken by enrollees. Once received by the IRE, an acknowledgment letter will be sent to the enrollee, which will provide a summary of the process that will occur. Once a decision is made, notification will be forwarded to the enrollee as well as the Health Plan informing of the IRE's decision as well as any next steps available to the enrollee.

In addition, Medicare/Medicaid benefit appeals enrollees are provided information regarding how to request a fair hearing.

Medicaid-only benefits – In the event of an upheld or partially upheld appeal decision, the notification letter forwarded to the appellant provides information regarding how to request a fair hearing.

State fair hearings

What is it?

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

When to use:

Members have 120 calendar days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter.

How to use:

The UnitedHealthcare Community Plan member may ask for a state fair hearing by writing a letter to:

Minnesota Department of Human Services
Appeals Division
P.O. Box 64941
St. Paul, MN 55164-0941

Fax number: 1-651-431-7523

- The member may ask UnitedHealthcare Community Plan **Member Services** at **1-888-269-5410** for help writing the letter
- The member may have someone attend with them. This may be a family member, friend, care provider or lawyer. Written consent is required

Processes related to reversal of our initial decision

Independent review entity

If the IRE reverses the health plan's decision in whole or in part, the plan must authorize or provide the services or benefits as expeditiously as the enrollee's health condition requires, however no later than the time frames listed:

- Standard Pre-Service – No later than 14 calendar days or authorize within 72 hours
- Expedited Pre-Service – Authorize or provide no later than 72 hours
- Payment – No later than 30 calendar days

State fair hearing

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

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

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

In instances where the fair hearing decision and the IRE decision conflict, the decision in the best interest of the member will prevail.

Chapter 13: Communication and outreach to care providers

Key contacts

Topic	Link	Phone Number
Education and Training	UHCprovider.com > Resources > Education and training	**1-877-440-9946**
Network News	UHCprovider.com > Resources > News	**1-877-440-9946**
Provider Manuals	UHCprovider.com/guides	**1-877-440-9946**

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, quality programs and more.
- **UnitedHealthcare Community Plan of Minnesota page:** This webpage has resources, guidance and rules specific to Minnesota. Be sure to check back frequently for updates.
- **Policies and protocols**: This 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)
- (links are available https://uhgazure.sharepoint.com/sites/Digital-Channel-Guidelines).
- **Health plans by state**: This is the fastest way to review all of the health plans UnitedHealthcare offers in Minnesota. To review plan information for another state, use the drop-down menu at UHCprovider.com > Resources > Health Plans. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **UnitedHealthcare Provider Portal**: This secure portal is accessible from UHCprovider.com. It allows you to access patient information such as eligibility and benefit information and digital ID cards. You can also perform administrative tasks such submitting prior authorization requests, checking claim status, submitting appeal requests, and find copies of PRAs and letters in Document Library.

  You can learn more about the portal in Chapter 1 of this guide or by visiting UHCprovider.com/portal. You can also access self-paced user guides for many of the tools and tasks available in the portal.

- **UnitedHealthcare Network News**: Bookmark the Network News page on UHCprovider.com. 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.

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, state-specific training and much more.

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

Email communication – required contact information

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

Submit your email address in one of the following ways:

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

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

State websites and forms

Find the following forms on the state's website at https://mn.gov/dhs/:

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

Chapter 14: Compliance program integrity/fraud, waste and abuse

Key contacts

Topic	Link	Phone Number
Fraud, Waste and Abuse (Payment Integrity)	uhc.com/fraud	1-800-455-4521

Ethics and integrity

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

Compliance program

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

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

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

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least 10 years from the close of the MN program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan, including Optum, will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

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

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

You must cooperate with the state or any of its authorized representatives, the MN DHS, the Centers for Medicare & Medicaid Services, 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.

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.

United Healthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of potential fraudulent activities performed by you or plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies according to state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

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

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

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

Find out how we follow federal and state regulations around false claims at UHCprovider.com/MNcommunityplan > **Integrity of Claims, Reports, and Representations to the Government.**

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

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

Exclusion checks

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

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

What you need to do for exclusion checks

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan, MN DHS or CMS may ask for documentation to verify they were completed.

Glossary

638 Facility
Facility funded by Title I or V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638).

Abuse (by care provider)
Care provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost, or in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost, as defined by 42 CFR 455.2.

Abuse (of member)
Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S 46-451.

Adult Guardianship

1. *Private Guardian* refers to a person or party who has been appointed and ordered by the court to execute the powers, authority, duties and responsibilities involved in the protective arrangement of a guardianship, whereby the agent manages the personal life affairs, as needed, for a ward, who has been deemed or determined to be an incapacitated person by the court in accordance with Minnesota Statutes, §§524.5-101 through 524.5 502.
2. *Public Guardia*n refers to when the Commissioner is ordered and appointed by the court to act as public guardian for an adult with a mental disability who lacks resources to employ a guardian, but needs this level of supervision and protection, and has no other private party willing and able to act as private guardian, in accordance with Minnesota Chapter Law 252A and Public Guardianship Rule #175, Minnesota Rules, Parts 9525.3010 through 9525.3100

Adverse Benefit Determination

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

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

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

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

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

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

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

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

Application Programming Interface (API)
API is a common interface used to instantly pull information and automate data feeds. It can replace existing digital solutions or enhance them, based on your needs and resources. It is becoming the newest digital method in health care to distribute information from payers to care providers and external organizations in a timely and effective manner.

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

Authorized Representative
A person who has assumed the responsibilities outlined in and pursuant to Minnesota Rules, Part 9505.0085, subpart 2.

Behavioral Health
Behavioral health is the assessment and treatment of mental health and substance use disorders.

Behavioral Health Home (BHH)
A MHCP-enrolled provider certified by the state to provide services in accordance with Minnesota Statutes, §256B.0757. BHH is a care coordination model that focuses on the behavioral, physical health, and social service and support needs of populations with serious mental illness. BHH comprises the following services delivered by an inter-professional team: comprehensive care management; care coordination; health promotion services; comprehensive transitional care; referral to community and social support services; and individual and family support services. BHH services are available to members who have been determined eligible by the BHH provider in accordance with Minnesota Statutes, §256B.0757, subd. 2, (b).

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.

Care Plan
The document developed in consultation with the member, the member's treating physician, health care or support professional, or other appropriate individuals, and where appropriate, the member's family, caregiver, or representative that, taking into account the extent of and need for any family or other supports for the member, identifies the necessary health and Home and Community-Based services to be furnished to the member.

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.

Certified Community Behavioral Health Clinic (CCBHC)
Minnesota Health Care Programs-enrolled provider certified by the state to provide services in accordance with Minnesota Statutes, §245.735 and PL 113-93, §223. CCBHCs provide an integrated behavioral and physical health delivery model. Services provided under this model include, but are not limited to, primary care screening and monitoring; outpatient mental health and substance use disorder services, including screening, assessment and diagnosis (including risk management); crisis mental health services (including 24-hour mobile crisis teams), crisis intervention services and crisis stabilization; patient-centered treatment planning, targeted case management, peer and family support, services for members of the armed forces and veterans; psychiatric rehabilitation services, including adult rehabilitative mental health services (ARMHS) and children's therapeutic services and supports (CTSS). CCBHC services are available to members who have been determined eligible for services by the CCBHC in accordance with Minnesota Statutes, §245.735.

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

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

Cost Sharing
Copayment, coinsurance or deductible.

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

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

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

Customized Living
Individualized package of regularly scheduled, health-related and supportive services provided to a person age 18 years or older who resides in a qualified assisted living facility licensed under Minnesota Statutes, Chapter 144DG.

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.

Dual-Eligible
Medicaid recipients who are also eligible for Medicare.

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

Early Periodic Screening Diagnosis and Treatment Program (EPSDT)
A package of services in a preventive (well child) exam covered by Medicaid as defined in 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.

Elderly Waiver
Home and Community Based Services waiver program authorized by a federal waiver under §1915(c) of the SSA, 42 USC §1396, and Minnesota Statutes, §256S.

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.

Emergency Transportation
Transportation for an emergency medical condition as defined within this manual.

Encounter
A record of health care-related services by care providers registered with Medicaid to a patient enrolled with UnitedHealthcare Community Plan on the date of service. You are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan electronically reports these encounters to state Medicaid. The state audits encounter submission accuracy and timeliness on a regular basis.

Enrollee
Enrollee is interchangeable with the term member. Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber or dependent.

Enrollment
The process where a person is determined eligible to receive Medicaid or Medicare benefits becomes an enrollee or member of a health plan.

Evidence-Based Care
An approach that helps care providers use the most current, scientifically accurate research to make decisions about members' care.

Expedited Appeal
An expedited review process for appeals determines that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

External Medical Review (EMR)
An independent review of the relevant information the MCO used related to an Adverse Benefit Determination based on functional or medical necessity. EMRs are conducted by third-party organizations, known as Independent Review Organizations (IROs), contracted by HHSC.

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

Formulary
List of drugs that includes therapeutic classes for both generic and brand-name medications. Within the formulary, a drug or dosage form may be designated as "preferred" or "non-preferred." Preferred drugs generally require minimal or no prior authorization; non-preferred drugs require prior authorization and may also require periodic regimen review or specific billing requirements. To disadvantage a drug means to modify these requirements to make use of a non-preferred drug similar to use of a preferred drug, or to make a preferred drug similar to a non-preferred drug.

Fraud
A crime that involves misrepresenting or concealing information to receive benefits or to make a financial profit.

Grievance
Unhappiness about the plan and/or care provider regarding any matter including quality of care or service concerns. Does not include adverse benefit determination (see appeals/dispute). Grievances may include, but are not limited to, the quality of care or services provided, and relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed to make an authorization decision.

Habilitation
This service allows an individual to reside successfully in a community setting by assisting the individual to acquire, retain, and improve self-help, socialization, and daily living skills or assisting with and training the individual on daily living activities and instrumental activities of daily living.

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

Health Care Home
A health care home is a specially contracted care provider that coordinates a comprehensive set of services, including service coordination services; patient self-management education; care provider education; behavioral health services; patient-centered and family-centered care; evidence-based models and minimum standards of care; patient and family support (including authorized representatives).

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

Home and Community Based Services (HCBS)
Services provided under a federal waiver under §1915(c) of the SSA, 42 USC §1396n, and Minnesota Statutes, §§256B.092, subd. 4, and 256S. These services are for members who meet specific eligibility criteria including being at risk of institutional care if not for the provision of HCBS services. The services are intended to prevent or delay nursing facility placements.

Home Care Services
Service is ordered by a physician, advanced practice registered nurse or a physician assistant and documented in a service plan that is reviewed by the ordering practitioner at least once every 60 days for the provision of home health services or home care nursing, or at least once every 365 days for personal care assistance; and the services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or outside the home when normal life activities take the member outside the home. Services include the following as outlined in Minnesota Statutes, §256B.0625:

- Home health aide services
- Skilled nursing visits, including telehome care visits, provided by a certified Home Health Care Agency
- Home care nursing
- Durable medical equipment and associated supplies when accompanied by a home care service
- Personal Care Assistance services

Hospice
Palliative and supportive care and other services provided by an interdisciplinary team under the direction of an identifiable hospice administration to terminally ill hospice patients and their families to meet the physical, nutritional, emotional, social, spiritual and special needs experienced during the final stages of illness, dying and bereavement.

Independent Review Organization
A third-party organization contracted by HHSC that conducts an External Medical Review (EMR) during member appeal processes related to Adverse Benefit Determinations based on functional or medical necessity.

Indian Health Care Provider (IHCP)
Health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U). IHCP includes a 638 Facility and provision of Indian Health Service Contract Health Services (IHS CHS).

Indian Health Service (IHS)
The federal agency charged with administering the health programs for American Indians.

Indian Health Service Contract Health Services (IHS CHS)
Health services covered by UnitedHealthcare Community Plan that would otherwise be provided at the expense of the IHS, from public or private medical or hospital facilities other than those of the IHS under a contract with IHS and through a referral from IHS, to American Indian Enrollees

Indian Health Services Facility (IHS Facility)
A facility administered by the IHS that is providing health programs for American Indians.

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.

Long-Term Services and Supports (LTSS)
Services and supports provided to members of all ages who have functional limitations and/or chronic illnesses, that have the primary purpose of supporting the opportunity to achieve person-centered goals and supporting the ability of the member to live or work in the setting of their choice. Living or work settings may include the member's home, a worksite, a provider-owned or controlled residential setting, a nursing facility or other institutional setting

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.

Medicare
A federal insurance program that primarily provides health insurance for Americans aged 65 and older, but also for some younger people with disability status as determined by the Social Security Administration (SSA).

Medicare is divided into 4 Parts: A, B, C and D. Part A covers hospital, skilled nursing and hospice services. Part B covers outpatient services. Part D covers self-administered prescription drugs. Additionally, Part C is an alternative that allows patients to choose their own plans that provide the same services as Parts A and B, but with additional benefits.

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 or Medical Necessity means a health service that is:

1. Consistent with the member's diagnosis or condition
2. Recognized as the prevailing standard or current practice by the provider's peer group; and
3. Rendered:
   - In response to a life threatening condition or pain;
   - To treat an injury, illness or infection;
   - To treat a condition that could result in physical or mental disability;
   - To care for the mother and unborn child through the maternity period;
   - To achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; or
   - As a preventive health service.

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

Non-emergency Transportation (NEMT)
The modes of transportation defined in Minnesota Statutes, §256B.0625, subd. 17. NEMT includes member reimbursement; volunteer transport; unassisted transport, (including transportation by a taxicab or public transit); assisted transport (transport provided to members who require assistance by an NEMT provider); lift-equipped/ramp transport; stretcher transport; and protected transport. NEMT does not include ambulance transportation with treatment.

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 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.

Peer-to-Peer
Discussion held between the physician requesting, ordering or intending to provide a prior authorized service and our Medical Director or their physician designee regarding the medical necessity, appropriateness or the experimental or investigational nature of a healthcare service.

Person Master Index (PMI)
The state identification number assigned to an individual beneficiary.

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, advanced practice registered nurse or physician assistant, as allowed under Minnesota Rules, Part 4685.0100, subpart 12a and 12b and the terms of the plan who provides, coordinates or helps members access a range of health care services.

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

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

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

Restricted Recipient
Recipients are required to receive health services only from their designated providers. This program was developed to improve safety and quality of care, reduce instances of abuse and cut unnecessary costs.

Routine Care
Health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.

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 Minnesota DHS.

Specialist
A physician licensed in the state of Minnesota 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.

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.

Unique Minnesota Provider Identifier (UMPI)
Unique identifier assigned by the state for certain atypical providers not eligible for an NPI.

UnitedHealthcare Community Plan
An affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

Urgent Care
Services required to prevent serious deterioration of health after the onset of an unforeseen condition or injury.

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 practice a reasonably prudent person would deem careless or would allow inefficient use of resources, items, or services. It is your obligation to report knowledge or suspicion of fraud, waste or abuse.