2024
Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary

Rhode Island

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United Healthcare® Community Plan

Welcome

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

Click the following links to access different manuals:

- **Administrative Guide** – UHCprovider.com/guides Under UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans), click on View Guide. Some states may also have Medicare Advantage information in their Community Plan manual.
- **A different Community Plan manual** – UHCprovider.com/guides Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on Find Your State

Easily find information in this manual using the following steps:

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

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

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

Important information about the use of this manual

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

This manual will be amended as policies change.

Terms and definitions as used in this manual:

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

Table of Contents

Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	1-855-766-0344
Training	UHCprovider.com/training	
Provider Portal	UHCprovider.com, then Sign In using your One Healthcare ID or go to Provider Portal Self Service: UHCprovider.com/en/resource-library/link-provider-self-service.html New users: UHCprovider.com > New User and User Access	
CommunityCare Provider Portal Training	CommunityCare Provider Portal User Guide	1-866-842-3278, option 1
Provider Portal Support	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal Contact Us page.	1-855-819-5909
Resource Library	UHCprovider.com > Resources > Resource Library	

UnitedHealthcare Community Plan provides benefits and service to members, including:

- Children with special health care needs
- RIte Care
- Rhody Health Partners
- Rhody Health Partners ACA Adult Expansion

UnitedHealthcare Community Plan also supports Dual Complete (HMO SNP) members.

If you have questions about the information in this manual or about our policies, go to UHCprovider.com or call Provider Services at **1-855-766-0344**.

How to join our network

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

Already in network and need to make a change?

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

Our approach to health care

Care Model

The Care Model program seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community partners 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. The 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, resulting in better quality of life,

improved access to health care and reduced expenses. Care Model provides a care management/coordination team that helps increase member engagement, offers resources to fill gaps in care and develops personalized health goals using evidence-based clinical guidelines. This approach is essential to improving the health and well-being of the individuals, families and communities UnitedHealthcare Community Plan serves. Care Model provides:

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

The Care Model program goals are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates.
- Improve access to PCP and other needed services, measured by number of PCP visit rates within identified time frames.
- Identify and discuss behavioral health (BH) needs, measured by number of 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 Care Model, call Provider Services at 1-855-766-0344.

Compliance

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

Cultural resources

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

- **Cultural competency training and education**

  Free continuing medical education (CME) and non-CME courses are available on our **Cultural Competency page** as well as other important resources.

  Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process**.

- **Translation/interpretation/auxiliary aide services**

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

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

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

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

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

- **Care for members who are deaf or hard of hearing**

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

UnitedHealthcare Community Plan 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 services for deaf and hard of hearing individuals are available. If a UnitedHealthcare Community Plan member needs interpreter services, they can call the phone number on their ID card.
  - If you need a professional interpreter during regular business hours, call Provider Services at **1-855-766-0344**. After hours, call **1-877-261-6608**.
  - Enter the client ID [728033] (do not hit #). Press 1 for Spanish and 2 for all other languages.
- **Materials for limited-English speaking members:** We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members. For more information, go to uhc.com > **Language Assistance.**

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual Care Guidelines (We formerly used MCG Care Guidelines.) for care determinations.

Online resources

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

Electronic Data Interchange (EDI)

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

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

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

Visit **UHCprovider.com/EDI** for more information. Learn how to optimize your use of EDI at **UHCprovider.com/optimizeEDI**.

Getting started

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

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

Provider Portal secure care provider website

Provider Portal provides a secure online portal to support your administrative tasks including eligibility, claims and prior authorization and notifications. To sign in to the Provider Portal, go to **UHCprovider.com** and click the Sign In button in the upper right corner. For more information about all online services, go to **Self Service Tools and Eligibility** or go to the Provider Portal Self Service page at **UHCprovider.com/en/resource-library/link-provider-self-service.html**.

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

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

The secure care provider website lets you:

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

- Find certain web pages more quickly using direct URLs. You'll see changes in the way we direct you to specific web pages on our UHCprovider.com provider portal. You can now use certain direct URLs, which helps you find and remember specific web pages easily and quickly. You can access our most used and popular web pages on UHCprovider.com by typing in that page's direct URL identified by a forward slash in the web address, e.g. UHCprovider.com/claims. When you see that forward slash in our web links, you can copy the direct URL into your web page address bar to quickly access that page.

You will conduct business with us electronically. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use both EDI and UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically. **To access the Provider Portal, go to UHCprovider.com, then Sign In**.

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

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

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

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

Direct Connect

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

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

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

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

Privileges

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

Provider Services

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

Provider Services can assist you with questions on Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more.Provider Services works closely with all departments in UnitedHealthcare Community Plan.

How to contact us

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

Topic	Contact	Information
Behavioral Health/ Optum	providerexpress.com 1-800-1-888-2998 (toll-free)	Find out about behavioral health eligibility, claims, benefits, authorization and appeals.
Benefits	UHCprovider.com/benefits 1-855-766-0344	Confirm a member's benefits and/or prior authorization.
Cardiology Prior Authorization (Clinical Request Line/CareCore National)	For prior authorization or a current list of CPT codes that require prior authorization, visit UHCprovider.com > Prior Authorization and Notification > Cardiology. 1-866-889-8054	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Care Model (Care Management/ Disease Management)	RI Health Services 1-800-672-2156 or 401-732-7373	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
Claims	Use the Provider Portal at UHCprovider.com/claims 1-855-766-0344 Mailing address: **UnitedHealthcare Community Plan** P.O. Box 31361 Salt Lake City, UT 84131 Fax: 801-567-5497 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 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 Provider Portal, then select the UnitedHealthcare Online app 1-855-766-0344 Mailing address: **UnitedHealth Group Recovery Services** P.O. Box 31361 Salt Lake City, UT 84131	Ask about claim overpayments.
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
Electronic Payments and Statements (EPS)	OptumBank.com 1-866-842-3278	Enroll in EPS or ask questions about EPS capabilities
Eligibility	To access eligibility information, go to UHCprovider.com then Sign In to the Provider Portal or go to UHCprovider.com/eligibility. 1-855-766-0344	Confirm member eligibility.
Enterprise Voice Portal	1-855-766-0344	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud and Abuse (Payment Integrity)	Payment Integrity Information: UHCprovider.com/RIcommunityplan > Integrity of Claims, Reports, and Representations to the Government Reporting: uhc.com/fraud 1-800-455-4521 or 1-877-401-9430	Learn about our payment integrity policies. Report suspected fraud, waste or abuse by a care provider or member by phone or online.
Laboratory Services	UHCprovider.com > Find Dr > Preferred Lab Network Labcorp: 1-800-833-3984	Labcorp is the preferred lab provider.

Topic	Contact	Information
Medicaid [RI Department of Health and Human Services]	Dhs.ri.gov 1-855-697-4347 (DHS Call Center) 401-784-81-877 (Adults in Managed Care Line) 401-784-8100 (Medicaid Line)	Contact Medicaid directly.
Medical Claim, Reconsideration and Appeal	Sign in to the Provider Portal at UHCprovider.com or go to UHCprovider.com/claims for more information. 1-800-587-5187 Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 31361 Salt Lake City, UT 84131 Fax: 801-567-5497 Appeals mailing address: **UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	myuhc.com 1-800-587-5187 / TTY 711 for help accessing member account	Assist members with issues or concerns. Available 8 a.m. – 6 p.m. Eastern Time, Monday through Friday
Mental Health & Substance Abuse (Optum Behavioral Health) (Also see "Behavioral Health")	Liveandworkwell.com 1-800-435-7486	Available 24/7. Refer members for behavioral health services. A PCP referral is not required.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	1-800-587-5187 TDD 711	Available 8 a.m. – 6 p.m. Eastern Time, Monday through Friday, except state-designated holidays.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network Management Support	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. 1-855-766-0344	Self-service functionality to update or check credentialing information.

Topic	Contact	Information
Obstetrics (OB) Care/Pregnancy and Baby Care	Healthy First Steps Pregnancy Notification Form at **UHCprovider.com**, then the Provider Portal. 1-800-599-5985 Healthy First Steps Rewards **uhchealthyfirststeps.com**	For pregnant members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form. Refer members to **uhchealthyfirststeps.com** to sign up for Healthy First Steps Rewards.
Oncology Prior Authorization	UHCprovider.com > Prior Authorization > **Oncology** Optum 1-888-397-8129 Monday - Friday 7 a.m. – 7 p.m. CT	For current list of CPT codes that require prior authorization for oncology
One Healthcare ID Support Center	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. 1-855-819-5909	Contact if you have issues with your ID. Available 7 a.m. – 9 p.m. CT, Monday through Friday; 6 a.m. – 6 p.m. CT, Saturday; and 9 a.m. – 6 p.m. CT, Sunday.
Pharmacy Services	UHCprovider.com/RIcommunityplan > **Pharmacy Resources and Physician Administered Drugs** 1-800-310-6826 1-877-305-8952 (OptumRx)	OptumRx oversees and manages our network pharmacies.
Prior Authorization/ Notification for Pharmacy	**UHCprovider.com/priorauth** 1-800-310-6826	Request authorization for medications as required. Use the Provider Portal to access the PreCheck MyScript tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives.

Topic	Contact	Information
Prior Authorization Requests/Advance Admission Notification for Health Services (Medical and Obstetrics)	To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N Online Tool: **UHCprovider.com/paan** Phone: Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications." Or call Provider Services.	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required. • Complete the notification or prior authorization process. • Upload medical notes or attachments. • Check request status Information and advance notification/ prior authorization lists: UHCprovider.com/ RIcommunityplan > **Prior Authorization and Notification**.
Provider Services	1-855-766-0344	Available 6 a.m. – 4 p.m. ET, Monday through Friday.
Radiology Prior Authorization (Clinical Request Line/CareCore National)	**UHCprovider.com/radiology** 1-866-889-8054	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Reimbursement Policies	UHCprovider.com/RIcommunityplan > **Policies and Clinical Guidelines**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical Support	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. 1-866-209-9320 for Optum support or 1-866-842-3278, Option 1 for web support	Call if you have issues logging in to the Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit Line	1-800-784-1-8669	Ask about services for quitting tobacco/ smoking.
Transplant Evaluation and Services	1-888-936-7246	Call intake service to request authorization of transplant related services
Transportation	MTM (Medical Transportation Management) 844-714-2219 Monday-Friday, 7 a.m.-7 p.m. ET	Members need to call MTM to determine if they qualify for scheduled transportation assistance. **Transportation is an out-of-plan benefit covered by RI Medicaid.**

Topic	Contact	Information
Utilization Management (UM)	Provider Services 1-855-766-0344	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, then select **Policies and Clinical Guidelines.** Request a copy of our UM guidelines or information about the program.
Vaccines for Children (VFC) program	**health.ri.gov/immunization/for/providers/**	You must participate in the VFC Program administered by the Department of Health and Senior Services (DHSS) and must use the free vaccine when administering vaccine to qualified eligible children. You must enroll as VFC providers with DHSS to bill for the administration of the vaccine.

Chapter 2: Care Provider Standards and Policies

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	1-855-766-0344
Enterprise Voice Portal		
Eligibility	UHCprovider.com/eligibility	
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 cognitive disability, national origin, religion, type of illness or condition. You may only direct the member to another care provider type if that illness or condition may be better treated by someone else.

Communication between care providers and members

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

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

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

Provide official notice

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

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

You may use the care provider demographic information update form for demographic changes or to update NPI information for care providers in your office. This form is located at the Provider Portal at UHCprovider.com then Sign In > Provider Practice Profile.

Transition member care following termination of your participation

If your network participation ends, you are required to participate in the timely transition of care of your member. This includes providing service(s) for a reasonable time, at our contracted rate. Member and Provider Services are available to help you and our members with the transition. More information is on UHCprovider.com. You may also call Provider Services at 1-855-766-0344.

If you should terminate from our network, please be aware the termination shall not affect the method of payment or reduce the reimbursement to you by us for any of our members in active treatment for an acute medical condition at the time of your termination until the active treatment is concluded or, if earlier, 1 year after the termination. With respect to the patient, during the active treatment period, you are subject to all the terms and conditions of the terminated physician contract, including all reimbursement provisions which limit the patient liability.

We are unable to pay a care provider who is debarred from government programs during active treatment. In this case, the member must transition to another physician.

Arrange substitute coverage

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

For the most current listing of network care providers and health care professionals, review our care provider and health care professional directory at UHCprovider.com/RIcommunityplan.

Administrative terminations for inactivity

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

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

Changing an existing TIN or adding a health care provider

Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the address listed on the bottom of the form. The W-9 form and the Care Provider Demographic Information Update Form are available using the Provider Portal at UHCprovider.com > Sign In > My Practice Profile.

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

Updating your practice or facility information

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

- Completing the Provider Demographic Change Form and emailing it to the appropriate address listed on the bottom of the form.
- Calling our Enterprise Voice Portal at 1-855-766-0344.

After-hours care

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

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

Participate in quality initiatives

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

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

Provide access to your records

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

Performance data

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

Comply with protocols

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

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

Office hours

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

Protect confidentiality of member data

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

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

Follow medical record standards

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

Inform members of advance directives

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

Your Agreement

If you have a concern about your Agreement with us, send a letter with the details to the address in

your contract. A representative will look into your complaint. If you disagree with the outcome, you may file for arbitration. If your concern relates to certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, follow the dispute procedures in your Agreement. After following those procedures, if either party remains dissatisfied, you may file for arbitration.

Refer to **Chapter 12** of this manual for if a member asks you as a provider to appeal a clinical or coverage determination on their behalf.

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 a **UHCCommunityPlan.com**.

Care provider directory

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

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 Provider Directory inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional assistance in finding a care provider.

We are required to contact all participating care providers annually and independent physicians every 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 Provider Directory information is inaccurate, you may be subject to corrective action.

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

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

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

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

Provider attestation

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

When you submit demographic updates, list only those addresses where a member may make an appointment and see the health care provider. On-call and substitute health 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 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 Provider Portal at **UHCprovider.com/eligibility** or by calling Provider Services. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- Get prior authorization:
    1. To access the Prior Authorization app, go to **UHCprovider.com**, then click Sign In.
    2. Select the **Prior Authorization and Notification app**.

3. View notification requirements.

You may also find information on UHCprovider.com/RIcommunityplan > Prior Authorization and Notification.

Identify and bill other insurance carriers when appropriate.

If you have questions, please call UnitedHealthcare Web Support at **1-866-842-3278**, option 3, 7 a.m. – 9 p.m. CT, Monday 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

PCPs include internal medicine, pediatrics, geriatrics, general practice and family practice

PCPs are an important partner in the delivery of care, and RI Executive Office of Health and Human Services (EOHHS) members may seek services from any participating care provider. The RI EOHHS 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 (M.D.s), 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
- Geriatrics

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

Members may change their assigned PCP by contacting Member Services at any time during the month. Customer service is available 8 a.m. – 6 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 to any OB/GYNs, midwives, PAs, or NPs for women's health care services and any non-women's health care issues discovered and treated in the course of receiving women's health care services. This includes access to ancillary services ordered by women's health care providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP.

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support, and benefit from the primary care case management system. The coverage will include availability of 24 hours a day, 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. **Recorded messages are not acceptable.**

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

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.
- Provide all well baby/well-child services.
- Coordinate each UnitedHealthcare Community Plan member's overall course of care.
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a 1 MD practice and at least 30 hours per week for a 2 or more MD practice.
- Be available to members by 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

PCPs include internal medicine, pediatrics, geriatrics, general practice and family practice

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

- Offer office visits on a timely basis, based on the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide.
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment.
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Take part in all survey-related activities and must comply with and participate in periodic appointment access and availability survey calls related to routine, urgent, emergent and after hours availability.
- Refer services requiring prior authorization to Provider Services or our Clinical or Pharmacy departments, as appropriate.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS® or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
- Complying with the RI EOHHS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment standards are covered in Chapter 2 of this manual.

Coordination of care between PCPs and specialists

PCPs and specialists share responsibility for communicating essential patient information regarding consultations. The specialist is responsible for communicating the results of visits, recommendations and treatment plans. Information exchanges should be timely, relevant and accurate for ongoing patient management.

Coordination of care between PCPs and behavioral health clinicians

Make sure you are aware if a behavioral health clinician is treating your patient. Coordination of care is very important for members with severe and persistent mental illness (SPMI) and/or substance use problems. This is especially true when medications are prescribed, when there are co-existing medical/ psychiatric symptoms and when members have been hospitalized. Communication between clinicians can maximize the efficiency of diagnosis and treatment, while minimizing the risk of adverse medication interactions. It can also help reduce the risk of substance use or psychiatric relapse.

Federally qualified health center or primary care clinic as PCP

Members may choose a federally qualified health center (FQHC) or a primary care clinic (PCC) as their PCP.

- **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).
- **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 acutely serious or life-threatening. If a condition is discovered at a PCC that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

PCP checklist

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

Specialist care providers responsibilities

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

- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer.
- Verify the eligibility of the member before providing covered specialty care services.
- Provide only those covered specialty care services, unless otherwise authorized.
- Provide the PCP copies of all medical data, reports

and discharge summaries resulting from the specialist's care.

- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at 1 UnitedHealthcare Community Plan participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the RI EOHHS Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PCPs and specialists 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.

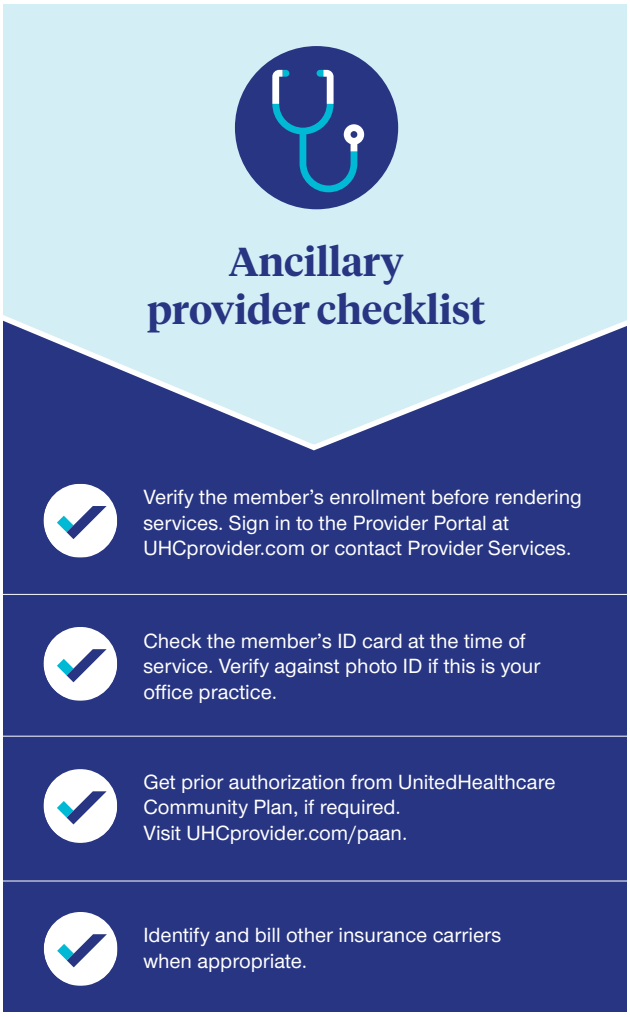
Specialists may use medical residents in all specialty care settings under the supervision of fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

UnitedHealthcare Community Plan also conducts periodic appointment access surveys to specialists to monitor for routine, urgent and emergent appointment availability for our membership.

Ancillary care provider responsibilities

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

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



Appointment standards (RI EOHHS 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 30 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 1 hour of the scheduled appointment time

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- 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.

Chapter 3: Care Provider Office Procedures and Member Benefits

Key contacts

Topic	Link	Phone Number
Member Benefits	UHCCommunityPlan.com/RI	1-800-587-5187
Member Handbook	UHCCommunityPlan.com/RI > Go to Plan Details, then Member Resources, View Available Resources	
Provider Services	UHCprovider.com	1-855-766-0344
Prior Authorization	UHCprovider.com/paan	
D-SNP	UHCprovider.com > Health Plans by State > Rhode Island	

Member benefit information

View member benefit coverage information online at UHCprovider.com. The following benefits are not all-inclusive.

Benefits	Services Included	Limitations
Abortion Services	Refer to state guidelines	
Adult Day Services	Covered when medically necessary	Prior authorization is required.
AIDS/HIV Case Management	Targeted Non-Medical	Covered. These case management services are for members living with AIDS, and for those at a high risk of acquiring HIV. Benefit includes and is not limited to counseling, assistance with accessing food, housing, transportation and referrals to community programs.
	Medical Case Management	Covered. Medical case management services provided by participating care providers.
Ambulance Services	Emergent and non-emergent transportation.	Covered. Prior authorization not required.
	Air ambulance.	Prior authorization required.
	Refer to additional ambulance service information in this chapter.	
Bariatric Surgery	Inpatient and outpatient bariatric surgery and specific obesity-related service.	Covered. Prior authorization not required.

Benefits	Services Included	Limitations
Behavioral Health Inpatient (Hospital)	Covered Benefit Behavioral Health is available 24 hours a day to help with emergency crises. Select option 8 for emergency crisis.	Prior Authorization required.
Behavioral Health – Outpatient	Contact Behavior Health at Optum Member: 1-800-587-5187 Provider: 1-855-766-0344	Covered through Optum.
Children's Evaluations	Includes evaluations for sexual abuse, parent/child evaluations, fires setter, PANDA clinic and other evaluations as medically necessary	Covered as needed.
Cancer-Related Treatment	Access to any related medically necessary service. This includes hospitalization, doctor services, other practitioner services, outpatient hospital services, chemotherapy and radiation.	Covered. Potential prior authorization required.
Chiropractic Services	Manual manipulation of the spine to correct spinal alignment.	Not covered.
Circumcision	Outpatient service: No age limits. Inpatient service:	Covered.
Cosmetic and/ or Reconstructive Surgery	Services or supplies provided in connection with cosmetic surgery are not covered, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member. Breast reconstruction following a mastectomy is covered.	Prior authorization required.
Dental Services	Routine dental services are not covered through UnitedHealthcare. Call State Dental Vendor 1-866-375-3257.	Not covered.
	For emergency and oral surgery dental services performed in an outpatient setting, UnitedHealthcare Community Plan will cover the facility and anesthesia services when deemed as medically necessary. The facility services require a prior authorization.	Covered: Facility and Anesthesia only.

Benefits	Services Included	Limitations
Diabetic Supplies	Durable medical equipment (DME) received at a pharmacy. Pharmacies must file claims to OptumRx. Examples of DME: 1. Diabetic supplies and equipment. 2. Glucose monitors. OptumRx for providers and pharmacies: 1-877-305-8952.	Covered. Preferred insulin syringes, insulin needles, lancets, alcohol swabs, and diabetes test strips covered. Prior authorization required on for non-preferred products.
Diagnostic Tests	**Radiology:** Radiology (imaging studies) require prior authorization from UnitedHealthcare Community Plan Clinical for: • CT; X-ray. • MRI (magnetic resonance imaging). • MRA (magnetic resonance angiogram). • PET scan (positron emission tomography). • Nuclear Medicine SPECT MPI (Myocardial perfusion imaging). • Select Nuclear Medicine Studies • Nuclear Cardiology.	Covered. Some diagnostic tests require a prior authorization and must always be medically necessary.
	Laboratory: Labcorp is the preferred lab provider. Care providers must have a NPI # on file or claims will deny.	Covered.
Dialysis	Covers dialysis supplies, diagnostic testing and medications. Services may be provided on an outpatient or inpatient basis	Covered based on medical necessity.
Drugs (Prescription and over-the-counter medications)	Generic substitution required unless otherwise ordered by a network provider. Many over-the-counter drugs are covered, including routine nicotine cessation, aspirin, and cold medicines. Medications for sexual or erectile dysfunction are not covered.	Covered. Prior authorization may be needed for some prescription drugs.

Benefits	Services Included	Limitations
Durable Medical Equipment (DME) and Medical Supplies	Obtain routine DME supplies through in-network providers DME may be rented, purchased, or repaired based on the member's duration and use needs. Determination on which 1 (purchase, rental, etc.) is applicable is made by either Medical Management or the Prior Notification team using the following criteria: • Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment. • Periodic rental payments are made only for the lesser of either the period the equipment is medically necessary, or when the total monthly rental payments equal the reasonable purchase cost for the equipment. • DME repair will be considered based on the age of the item and cost to repair it. • Medicaid beneficiaries younger than 21 years are entitled to all medical necessary DME.	Covered. An M.D. or D.O. must be the ordering care provider type. Physician assistants and nurse practitioners cannot be the ordering care provider type for these services. A prior authorization is required on all DME equipment valued at more than $500 per line item.
Early Intervention	Covered.	Covered for children up to age 3.

Benefits	Services Included	Limitations
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	EPSDT service is Medicaid's comprehensive preventive child health service for individuals younger than 21 years. Annual physicals for children 20 years and younger must meet EPSDT criteria. Comprehensive screenings and interim screenings include: • Care provider exam • Comprehensive health history • Vision screen • Health and developmental history • Hearing screenings • Measurements • Blood pressure • Vital signs • Nutritional counseling • Laboratory procedures • Health education/anticipatory guidance • Immunizations • Lead screenings • Environmental investigation • Dental screening	Covered.
Education Classes	Childbirth, parenting, smoking cessation, diabetes, asthma and nutrition	Covered.
Emergency, Post-stabilization, and Urgent Care	Covered.	Covered.
Experimental Procedures	Not covered.	Not covered.
Family Planning	Limited to 12 30-day supplies per year. Covered contraceptives include oral contraceptives, IUD, cervical cap, diaphragm and Depo-Provera. Covered non-prescription methods include foam, spermicidal jelly and condoms. Emergency contraceptives as needed. Sterilization is covered in many cases. Must meet state and federal guidelines and have Rhode Island Medicaid Consent Form signed at least 30 days prior.	Covered.

Benefits	Services Included	Limitations
Femoroacetabular Impingement Syndrome (FAI)	All planned elective hip arthroscopy for CPT codes 29914, 29915, and 29916	Prior authorization required.
Gender Dysphoria Treatment		Covered when ordered by a network care provider. Some services may require prior approval.
Hearing Services	Includes diagnostic screening, preventive visits and hearing aids.	Covered.
	Adults: As part of the Adult Health Screening Services, audiometry sweeps are covered for once every 4 years for adults over 21 years.	Prior authorization required for all DME equipment costing more than $1,000 per line item.
	Hearing aid services and repairs.	Prior authorization required for ALL services and repair request.
	Hearing aid batteries.	Covered, but limited to 32 per month.
Home Health Services	Therapy and Services	Covered when medically necessary. Prior authorization required for most services.
	Preventive Services	
	Home Modifications and Specialty Equipment Supplies	
Hospice	In-home hospice and short-stay inpatient hospice.	Prior authorization required. Covered when ordered by a network provider. Services are limited to Medicare covered services.
	Residential inpatient hospice services are covered.	
	Please refer to additional hospice information in this chapter.	
Hospital – Inpatient	Inpatient hospital care. Includes medical, surgical, post-stabilization, acute and rehabilitative services.	Covered. Private room not covered unless medically necessary. Prior authorization required.
	Maternity services.	Hospital must notify the plan no less than 48 hours for a vaginal birth and no less than 96 hours for a cesarean section birth. If longer, requires clinical information and medical necessity review.

Benefits	Services Included	Limitations
Hospital - Outpatient	Outpatient professional/Medical services professional component (in/outpatient) of surgical services, including: • Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care. • Administration of anesthesia by care provider (other than surgeon) or CRNA. • Second surgical opinions. • Same-day surgery performed in a hospital without an over-night stay. • Invasive diagnostic procedures such as endoscopic examinations. Electroconvulsive therapy (ECT) does not require a prior authorization.	Covered.
	Out of Network: Not covered except in situations where members require urgent or emergent medical care. In urgent or emergent medical situations, coverage limited up to the point of medical stabilization.	Prior authorization required for non-emergent/ non-urgent hospital services.
	Emergency room prescription.	Covered.
Immunizations	Covered for adults.	Covered.
	Coverage for children, birth through 18 years, is through the Vaccines For Children (VAC) program.	Covered.
Infertility Treatment		Not covered.
Interpreters	Please call Provider Services at 1-855-766-0344 to arrange for interpreter services. We require a 72-hour advance notice for languages and a 14-day advance notice for American Sign Language.	Covered.
Injectable Medications	Outpatient basis. Please visit UHCprovider.com/RIcommunityplan > Prior Authorization and Notification to view the current notification requirements for RI for the list of injectable medications requiring a prior authorization.	Covered. Prior authorization is required.
Joint Replacement	Covered for adults.	Covered.

Benefits	Services Included	Limitations
Laboratory Tests	Covered for diagnostic, screening, and monitoring purposes when medically necessary.	Covered.
Language Therapy		Covered when ordered by the PCP.
Mental Health and Substance Use Disorder Services (Inpatient and Outpatient)	Covered services include a full continuum of mental health and substance use disorder (SUD) treatment community-based narcotic treatment, methadone, and community detox. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Also includes hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST), Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs.	Covered as needed, including residential substance use treatment for youth.
Mid-level Practitioners Services	Includes care physician assistants (PA), advanced registered nurse practitioners (ARNP), family practice nurse practitioner (FPNP), pediatric nurse practitioner (PDNP), nurse anesthetists (CRNA), and nurse midwives.	Covered.
Neuropsych Testing	No prior authorization required if in-network.	Covered.

Benefits	Services Included	Limitations
Newborn Services	Facility and care provider services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.	Covered. Prior authorization is required.
	Non-routine newborn care, i.e. care for sick newborns (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered. Infants remaining in the hospital after mother's discharge require separate notification and will be subject to medical necessity review.	Prior authorization is required.
	Out of Network: not covered except in situations where members require urgent or emergent medical care. In urgent or emergent medical situations, coverage limited up to the point of medical stabilization.	Prior authorization required for non-emergent/ non-urgent hospital services.
Nutritional Counseling	Services include outpatient education.	Covered.
Observation	48-hour observation.	Covered.
Orthotics and Prosthetics	Orthotics and prosthetics with a retail purchase or cumulative rental cost of more than $1,000.	Prior authorization required.
Outpatient and Care Provider Visits	Services at a hospital or care center when a member stays less than a day. Doctor, other care provider visits, family planning, preventive services, and clinic visits. Specialty care provider visits. Emergency room visits including both hospital and care provider charges.	
Outpatient Surgery	Services include but are not limited to: Medically necessary surgeries are covered when performed in an ambulatory surgery center (ASC and hospital ASC). Covered when medically necessary and not otherwise excluded.	Covered. Some surgeries require pre-authorization.

Benefits	Services Included	Limitations
Podiatry Services	Covered for medically necessary services only; typically associated with severe circulatory disease or loss of sensation of feet or member has been diagnosed with a systemic condition by a care provider that there is medical necessity for professional foot care, such as: • Debridement of non-mycotic nails • Diabetes mellitus • Arteriosclerosis • Buerger's disease • Chronic thrombophlebitis • Peripheral neuropathies	Covered.
Pregnancy-Related Services	UnitedHealthcare Community Plan covers all OB services through the member's pregnancy. Services include pre- and post-natal care, tests, doctor visits and other services that affect pregnancy outcomes.	Covered.
	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. If the member is inpatient longer than the federal requirements, a prior authorization is required. Please call for **prior authorization**.	Authorization required. Submit your notification using the EDI 278N transaction, the Prior Authorization and Notification tool on the Provider Portal at **UHCprovider.com** or call Provider Services.
	Care providers 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. The initial pregnancy visit is not included in the global days and must be billed as a separate office visit. FQHCs will not be able to use global billing per EOHHS.	
	Non-routine newborn care, i.e. care for sick newborns (e.g., unusual jaundice, prematurity, sepsis, respiratory distress).	Prior authorization required.
	Please refer to additional maternity information in this chapter.	

Benefits	Services Included	Limitations
Prescription Services	Drugs prescribed by a physician. This includes education about how to take the drugs.	Drugs prescribed by a physician. This includes education about how to take the drugs.
Rehabilitation Therapies	All therapy services must be prescribed by a physician. Speech therapy must be performed by a licensed therapist. Therapy services must be directly related to an active plan of care designed by the prescribing physician and of such a level of complexity and sophistication that the judgment, knowledge and skills of a qualified therapist. All therapies must be medically necessary under accepted standards of medical practice to the treatment of the member's condition.	Covered. An M.D. or D.O. must be the ordering care provider type for physical, occupational or speech therapy. Physician assistants and nurse practitioners cannot be the ordering care provider type for these services.
Chronic Renal Disease/End Stage Renal Disease	Services related to chronic renal disease.	Covered.
Sexually Transmitted Diseases – Screening, diagnosis, and treatment.		Covered service when medically necessary.
Skilled Nursing Facility (SNF)	Short-term acute rehabilitation	Covered for a maximum of 30 consecutive days. Prior authorization is required.
	Long-term custodial care.	Covered.

Benefits	Services Included	Limitations
Sleep Studies	Either an outpatient hospital setting or sleep study clinic.	Covered when medically necessary.
	ATTENDED sleep studies typically performed in a sleep clinic, facility or lab.	Prior authorization required.
	UNATTENDED sleep studies performed in the member's home.	Prior authorization not required.
	Polysomnography is distinguished from sleep studies by the inclusion of sleep staging that includes a 1 to 4 lead electroencephalogram (EEG), electro-oculogram (EOG), and a submental electromyogram (EMG).	Prior authorization required.
	For a sleep study to be reported as a polysomnography, sleep must be recorded and staged.	
Spinal Surgery	Inpatient and outpatient spinal surgeries.	Covered. Prior authorization required.

Benefits	Services Included	Limitations
Sterilization and Hysterectomies	The plan covers once requirements are met. Requirements include, but are not limited to: Sterilization: the regulations require a written consent form (MMS – 110), male or female, must be signed by the individual at least 30 days, but not more than 180 days, before any sterilization procedure is performed. The individual must be at least 21 years of age at the time the consent form is signed by the member.	Covered. All inpatient services require a prior authorization in addition to the appropriate state consent form.
	Reversal of voluntary sterilization.	Not covered
	Hysterectomies: services cannot be reimbursed if performed for sterilization purposes. Members undergoing hysterectomies for medical reasons other than sterilization purposes must be advised orally and in writing that sterility will result. Per RI Administrative Code, "All claims for hysterectomies (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by Form MMS-101," Informed Consent Form," signed and dated by the member in which she states that she was informed before the surgery was performed that this surgical procedure will result impermanent sterility. For additional information see: **eohhs.ri.gov/** Please refer to additional information in this chapter.	All inpatient services require a prior authorization, in addition to the appropriate state consent form.
Synagis (drug)	Synagis requires prior authorization from **OptumRx**. Complete the Season Respiratory Syncytial Virus Enrollment Form and send to **OptumRx**. Please go to **UHCprovider.com/RIcommunityplan** > Pharmacy Resources and Physician Administered Drugs > Additional Pharmacy Resources > Synagis Enrollment Form.	Covered. Prior authorization required.

Benefits	Services Included	Limitations
Tobacco Cessation	Member must be 18 years of age, must be enrolled and actively participating in the Tobacco Free Quit line to be considered participating. The member must complete at least steps 1 through 4 in the Quit line Counseling.	Covered.
	Contact EOHHS if the member has not completed the program. Members may call the Tobacco Free Quit line at 1-800-784-8669 to enroll	Some limitations may apply.
	Up to 4 tobacco cessation counseling visits with their PCP are covered per session. • Coverage will include up to 2 90-day sessions during a 12-month period. No more than 4 total visits will be covered during a 90-day session, and no more than 8 total visits will be covered in the 2 90-day sessions during any 12 months. • Drugs for the Tobacco Cessation program are covered by the state of RI.	Covered.
Transportation Non-Emergency	All non-emergent transportation services are provided by the RI EOHHS (1-855-330-9131). RI EOHHS has partnered with Medical Transportation Management (MTM) to provide non-emergent transportation services to our members. Members must meet specific requirements to be eligible for transportation. They must make transportation arrangements at least 48 business hours before their medical appointment.	For air ambulance non-emergent transportation, prior authorization required.

Benefits	Services Included	Limitations
Transplant Evaluations	**Organ Transplant Services:** Evaluation and work-ups only are covered. Transplant surgery and after care are covered by the state.	Covered. Prior authorization required.
	Kidney Transplant Services: Services covered only when provided by a certified end-stage renal disease facility (recipient may become Medicare eligible after 3 months facility treatment or 1 month home dialysis). Services covered as an outpatient only.	
Ventricular Assist Devices	A mechanical pump that takes over the function of the damaged ventricle.	Covered. Prior authorization required.
Vision Services	Vision exams, prescription lens and eyeglasses.	Covered.
	Eye Exams: • Covered as medically necessary for ages 20 and younger • One every 24 months (from date of last visit) for ages 21 and older • Diabetic eye exams, for any age, every 12 months	NOTE: Diabetic screenings/tests including vision exams are covered yearly, when performed by an ophthalmologist and/or optometrists.
	Eye glasses (lenses and frame): Covered as medically necessary for ages 20 and younger. One pair every 12 months if there is a significant change in prescription. If a member has additional exams/eye glasses in the same 12 month period, a prior authorization is required.	Covered.
Weight Loss Surgery (Bariatric Surgery)	Members must meet several criteria prior to be approved for this procedure, for example documentation of participation and failure in a legitimate weight loss program.	Prior authorization required.

Assignment to PCP panel roster

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

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

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

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

You may also find the "Document Library" Quick Reference Guide at UHCprovider.com > Menu > Resource Library > UnitedHealthcare Provider Portal > Document Library > **Learn more about Document Library**. Click on the available report you want to view.

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 geriatrics. 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

Deductibles and copayments do not apply for the RIte Share program.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

Medically necessary definition

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

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

Member assignment

Assignment to UnitedHealthcare Community Plan

RI EOHHS assigns eligible members to UnitedHealthcare Community Plan daily. We manage the member's care on the date the member is enrolled until the member is disenrolled from UnitedHealthcare Community Plan. RI EOHHS 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/RI**. Go to Plan Details, then Member Resources, View Available Resources.

Immediate enrollment changes

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

Get eligibility information by calling Provider Services at 1-855-766-0344.

Unborn enrollment changes

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

Members may call RI EOHHS.

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 RI's Medicaid program. The RI EOHHS determines program eligibility. An individual who becomes eligible for the RI EOHHS program either chooses or is assigned to 1 of the RI EOHHS-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.

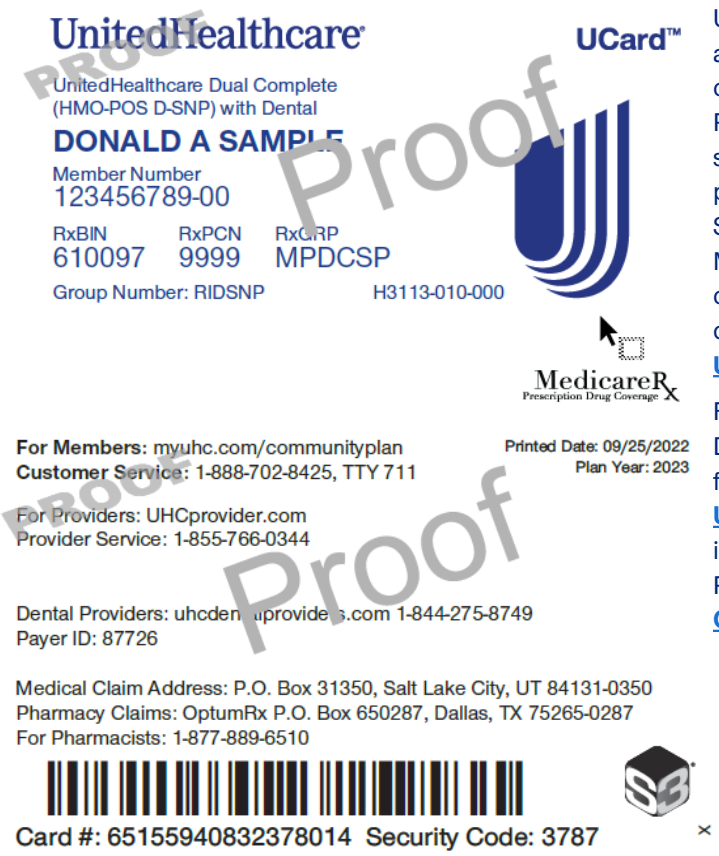
If a fraud, waste and abuse event arises from a care provider or a member, file a report at **uhc.com/fraud**. Or you may call the **Fraud, Waste, and Abuse Hotline**.

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

Member identification numbers

Each member receives a 9-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member.

Sample medical Member ID card



UnitedHealthcare Dual Complete (HMO SNP)

UnitedHealthcare Dual Complete® (HMO SNP) is a Medicare Advantage HMO plan with a Medicare contract. Members must be entitled to Medicare Part A, be enrolled in Medicare Part B, live within our service area, and be a United States citizen or lawfully present in the United States. This plan is a Dual Eligible Special Needs Plan (D-SNP) for people who have both Medicare and Medicaid, and don't pay anything for covered medical services. Eligibility to enroll in this plan depends on the type of Medicaid. Please reference **UHCCommunityPlan.com** for further details.

For general information regarding UnitedHealthcare Dual Complete, please see the Administrative Guide for Commercial, Medicare Advantage and DSNP at **UHCprovider.com/guides**. For state-specific DSNP information, go to UHCprovider.com > Menu > Health Plans by State > Rhode Island > Medicare > **Dual Complete Special Needs Plans**.

Verifying member enrollment

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

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

Chapter 4: Medical Management

Key contacts

Topic	Link	Phone Number
Prior Authorization	UHCprovider.com/paan	1-855-766-0344
Pharmacy	professionals.optumrx.com	

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.

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

Emergency ambulance transportation

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

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

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

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

Non-emergent ambulance transportation

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

Non-emergent transportation must be requested at least 48 business hours in advance. Call MTM or see eohhs.ri.gov for more information.

Schedule non-emergent stretcher/ambulance transportation up to 30 days in advance.

Non-emergency medical transportation (NEMT)

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

Cardiology

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

You must obtain prior authorization for the following cardiology procedures:

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

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

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

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

Request prior authorization online or by phone.

- Online: **UHCprovider.com/cardiology.** Select the Go to Prior Authorization and Notification Tool.
- Phone: 1-866-889-8054 Monday through Friday.

Make sure the medical record is available.

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

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

Emergency/urgent care services

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

Covered services include:

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

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

Prior notification is not required for emergency services.

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

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

1. A plan care provider with privileges at the treating hospital takes over the member's care.
2. A plan care provider takes over the member's care by sending them to another place of service.
3. 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 but within the United States and its territories.

Urgent care (non-emergent)

Urgent care services are covered.

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

Emergency care resulting in admissions

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

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

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

For policies and protocols, go to UHCprovider.com, then select **Policies and Protocols, Community Plan Policies**.

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

Facility admission notification requirements

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

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

Family planning

Family planning services are preventive health, medical, counseling and educational services that help members manage their fertility and achieve the best reproductive and general health. 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 the RI EOHHS 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, but no more than 180 days, before any sterilization procedure is performed. They must also 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 EOHHS regulations at **health.ri.gov** for more information on sterilization.

Health education

Our health education program is led by our qualified, full-time health education manager. You are encouraged to collaborate with us to ensure health education 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, mobile apps and newsletters that include recommended routine appointment frequency, necessary testing, monitoring and self-care. We send health education materials, based on evidence-based guidelines or standards of care, directly to members that address topics that help members manage their condition. Our

program provides personalized support to members in case management. The case manager collaborates with the member to identify educational opportunities, provides the appropriate health education and monitors the member's progress toward management of the condition targeted by the health education program.

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

Hospice

Covered for all members who are certified by a physician as being terminally ill. Services limited to those Medicare covers.

Laboratory

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

Use a UnitedHealthcare Community Plan 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 dentists in 1 of these laboratories do not require prior authorization except as noted on our prior authorization list.

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

See the Billing and Encounters chapter for more information.

Maternity/pregnancy/ well-child care

Pregnancy notification risk screening

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

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

HFS-maternal care model

The HFS-Maternal care model strives to:

- Increase early identification of expectant mothers and facilitate case management enrollment.
- 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.
- Refer members to contracted doulas.

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 4th and subsequent obstetrical ultrasound procedures will only be allowed for identified high-risk members. High-risk member claims must include the corresponding diagnosis code.

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

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

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

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**, the online Prior Authorization and Notification tool at **UHCprovider.com/paan**, or by calling Provider Services.

To notify UnitedHealthcare Community Plan of deliveries, use the electronic Newborn Notification form on UHCprovider.com/RIcommunityplan > **Provider Forms and References**. Provide the following information within 1 business day of the admission:

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

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

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

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

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

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

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

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

Newborn enrollment

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

The hospital provides significant support to the enrollment process by providing required birth data at the time of admission.

Bright Futures assessment

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

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

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

Home care and all prior authorization services

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

Hysterectomies

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

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

Find the form on the **RI Department of Social Services**

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

1. As the care provider performing the hysterectomy, you certify in writing the member was sterile before the procedure. You must also state the cause of the sterility.
2. You certify, in writing, the hysterectomy was performed under a life-threatening emergency in which prior acknowledgment was not possible. Include a description of the emergency.

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

Pregnancy termination services

Pregnancy termination services are covered when medically necessary and to the extent permitted under Rhode Island General Law, Sections 42-12.3-3 and 23-4.13-2. All pregnancy termination claims must be accompanied by a signed physician certification statement form in accordance with applicable Rhode Island Medicaid policy. Members must use the UnitedHealthcare Community Plan care provider network.

Members must use the UnitedHealthcare Community Plan care provider network.

Sterilization and hysterectomy procedures

Reimbursement for sterilization procedures are based on the member's documented request. This policy helps ensure UnitedHealthcare Community Plan members thinking about sterilization are fully aware of the details and alternatives. It also gives them time to consider their decision. In addition, the 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 RI 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 RI 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 RI Department of Social Services website.

Have 3 copies of the consent form:

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

Neonatal Intensive Care Unit (NICU) case management

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

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

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

Inhaled nitric oxide

Use the NRS guideline for inhaled nitric oxide (iNO) therapy at UHCprovider.com > Menu > Policies and Protocols > **Clinical Guidelines**.

Oncology prior authorization

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

For information about our Oncology prior authorization program, including radiation and/or chemotherapy guidelines, requirements and resources, go to UHCprovider.com > **Prior Authorization** or call Optum at 1-888-397-8129 Monday -Friday 7am – 7pm CT.

Opioid supply limit

UnitedHealthcare Community Plan has a 90 morphine milligram equivalents (MME) supply limit for the long-acting opioid class. Prior authorization criteria coincides with the Center for Disease Control and Prevention's (CDC) recommendations for the treatment of chronic non-cancer pain. Prior authorization applies to all long-acting opioids. The CDC guidelines on long-acting opioids are available online at **cdc.gov**. For more information about opioids, see Chapter 7: Mental Health and Substance Use.

For short-acting opioids, we implemented a quantity limit of 20 and less than 30 MME per day for patients new to opioid therapy. Requests for opioids beyond these limits require prior authorization.

Pharmacy

Pharmacy preferred drug list

UnitedHealthcare Community Plan determines and maintains its preferred drug list (PDL) of covered medications. The PDL helps you select medically appropriate, high quality and cost-effective drugs for members. It applies to all our members enrolled in UnitedHealthcare Community Plan of RI, Medicaid and only for prescription medications dispensed by participating pharmacies to outpatient members.

Check the current **UnitedHealthcare Community Plan of Rhode Island Preferred Drug List** before writing a prescription for either prescription or over-the-counter drugs.

The PDL is organized by therapeutic class. Specialty pharmacy medications are available through our specialty pharmacy network. Drugs on the PDL that are part of this program are identified by a "SP" in the "Requirements and Limits" section of each page.

You must prescribe and encourage the use of generic drugs listed on the PDL whenever appropriate. We may not cover brand-name drugs not listed on the PDL if an equally effective generic drug is available and is less costly unless. Prior authorization will be required for a drug not listed on the PDL.

You can get real-time prescription benefit information with the PreCheck MyScript Solution on Link. PreCheck MyScript is integrated directly within your EMR and allows you to easily run a pharmacy trial claim and get real-time prescription coverage detail for your UnitedHealthcare Community Plan patients. Some benefits of PreCheck MyScript include:

- See which prescriptions currently require prior authorization or are not covered or non-preferred.
- Designed to integrate seamlessly into your workflow.
- Saves you time by reducing the need to fax or call for prescription coverage information.
- Reduces patient frustration and delays at the pharmacy when prior authorization is needed, or medications may not be covered.
- PreCheck My Script is integrated with the following electronic medical record (EMR) platforms: Allscripts, Athenahealth®, Cerner, DrFirst®, Epic and NewCropRx.Access may be dependent on the individual health system. If PreCheck MyScript is currently not available directly in your EMR, you can access the tool through the **UnitedHealthcare Provider Portal**.

If a member requires a non-preferred medication, call Pharmacy Prior Authorization department at 1-800-310-6826 or use the online Prior Authorization and Notification tool on the Provider Portal. You may also use CoverMyMeds at **covermymeds.com** to submit the request.

We provide you PDL updates before the changes go into effect. Find these updates on UHCprovider.com > Resource Library > **Drug Lists and Pharmacy** > UnitedHealthcare Prescription Drug Lists (PDL) / Drug Formulary > Prescription Drug List Updates for Community Plan. Find the PDL and Pharmacy Prior Notification Request form at **UHCprovider.com/priorauth.**

Pharmacy prior authorization

Medications can be dispensed as an emergency 5-day 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** or use the online Prior Authorization and Notification tool on the Provider Portal. You may also use CoverMyMeds at **covermymeds.com** to submit the request. We provide notification for prior authorization requests within 24 hours of request receipt.

Over-the-counter products

UnitedHealthcare Community Plan covers certain over-the-counter (OTC) products. A member needs a prescription to benefit from this program. Covered OTC products include allergy relief, antifungals, antacids, cough and cold remedies, laxatives, pain products and vitamins.

Plan exclusions

The following drug categories are excluded from coverage under the outpatient pharmacy benefit and are not part of the UnitedHealthcare Community Plan PDL.

- DESI drugs
- Experimental / research drugs
- Cosmetic drugs
- Nutritional / diet supplements
- Blood and blood plasma products
- Agents used to promote fertility
- Agents used for erectile dysfunction
- Agents used for cosmetic hair growth
- Drugs from manufacturers that do not participate in the FFS Medicaid Drug Rebate Program
- Diagnostic products
- Medical supplies and DME except as listed: insulin syringes, insulin needles, lancets, alcohol swabs, spacers, preferred diabetes test strips, peak flow meters (Astech, Assess, Peak Air brands, max 2 per year), vaporizer (limit of 1 per 3 years), humidifier (limit of 1 per 3 years)

Specialty pharmacy medications

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

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

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

Step therapy and quantity limits

UnitedHealthcare Community Plan applies automated prerequisite step therapy criteria and quantity limit edits to certain medications. Step therapy edits are clinically appropriate and have cost-effective alternatives for the member's condition. Quantity limit edits follow FDA approved guidelines and protects members from high doses.

The Pharmacy and Therapeutics Committee established criteria for step therapy and quantity limit edits that follow evidence-based review principles. These principles include current literature reviews and consultation with practicing physicians and pharmacists. These experts possess a wide range of specialized medical expertise, government agency policies (i.e., FDA), and national accreditation organization standards. They update criteria at least annually and when new evidence becomes available.

When you prescribe a step therapy drug, but the member does not meet the step therapy criteria,

we require prior authorization. We also require prior authorization for monthly prescriptions with quantities greater than the indicated limit.

View a complete list of medications with step therapy and quantity limits in the UnitedHealthcare Community Plan PDL at UHCprovider.com. The list marks step therapy drugs with a "ST." It lists quantity limit drugs with a "QL."

Radiology

We use the prior authorization process to 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 > Go to Prior Authorization and Notification Tool
- Phone: **1-866-889-8054** from 8 a.m. - 5 p.m. CT, Monday through Friday. Make sure the medical record is available.

For a list of Advanced Outpatient Imaging Procedures that require prior authorization, a prior authorization crosswalk, and/or the evidence-based clinical guidelines, refer to UHCprovider.com/RIcommunityplan > Prior Authorization and Notification > Radiology Prior Authorization and Notification Program.

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

SBIRT Services are covered when:

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

What is included in SBIRT?

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

(ASSIST) and the Drug Abuse Screening Test (DAST).

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

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

SBIRT services are covered when all the following are met:

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

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

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

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

Medication-assisted treatment

Medication-assisted treatment (MAT) combines behavioral therapy and medications to treat opioid use disorders (OUD). The 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 professional on **liveandworkwell.com**.

To find a medical MAT provider in Rhode Island:

1. Go to **UHCprovider.com**
2. Select either "Find Dr" or "Find a Care Provider" from the menu on the home page
3. Select the care provider information
4. Click on "Medical Directory"
5. Click on "Medicaid Plans"
6. Click on applicable state
7. Select applicable plan
8. Refine the search by selecting "Medication Assisted Treatment"

If you have questions about MAT, please call Provider Services at **1-855-766-0344**, and enter your TIN. Say "representative," then "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 CDC.

The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all members at increased risk unless they have documentation of prior positive test results or currently under TB 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 reporting confirmed and suspected TB cases to the LHD. PCPs must report known or suspected cases of TB to the LHD TB Control Program within 1 day of identification.

Waiver programs

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

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

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

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

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

Other federal waiver programs

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

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

- Patient name and ID number.
- Ordering care provider or health care professional name and TIN/NPI.
- Rendering care provider or 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 SUD authorizations, please contact Optum.

If you have questions, go to UHCprovider.com/RIcommunityplan > Prior Authorization and Notification Resources.

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent Pre-service	Within 5 working days of receipt of medical record information or no longer than 14 calendar days of receipt	Within 24 hours of the decision	The earlier of within 2 business days of decision or within 14 calendar days of receipt of request
Urgent/Expedited Pre-service	Within 3 days of request receipt	Within 3 days of the request	Within 3 days of the request
Concurrent Review	Within 3 calendar days of request	Notified within 24 hours of determination	Within 3 calendar days of request for members if concurrent urgent member notification cannot be done
Retrospective Review	Within 30 calendar days of request	Within 24 hours of determination	Within 30 calendar days of request

Case management

We provide case management services to members with complex medical conditions or serious psychosocial issues. The Care Model Team assesses members who may be at risk for multiple hospital admissions, increased medication use, or would benefit from a multidisciplinary approach to medical or psychosocial needs.

Refer members for case management by calling RI Health Services at **1-800-672-2156** or **401-732-7373**. Additionally, UnitedHealthcare Community Plan provides the **Healthy First Steps** program, which manages women with high-risk pregnancies.

Concurrent review guidelines

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

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

Concurrent review details

Concurrent review is notification within 24 hours or 1 business day of admission.The review looks at 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 to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, SNFs, home health care and ambulatory facilities.

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

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

Determination process

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

Evidence-based clinical guidelines

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

Medical and drug policies and coverage determination guidelines

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

Reimbursement

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

- Determine if the member is eligible on the date of service by using the Provider Portal on **UHCprovider.com**, contacting UnitedHealthcare Community Plan's Provider Services or the RI 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 RI EOHHS. 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 provider 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 his or her report to the member's PCP and treating care provider, if different. The member may help the provider 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 **1-855-766-0344** for assistance or to request prior authorization.
- Once the second opinion has been given, the member and the provider discuss information from both evaluations.
- If follow-up care is recommended, the member meets with the provider before receiving treatment.

Services not covered by UnitedHealthcare Community Plan

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

- Any health care not given by a doctor from our list (except emergency treatment)
- Any care covered by Medicaid but not through managed care.

The following benefits are not covered by UnitedHealthcare or RI Medicaid.

- Experimental procedures, except where state mandate for coverage exists.
- Private rooms (except for a medical necessity).
- Cosmetic surgery.
- Infertility treatment services.
- Services outside of United States and its territories.
- Services outside of Rhode Island, unless a network provider or if a covered benefit is not available in network. Emergencies are covered both in and out of network.
- Medications for sexual or erectile dysfunction.

Services requiring prior authorization

For a list of services that require prior authorization, go to UHCprovider.com/RIcommunityplan > 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:** within 24 hours, unless otherwise indicated.
- **Inpatient Admissions; After Ambulatory Surgery:** within 24 hours, unless otherwise indicated.
- **Non-Emergency Admissions and/or Outpatient Services (except maternity):** at least 14 business days beforehand; if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time.

Utilization management guidelines

Call **1-800-587-5187** (TTY 711) to discuss the guidelines and utilization management.

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

Utilization management (UM) appeals

UM appeals are considered medically necessary appeals. 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: Early and Periodic Screening, Diagnostic and Treatment/Prevention

Key contacts

Topic	Link	Phone Number
EPSDT	eohhs.ri.gov	401-462-5274
Vaccines for Children	health.ri.gov/immunization/for/providers/	401-222-5960

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

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

For complete details about full and partial screening, examination, and immunization requirements, go to **EPSDT Schedule**.

Children's evaluations – RIte Care only

Covered as needed. This includes evaluations for sexual abuse, parent/child evaluations, fire setter, PANDA clinic and other evaluations as medically necessary.

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 them to DDS for approval and assignment of a Regional Center Case Manager, who schedules an intake assessment. Eligibility determination 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.

Early Start Program

The Early Start Program provides early intervention services to infants and toddlers with disabilities and their families.

Referral – refer children who are identified as potentially requiring developmental intervention services to the appropriate agency for evaluation once you identified

the need for services. Provide information as requested to complete the referral process. If the child has a visual impairment, hearing impairment, or severe orthopedic impairment, or any combination of these impairments, contact the Local Education Agency (LEA) for evaluation and early intervention services. After contacting the regional center or local education agency, a service coordinator will be assigned to help the child's parents through the process to determine eligibility.

Continuity of Care – support the development of the Individualized Family Service Plan (IFSP) developed by the Early Start Program through either the Regional Center (RC) or LEA. The assigned coordinator will help the local RC or local Early Start Program and you to ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the IFSP. UnitedHealthcare Community Plan provides member case management and care coordination to help ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the IFSP developed by the Early Start Program, with your participation.

To make a referral or learn more, contact any of the Rhode Island Early Intervention Providers. It is available at **eohhs.ri.gov**.

For more information or assistance in choosing a provider, you may also contact RI Parent Information Network (RIPIN) at **401-270-0101**.

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 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 if you find a child has a lead blood level over 3.5 ug/dL. Children with elevated blood lead levels will be offered enrollment in a care coordination program.

State-funded programs

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

For more information about WIC, go to **health.ri.gov/programs/detail.php?pgm_id=36**.

Targeted case management

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

Identification – The 5 target populations include:

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

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

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

Vaccines for Children (VFC) program

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** if you have questions.

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

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

Chapter 6: Value-Added Services

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	1-855-766-0344
Healthy First Steps Rewards	uhchealthyfirststeps.com	1-800-599-5985
Value-Added Services	UHCCommunityPlan.com/RI > View plan details	1-855-766-0344

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 **1-877-842-3210** 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 on evidence-based guidelines or standards. All printed materials are written at a fifth grade reading level. They are available in English as well as other languages. 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 and help them manage the illness.

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

Referral – PCPs may make referrals to support practice-based interventions by contacting the Health Services team at **1-866-270-5785**.

Healthy First Steps Rewards

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

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

How It Works

- Care providers and UnitedHealthcare Community Plan reach out to members to enroll them.
- Members enter information about their pregnancy and upcoming appointments online. Members get reminders of upcoming appointments and record completed visits.

How You Can Help

- Identify UnitedHealthcare Community Plan members during prenatal visits.
- Share the information with the member to talk about the program.

- Encourage the member to enroll in Healthy First Steps Rewards at uhchealthyfirststeps.com.

LifeLine (cellphone program)

If the member doesn't have a mobile phone, they may call Member Services to learn more about Lifeline, a no-cost federal phone program.

Call Member Services at **1-877-842-3210**, TTY **711** to learn more about MyHealthLine and for information on select Lifeline* services.

This Federal Lifeline program provides the cellphones. Our members who meet federal eligibility requirements receive 350 voice minutes per month and unlimited texting, plus a pre-programmed member services number that does not count against the minutes. They are also automatically enrolled in the Connect4health texting program.

Lifeline is a government assistance program. The service is non-transferable. Only eligible consumers may enroll in the program. The program is limited to 1 discount per household. Phone is subject to location and eligibility.

SUD recovery coaching

Our SUD 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, claims data and health risk assessment (HRA). The program has no age limit.

UHC Latino

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

Chapter 7: Mental Health and Substance Use

Key contacts

Topic	Link	Phone Number
Behavioral Health/Provider Express	providerexpress.com	1-800-1-888-2998
Provider Services	UHCprovider.com	1-855-766-0344

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. Also find behavioral health benefit information at this website. The site includes:

- Clinical resources: guidelines, policies and manuals
- Admin resources: ALERT program details and claim submission tips
- As well as videos, training, network and credentialing details and contact information.

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

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

How to join our network: Credentialing information is available at providerexpress.com.

Covered services

UnitedHealthcare Community Plan offers covered behavioral health services for mental, emotional and SUDs. 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 SUD diagnoses, symptoms, treatments, prevention and other resources in 1 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 liveandworkwell.com to find articles, self-care tools, providers, and other mental health and substance use disorder resources.

Eligibility

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

Authorizations

Members may access all behavioral health outpatient services (mental health and substance use). Prior authorization may be required for more intensive services, day treatment or partial, inpatient or residential care. Get prior authorization by going to UHCprovider.com/priorauth or calling Provider Services.

Collaboration with other health care professionals

Coordination of care

When a member is receiving services from more than 1 professional, you must coordinate to deliver

comprehensive, safe and effective care. This is especially true when the member:

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

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

Portal access

Website: **UHCprovider.com**

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

Website: **UHCprovider.com/RIcommunityplan**

View the Prior Authorization list, find forms and access the care provider manual. Or call Provider Services at **1-855-766-0344** to verify eligibility and benefit information (available 7 a.m. – 4 p.m. Eastern Time, Monday through Friday).

Website: **providerexpress.com**

Update provider practice information, review guidelines and policies, and view the national Optum Network Manual or call Provider Services at **1-855-766-0344**.

Claims

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

Monitoring audits

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

Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction. We engage in strategic community partnerships and approaches for special populations with unique risks, such as pregnant women and infants. We use our robust data infrastructure to identify needs, drive targeted actions, and measure progress. Finally, we help ensure our approaches are trauma-informed and reduce harm where possible.

Brief summary of framework

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

Increasing education and awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep OUD-related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits

are developed to provide access to clinical practice guidelines, free SUDs/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.

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**. Click Resource Library to find a list of tools and education.

Prevention

We are invested in reducing the abuse of opioids, while facilitating the safe and effective treatment of pain. Preventing OUD before they occur through improved pharmacy management solutions, improved care provider prescribing patterns, and member and care provider education is central to our strategy.

Pharmacy lock-in

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

Expanding medication assisted treatment (MAT) access and capacity

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

To find a behavioral health MAT provider in RI:

1. Go to the provider website, liveandworkwell.com > **Find a Provider**.
2. Enter the needed location in the search bar and select “Search.” A list of in-network behavioral health providers will be displayed on the next page
3. On the left side of the page, select your preferred options (Refine Results column).

As you choose options, the provider list will refresh.

We contract with OUD Centers of Excellence (where available), which are certified by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) State of Rhode Island to provide assessments and treatment for opioid dependence, offer expedited access to care and serve as a resource for community-based providers.

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

Chapter 8: Member Rights and Responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	UHCCommunityPlan.com/RI	1-800-587-5187
Member Handbook	UHCCommunityPlan.com/RI > Community Plan > Member Benefits	1-800-587-5187

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

Privacy regulations

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

Access to protected health information

Members may access their medical records or billing information either held at your office or through 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 the 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 (Enter ZIP Code > Click Find Plan Information > Click Plan > Member Handbook).

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

Member responsibilities

Members should:

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

their health.

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 of Quality Assurance (NCQA) are to:

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

Chapter 9: Medical Records

Medical record charting standards

You are required to keep complete and orderly medical records, on 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 use, 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: - Timeframe for follow-up visit as appropriate - Appropriate use of referrals/consults, studies, tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review. • There is evidence of care provider follow-up of abnormal results. • Unresolved issues from a previous visit are followed up on the subsequent visit. • There is evidence of coordination with behavioral health care provider. • Education, including lifestyle counseling, is documented. • Member input and/or understanding of treatment plan and options is documented. • Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented.

***Critical element**

Member copies

A member or their representative is entitled to 1 free copy of their medical record. Additional copies may be available at the member's cost. Medical records are generally kept for a minimum of 5 years unless federal requirement mandate a longer time frame (i.e., immunization and tuberculosis records required for lifetime).

Medical record review

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

- Problem list with:
  - Biographical data with family history.
  - Past and present medical and surgical intervention.
  - Significant medical conditions with date of onset and resolution.
  - Documentation of education/counseling regarding HIV pre- and post-test, including results.
- Entries dated and the author identified.
- Legible entries.
- Medication allergies and adverse reactions (or note if none are known).
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen 3 or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record.
- Tobacco habits, alcohol use and substance use (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 (QM) Program and Compliance Information

Key contacts

Topic	Link	Phone Number
Credentialing	Medical: Network management support team Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. Chiropractic: **myoptumphysicalhealth.com**	1-855-766-0344
Fraud, Waste and Abuse (Payment Integrity)	**uhc.com/fraud**	1-800-455-4521

What is the quality improvement program?

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

The program consists of:

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

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

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

- Providing requested timely medical records.
- Cooperation 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, remote access or secure email.
- Completing practitioner appointment access and availability surveys.

We require your cooperation and compliance to:

- Allow the plan to use your performance data.
- Offer Medicaid members the same number of office hours as commercial members (or don't restrict office hours you offer Medicaid members.)

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 an independent market research firm to conduct, analyze and report findings.

Survey results are reported to our Extended Leadership Team and Provider Advisory Committee. They compare the results year over year as well as to other UnitedHealthcare Community Plan plans.

Clinical practice guidelines

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

UHCprovider.com/cpg

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable RI 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 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.

The 21st Century Cures Act

The 21st Century Cures Act (Cures Act) 114 P.L. 255 requires all Medicaid FFS and MCOs, regardless of specialty, to be screened by and enrolled with the state Medicaid agency. Providers who do not comply with this requirement risk being terminated from the UnitedHealthcare Community Plan of Rhode Island's Medicaid managed care network.

Providers must submit their Enrollment Applications with the EOHHS using Rhode Island Medicaid Healthcare Portal at riproviderportal.org. EOHHS has published a Provider Enrollment User Guide and FAQ on the portal to assist you with your enrollment. If you have questions or concerns, call the EOHHS Customer Service Help Desk at 401-784-8100 for in-state and long-distance calls, or 1-800-964-6211 for in-state toll calls. You may also email RIProviderServices@gainwelltechnologies.com.

Existing providers should continue to provide services to Rhode Island Medicaid managed care members while their Enrollment Application is being processed. The applying provider's participation will not be terminated during this time-period. However, continued non-compliance with the enrollment mandate may result in delayed or denied claims payment. It may also include termination of your contract as determined by EOHHS.

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)
- Physician assistants

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 NPI number.
- Have a current unrestricted license to operate.
- Have been reviewed and approved by an accrediting body.
- Have malpractice coverage/liability insurance that meets contract minimums.
- Agree to a site visit if not accredited by the Joint Commission (JC) or other recognized accrediting agency.
- Have no Medicare/Medicaid sanctions.

Excluded from this process are practitioners who:

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

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

The National Credentialing Center (NCC) completes these reviews. Find applications on the CAQH website.

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

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

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

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

Peer review

Credentialing process

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

Recredentialing process

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

Performance review

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

Applicant rights and notification

You have the right to review information you submitted to support your credentialing/recredentialing application. This excludes personal or professional references or peer review protected information. You have the right

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

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

Confidentiality

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

Resolving disputes

Contract concerns

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

UnitedHealthcare Community Plan of New England
Network Management Resource Team
475 Kilvert Street
Warwick, RI 02886

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

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

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

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

HIPAA compliance – your responsibilities

Health Insurance Portability and Accountability Act

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

Transactions and code sets

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

Unique identifier

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

National Provider Identifier

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

requires the NPI on paper transactions.

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

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

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

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

Ethics and integrity

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

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 RI 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 RI Department of Health and Human Services.

Record retention, reviews and audits

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

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

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

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

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

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

Delegating and subcontracting

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

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of care (QOC) and services concerning participating care providers

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

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

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

Chapter 11: Billing and Submission

Key contacts

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

Our claims process

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

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

Claims: From submission to payment

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

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

National Provider Identifier

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

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

Your clean claims must include your NPI and federal TIN.

General billing guidelines

We only consider reimbursing claims if you met billing and coverage requirements. 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. The modifier must be used based on the date of service.

Member ID card for billing

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

Acceptable claim forms

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

Use the 02/12 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 health care provider to a covered UnitedHealthcare Community Plan member.
- All the required documentation, including correct diagnosis and procedure codes.
- The correct amount claimed.

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

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

Care provider coding

UnitedHealthcare Community Plan complies with EPSDT state standards based on claims data and chart review. Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to find an ICD-9 or ICD-10 code.

Electronic claims submission and billing

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

- All claims are set up as "commercial" through the clearinghouse.
- Our payer ID is 1-87726.
- 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 CMS 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 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 > Menu > Resource Library > Electronic Data Interchange > Clearinghouse.

e-Business Support

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

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

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

340b drug billing

- Drugs billed to the medical benefit for applicable 340B claims-
- Modifier: UD
- Description: Medicaid level of care 13, as defined by each state
- Drugs billed to the pharmacy benefit for applicable 340B claims-
- NCPDP field 409-D9: Ingredient Cost Submitted = 340B Acquisition Cost with the associated value 08 in NCPDP field 423-DN: Cost Basis
- NCPDP field 420-DK: Submission Clarification Code = 20

Electronic payment solutions

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

Why choose ACH/direct deposit?

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

What does this mean to you?

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

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

All regulated entities have a Management Agreement with United HealthCare Services, Inc. (UHS), under which UHS provides a whole host of administrative services (many of which are provided to UHS by an Optum entity and then passed through to the regulated entities), including those of a financial nature. Those agreements are filed with the DOI in the regulated entity's state of domicile for approval.

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on UHCprovider.com > Resource Library > Electronic Data Interchange (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 ER services using revenue codes and the UB-04 claim form:

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

Form reminders

- Note the attending provider name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims.
- Send the referring provider NPI and name on outpatient claims when this care provider is not the attending provider.
- Include the attending provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims.
- Behavioral health care providers can bill using multiple site-specific NPIs.

Subrogation and coordination of benefit

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

- **Subrogation:** We may recover benefits paid for a member's treatment when a third party causes the injury or illness.
- **COB:** We coordinate benefits based on the member's 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 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 > Menu > Policies and Protocols > For Community Plans > Reimbursement Policies for Community Plan > Global Days Policy, Professional - Reimbursement Policy - UnitedHealthcare Community Plan.

Correct Coding Initiative

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

Comprehensive and component codes

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

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

Clinical Laboratory Improvements Amendments

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

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

Billing multiple units

When billing multiple units:

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

Billing guidelines for obstetrical services

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

- If billing for both delivery and prenatal care, use the date of delivery.
- Use 1 unit with the appropriate charge in the charge column.

Billing guidelines for transplants

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

Ambulance claims (emergency)

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

National Drug Code

Claims must include:

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

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

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

Medical necessity

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

Place of Service codes

Go to CMS.gov for Place of Service codes.

Asking about a claim

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

Provider Services

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

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

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

UnitedHealthcare Community Plan provider portal

You can view your online transactions with the Provider Portal by signing in at UHCprovider.com with your One Healthcare ID. This portal offers you with online support any time. If you are not already registered, you may do so on the website.

UnitedHealthcare Provider Portal: Your gateway to UnitedHealthcare Community Plan online provider tools and resources

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

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

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

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

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

Resolving claim issues

To resolve claim issues, contact Provider Services, use the Provider Portal or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 31361
Salt Lake City, UT 84131

Fax number: 801-567-5497

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

For paper claims

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

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

Timely filing

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

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

All of the above must include documentation the claim is for the correct member and the correct date of service. A submission report alone is not considered proof of timely filing for electronic claims. They must be accompanied by an acceptance report.

The date on the other carrier's payment correspondence starts the timely filing period for submission to UnitedHealthcare Community Plan.

To be timely, you must receive the claim within the timely filing period from the date on the other carrier's correspondence. If we receive the claim after the timely filing period, it will not meet the criteria.

If a claim is rejected, and corrections are not received within 365 days from date of service or per provider contract, 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 they provide 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 RhodeIsland_PR_Team@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 Reconsinderations, 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 contract. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

For claims, billing and payment questions, go to **UHCprovider.com**. We no longer use fax numbers. Please use our online options or phone number.

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 FOR MAIL**	**CONTACT PHONE NUMBER**	**WEBSITE (Care Providers Only) for Online Submissions**	**Care Provider FILING TIME FRAME**	**UnitedHealthcare Community Plan RESPONSE TIME FRAME**
Care Provider Claim 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 31361 Salt Lake City, UT 84131-0364	UHCprovider.com	1-855-766-0344 Fax: 801-994-1082	Use the Claims Management tools or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	90 calendar days from denial	15 calendar days from when we received
Care Provider Claim Reconsideration	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care Provider	UnitedHealthcare Community Plan P.O. Box 31361 Salt Lake City, UT 84131-0364	UHCprovider.com	1-855-766-0344 Fax: 801-567-5497	Use the Claims Management tools or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	365 calendar days from date on original PRA	30 calendar days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
SITUATION	**DEFINITION**	**WHO MAY SUBMIT?**	**SUBMISSION ADDRESS**	**ONLINE FORM FOR MAIL**	**CONTACT PHONE NUMBER**	**WEBSITE (Care Providers Only) for Online Submissions**	**Care Provider FILING TIME FRAME**	**UnitedHealthcare Community Plan RESPONSE TIME FRAME**
Care Provider Claim Level-One Appeal	A review in which you did not agree with the outcome of the reconsideration or the clinical denial.	Care Provider	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	UHCprovider.com	1-855-766-0344	Use the Claims Management tools or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	Clinical denials: 90 calendar days from date on original PRA Administrative denials: 365 calendar days from reconsideration decision	30 calendar days
Care Provider Claim Second-Level Appeal	A second review in which you did not agree with the outcome of the first-level appeal.	Care Provider	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	UHCprovider.com	1-855-766-0344	Use the Claims Management tools or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	90 calendar days from first level decision	30 calendar days
Care Provider External Review	A review in which an external review organization (ERO) determines the outcome after both levels of appeal have been completed.	Care Provider	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	N/A	1-855-766-0344	N/A	4 months after receipt of a notice of the decision on a final internal appeal to request an external appeal by an ERO	45 calendar days
Care Provider Grievance	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member.	Care Provider	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	UHCprovider.com	1-855-766-0344	Use the Claims Management tools or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	N/A	90 calendar days
Member Appeal	A request to change an adverse benefit determination that we made.	• Member • Care provider on behalf of a member with their written consent	UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131	N/A	1-800-587-5187	N/A	Must be received 60 calendar days from the date on the notice of adverse benefit determination	Urgent appeals- 72 hours of receipt of appeal Standard appeals- 30 calendar days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
SITUATION	**DEFINITION**	**WHO MAY SUBMIT?**	**SUBMISSION ADDRESS**	**ONLINE FORM FOR MAIL**	**CONTACT PHONE NUMBER**	**WEBSITE (Care Providers 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 on behalf of a member with member's written consent	UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131	N/A	1-800-587-5187	Use the Claims Management tools or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	N/A	90 calendar days

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

UnitedHealthcare Community Plan and its in-network care providers may agree to more stringent requirements within care provider contracts 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

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

Mailing address:

UnitedHealthcare Community Plan
P.O. Box 31361
Salt Lake City, UT 84131

Fax number: 801-994-1082

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 31361
Salt Lake City, UT 84131

Fax number: 801-994-1082

Claim reconsideration (step 1 of dispute)

What is it?

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

When to use:

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

How to use:

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

- **Electronically:** Use the Claim Reconsideration application on the Provider Portal. Include electronic attachments. You may also check your status using the Provider Portal.
- **Phone:** Call Provider Services at 1-855-766-0344 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 31361
  Salt Lake City, UT 84131

  Fax number: 801-994-1082

  Available at UHCprovider.com/claims.

Questions about your appeal or need a status update? Call Provider Services.

If you filed your appeal online, you should receive a confirmation email or feedback from the secure provider portal link.

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved.

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

Valid proof of timely filing documentation (reconsideration)

What is it?

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

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

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

How to use:

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

- **Electronic claims:** Include the EDI acceptance report stating we received your claim.
- **Mail reconsiderations:** Submit a screen shot from your accounting software that shows the date you submitted the claim. The screen shot must show:
  - Correct member name.
  - Correct date of service.
  - Claim submission date. We have a 1-year timely filing limitation to complete all steps in the reconsideration process. It starts on the date of the first EOB.

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 based on our Agreement and applicable law.

If you prefer we recoup the funds from your next payment, call Provider Services.

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

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

- Name and contact information for the person authorized to sign checks or approve financial decisions.
- Member identification number.
- Date of service.
- Original claim number (if known).

- Date of payment.
- Amount paid.
- Amount of overpayment.
- Overpayment reason.
- Check number.

Where to send:

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

UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-01-800

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

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

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

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

Sample overpayment report

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

Member ID	Date of Service	Original Claim #	Date of Payment	Paid Amount	Amount of Overpayment	Reason for Overpayment
11111	01/01/14	14A000000001	01/31/14	115.03	115.03	Double payment of claim
2222222	02/02/14	14A000000002	03/15/14	279.34	27.19	Contract states $50, claim paid 77.29
3333333	03/03/14	14A000000003	04/01/14	131.41	99.81	You paid 4 units, we billed only 1
44444444	04/04/14	14A000000004	05/02/14	412.26	412.26	Member has other insurance
55555555	05/05/14	14A000000005	06/15/14	332.63	332.63	Member terminated

Appeals (step 2 of dispute)

What is it?

An appeal is a review of a reconsideration of an administrative denied claim or a clinically denied claim. It is a 1-time formal review.

There are 2 levels of an appeal.

When to use:

If you do not agree with the outcome of the claim reconsideration or the clinical denial on a claim, use the claim appeal process.

How to use/file:

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

- **Electronic claims:** Use the Claims Management or Claims on the Provider Portal. 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

Request an expedited appeal by calling **1-800-587-5187** (TTY 711).

Request an expedited appeal when the appeal involves:

- Continued or extended health care services, procedures, or treatments.
- Additional services for a member undergoing a course of continued treatment.
- A denial in which the health care provider believes an immediate appeal is warranted.
- When the standard time frame could risk life, health, or bodily function.

External review

What is it?

A final review of a claim by an external review organization (ERO).

When to use:

If you do not agree with the outcome of both levels of appeal, use the external review process.

How to use:

Submit all related documents to support your request. Send your information electronically or by mail.

- **Electronic claims:** Use the Claims Management tools or Claims on the Provider Portal. You may upload attachments.
- **Mail:**

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

We forward your information to the ERO. The ERO has 45 calendar days to make a determination.

Provider grievance

What is it?

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

When to file:

You may file a grievance about:

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

How to file:

File verbally or in writing.

- **Phone:** Call Provider Services at **1-855-766-0344**
- **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 benefit determination.

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

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

When to use:

You may act on the member's behalf with their written consent. You may provide medical records and supporting documentation as appropriate.

Where to send:

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

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

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

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

How to use:

Whenever we deny a service, we must provide the member with UnitedHealthcare Community Plan appeal rights. The member, or you acting on the member's behalf, has the right to:

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

We resolve a standard appeal 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. You (acting on the member's behalf) or the member requests we take longer.
2. We request additional information and explain how the delay is in the member's interest.

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

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

External appeals

If the member isn't satisfied with the outcome of the appeal, the member can request an external appeal either through a DHS Fair Hearing or an external review agency. This hearing is free-of-charge. Members must exhaust the appeal process before requesting a State

Fair Hearing. To request a DHS-121 (Request for Hearing Form), call the Department of Human Services at **1-800-697-4347** (TTY:711) or the Rhody Health Partners Help Line at **401-784-81-877**.

Members may ask for an external appeal through a DHS Fair Hearing or an external review agency.

1. State Fair Hearing must be asked for within 120 calendar days after receiving the appeal notice that the adverse benefit determination is upheld.
2. An external appeal must be filed within 4 months of receiving the notice that the appeal was denied. There is no cost to a member for an external review associated with filing an external appeal with an ERA. Call us at 1-800-587-5187 (TTY 711) if you need help filing an external appeal.

Members who are not satisfied with the outcome of their appeals also have the right to notify the Office of the Health Insurance Commissioner at:

RI Insurance Resource, Education, and Assistance Consumer Helpline (RIREACH)
1210 Pontiac Ave.
Cranston, RI 02920

Phone: **1-855-747-3224** (RIREACH)

Web: **rireach.org**

Processes related to reversal of our initial decision

When an appeal or State Fair Hearing resolution is reversed, the authorization is updated to provide the services within 72 hours from the date we receive notice.

If the services were provided pending the outcome of the appeal, we pay for those services.

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:

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**)

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

Fraud, waste and abuse

Call the toll-free **Fraud, Waste and Abuse Hotline** to report questionable incidents involving plan members or care providers.

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

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

An important aspect of the Compliance Program is reviewing our operation's high-risk areas. Then we implement reviews and audits to help ensure compliance with law, regulations and contracts. You are contractually obligated to cooperate with the company and government authorities.

Call **1-855-766-0344** for the UnitedHealth Group policy on Fraud, Waste and Abuse. Find out how we follow federal and state regulations around false claims at UHCprovider.com/RIcommunityplan > **Integrity of Claims, Reports, and Representations to the Government**.

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

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

Exclusion checks

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

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

What you need to do for exclusion checks

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

Chapter 13: Care Provider Communications and Outreach

Key contacts

Topic	Link	Phone Number
Provider Education	UHCprovider.com > Resources > Resource Library	1-855-766-0344
News and Bulletins	UHCprovider.com > Network News	
Provider Manuals	UHCprovider.com/guides	

Connect with us on social media:

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

- Website
- Forums/town hall meetings
- Office visit
- Newsletters and bulletins
- Manual
- Educational materials such as newsletters and bulletins
- Provider service updates – new tools and initiatives (e.g., PreCheck MyScript)

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

You may also find training on various topics at UHCprovider.com > Resources > Resource Library. Look under More Resource Topics, then click Training.

Care provider websites

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

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

- An online version of this manual
- Clinical practice guidelines (which cover diabetes, ADHD, depression, preventive care, prenatal, and other guidelines)
- Electronic data interchange
- Quality and utilization requirements

Care provider office visits

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

Care provider newsletters and Network Bulletins

UnitedHealthcare Community Plan produces a care provider newsletter to the entire RI network at least 3 times a year. The newsletters include articles about:

- Program updates
- Claims guidelines
- Information regarding policies and procedures
- Cultural competency and linguistics
- Clinical practice guidelines
- Special initiatives
- Emerging health topics

Network Bulletin

The Network Bulletin is a monthly publication that features important protocol and policy changes, administrative information and clinical resources:

- Program updates
- Claims guidelines
- Information regarding policies and procedures
- Cultural competency and linguistics
- Clinical practice guidelines
- Special initiatives
- Emerging health topics

View the latest news or sign up to receive the monthly bulletin at **UHCprovider.com** > Network News.

Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for Provider Services, a removable quick reference guide and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting Provider Services.

State forms and websites

Find these forms on the **EOHHS website**:

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

Glossary

AABD
Aid to the aged, blind and disabled

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.

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.

Adverse Benefit Determination
(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service.

(4) The failure to provide services in a timely manner, as defined by the state.

(5) The failure of someone or a company to act within the time frames provided in the contract and within the standard resolution of grievances and appeals.

(6) For a resident of a rural area,the denial of an member's request to exercise his or her right, to obtain services outside the network.

(7) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

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

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

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

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

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

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

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

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

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

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

Case Manager
The individual responsible for coordinating the overall service plan for a member in conjunction with the

member, the member's representative and the member's primary care provider (PCP).

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

CHIP
Children's Health Insurance Program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Electronic Data Interchange (EDI)
The electronic exchange of information between 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.

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

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.

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

Fee For Service (FFS)
A method of payment to care providers on an amount-per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule.

FHC
Family Health Center

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

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

Grievances may include, but are not limited to, the quality of care or services provided, and relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by Rhode Island EOHHS.

Specialist
A care provider licensed in the state of Rhode Island 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 UnitedHealthcare Community Plan.

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

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

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

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

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

serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

Utilization Management (UM)
Involves coordinating how much care members get. It also determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.