2019
Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary Care

UnitedHealthcare Community Plan of Iowa
Welcome

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

If you have any questions about the information or material in this manual or about any of our policies or procedures, call Provider Services at 888-650-3462.

In addition, the UnitedHealthcare Community Plan of Iowa office is located at:

UnitedHealthcare Community Plan
1089 Jordan Creek Parkway
West Des Moines, IA 50266

CLICK THE FOLLOWING LINKS TO ACCESS DIFFERENT MANUALS:

- UnitedHealthcare Administrative Guide for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual, go to UHCprovider.com. Click Menu on top left, select Administrative Guides and Manuals, then Community Plan Care Provider Manuals, select 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 at 888-650-3462.

Important Information About the Use of This Manual

PARTICIPATION AGREEMENT

In this manual, we refer to your Participation Agreement as “Agreement.”

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.
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Chapter 1: Introduction

UnitedHealthcare Community Plan of Iowa offers benefits to members who qualify for the following programs:

- Medicaid
- Iowa Health and Wellness Plan
- Home- and Community-Based Services Waivers
- Healthy and Well Kids in Iowa (Hawki) — Health insurance program for children younger than age 19

If you have questions about the information in this manual or about our policies, go to UHCprovider.com or call Provider Services at 888-650-3462.

How to Join Our Network

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

Our Approach to Health Care

WHOLE PERSON CARE MODEL

The Whole Person Care (WPC) program seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community to improve care coordination and elevate outcomes. Targeting UnitedHealthcare Community Plan members with chronic complex conditions who often use health care, the program helps address their needs holistically. WPC 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. WPC 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. WPC provides:

- Market-specific care management covering medical, behavioral and social care.
- Extended care team including Primary Care Provider (PCP), pharmacist, medical and behavioral director, and peer specialist.
- Field-based interventions engage members, connecting them to needed resources, care and services.
- Personal and multidisciplinary care plan.
- Assistance with appointments with PCP and coordinating appointments. The Community Health Worker (CHW) refers members to a Registered Nurse (RN), Behavioral Health Advocate (BHA) or other specialists as required for complex needs.
- Education and support with complex conditions.
- Tools for helping members engage with providers, such as appointment reminders and help with transportation.
- Foundation to build trust and relationships with hard-to-engage members.

The goals of the WPC program are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates.
- Improve access to PCP and other needed services, measured by number of PCP visit rates within identified time frames.
- Identify and discuss behavioral health needs, measured by number of behavioral health (BH) care provider visits within identified time frames.
Chapter 1: Introduction

• 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.

Our clinical model helps members live healthier lives through integrated health care and services, enabling them to live in the community of their choice. It provides, affordable options focused on improving health literacy, which connects them to a medical/behavioral health home. It also helps them take care of their health, well-being, and function.

As a result, we help ensure seamless care transitions and coordination of health care. Clinical programs — Care Coordination, Utilization Management, Disease Management, and Specialty — are connected through the Interdisciplinary Care Team and a member record.

Wellness

Routine medical exams and screenings are important for our members. We monitor them to help close gaps in care through a universal tracking database and identify members who have not had their HEDIS®-recommended exam or screenings. Members who complete recommended exams, screenings and health risk assessment may have their monthly contributions waived through the Healthy Behaviors Program. Our Baby Blocks Program encourages member compliance for prenatal, postnatal and the first 15 months of life. Gaps in care reporting is available for your utilization through our online coordination tool, Community Care.

We have disease management programs to meet the needs of our members with chronic illnesses and support efforts for member self-management. These programs include diabetes and maternity. Participants are invited to the member record on this platform by email.

Care Provider Resources

UnitedHealthcare Community Plan manages a comprehensive care provider network of independent practitioners and facilities. The network includes health care professionals such as PCPs, specialists, medical facilities, allied health professionals and ancillary service care providers. UnitedHealthcare Community Plan offers several options to support care providers who need assistance.

For more information, visit UHCprovider.com > Tools & Resources > Training and Education > Medicare > Community Care.

Care plans are updated at least annually if indicated by a change in member condition or circumstances. A member may request a re-assessment and a re-visit to their care plan at any time. Once the plan is in place, our care coordinators monitor service delivery and member treatment participation and circumstances.

For more information, visit UHCprovider.com/IAprovider > Provider Forms and Reference Guides > Coordination of Care Reference Guide.

If you see a change in member condition or interactions, report it to their care coordinator directly or call Provider Services at 888-650-3462.

In addition, we screen all our members with a health risk screening when they are:

• Newly enrolled to our health plan, within 90 days of enrollment,
• Re-enrolling to our health plan and have not been enrolled in the prior 12 months, or
• Reasonably believed to be pregnant.

We conduct the screening in person, by phone, through a secure website or by mail. During the initial health risk screening process, we help members arrange an initial visit with their PCP for a baseline medical assessment and other preventive services.
Referring Your Patient

To refer your patient who is a UnitedHealthcare Community Plan member to WPC, call Member Services at 800-587-5187, TTY 711. You may also call Provider Services at 888-650-3462.

SECURE CARE PROVIDER WEBSITE

UnitedHealthcare Community Plan provides a secure portal to network care providers, facilities and medical administrative staff called Link at UHCprovider.com. This website offers an innovative suite of online health care management tools, including the ability to view all online transactions for UnitedHealthcare Community Plan members. It can help you save time, improve efficiency and reduce errors caused by conventional claims submission practices.

To access Link, the secure care provider website, go to UHCprovider.com and either sign in or create a user ID for Link. 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 limit.
- 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 Current Procedural Terminology (CPT) codes. Type the CPT code in the header search box 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.

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 of Iowa.

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.

NETWORK MANAGEMENT DEPARTMENT

Within UnitedHealthcare Community Plan, the Network Management Department can help you with your contract, credentialing and in-network services. The department has network account managers and provider advocates who are available for visits, contracting, credentialing and other related issues.

If you need to speak with a network contract manager about credentialing status or contracting, call Provider Services at 888-650-3462.

CULTURAL COMPETENCY RESOURCES

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. Linguistic and cultural barriers can negatively affect access to health care participation. You must help UnitedHealthcare Community Plan meet this obligation for our members.

UnitedHealthcare Community Plan is committed to helping ensure that we and our network treat members with respect and dignity. We do not discriminate based on race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, health status, income status, or physical or mental disability.

We help ensure cultural competency with a whole member approach that honors members’ beliefs and culture. It fosters staff and care provider attitudes and personal communication styles with respect to the members’ environment, culture and beliefs. As a result, we offer 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.

In addition, we are committed to helping people with physical and behavioral disabilities get the services they need. We believe care delivery includes respecting the worth of each person, preserving personal dignity and helping ensure members can choose where they live and who provides their services.

These considerations include:

• Compliance with American Disabilities Act (ADA) indicated through policies and procedures
• Mobility and accessibility, including wheelchair ramps and entrance access
• Accessible medical equipment and services adapted to member needs and disability (i.e. adjustable examination table)
• Community resources and assistance, including transportation

If you are unable to help with a member’s access needs, including counseling or referral services, call Provider Services at 888-650-3462. We can refer the member to a network care provider who can make the necessary accommodations.

EVIDENCE-BASED CLINICAL REVIEW CRITERIA AND GUIDELINES

UnitedHealthcare Community Plan uses MCG Care Guidelines (formally Milliman Care Guidelines) for care determinations.

CARE PROVIDER PRIVILEGES

To help our members access appropriate care and lower 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.

COMPLIANCE

HIPAA mandates 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.
## How to Contact Us

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<tr>
<th>Topic</th>
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<th>Information</th>
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<tr>
<td>Benefits</td>
<td><strong>UHCprovider.com/link</strong> 888-650-3462</td>
<td>Confirm a member’s benefits and/or prior authorization.</td>
</tr>
<tr>
<td>Cardiology Prior Authorization</td>
<td>For prior authorization or a current list of CPT codes that require prior authorization, visit <strong>UHCprovider.com/priorauth</strong> 866-889-8054</td>
<td>Request prior authorization of the procedures and services outlined in this manual’s prior authorization requirements.</td>
</tr>
<tr>
<td>Claims</td>
<td>Use the Link Provider Portal at <strong>UHCprovider.com/claims</strong> 888-650-3462</td>
<td>Use payer ID 87726. Ask about a claim status or about proper completion or submission of claims.</td>
</tr>
<tr>
<td></td>
<td>Mailing address: UnitedHealthcare Community Plan ATTN: Claims P.O. Box 5220 Kingston, NY 12402-5220</td>
<td></td>
</tr>
<tr>
<td>Claim Disputes</td>
<td>Sign in to <strong>UHCprovider.com/claims</strong> to access Link, then select the UnitedHealthcare Online app. 888-650-3462 Fax: 801-994-1092</td>
<td>Claim disputes include overpayment, underpayment, payment denial, or an original or corrected claim determination you don’t agree with.</td>
</tr>
<tr>
<td></td>
<td>Reconsiderations mailing address: UnitedHealthcare Community Plan P.O. Box 5220 Kingston, NY 12402-5220</td>
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<tr>
<td></td>
<td>Appeals mailing address: UnitedHealthcare Community Plan ATTN: Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364</td>
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<tr>
<td>Claim Overpayments</td>
<td>See the Overpayment section for requirements before sending your request. Sign in to <a href="https://UHCprovider.com/claims">UHCprovider.com/claims</a> to access Link, then select the UnitedHealthcare Online app. 888-650-3462</td>
<td>Ask about claim overpayments.</td>
</tr>
</tbody>
</table>
|                                           | Mailing address: UnitedHealthcare Community Plan  
ATTN: Recovery Services  
P.O. Box 740804  
Atlanta, GA 30374-0800 |                                                                                                                                  |
| Community-Based Case Management           | ia_ltcss@uhc.com  
Provider Services 888-650-3462 | Ask about Home and Community-Based Services (HCBS).                                                                 |
| Electronic Data Intake Support            | ac_edi_ops@uhc.com  
800-210-8315 | Ask about any EDI-related issues, including electronic claims (837), payer level rejections, electronic payments and statements (835), issues with eligibility (270/271) or claim status (276/277). |
| Eligibility                               | To access the app, sign in to [UHCprovider.com/eligibility](https://UHCprovider.com/eligibility) to access Link, then select the UnitedHealthcare Online app 888-650-3462 | Confirm member eligibility. Eligibility is determined by the state or state designees. You can also check eligibility using IME’s Eligibility and Verification Information System (ELVS). For more information, refer to Iowa DHS at [dhs.iowa.gov](http://dhs.iowa.gov). |
| Fraud and Abuse                           | 800-455-4521 or 877-401-9430 | Notify us of suspected fraud or abuse by a care provider or member.                                                   |
| Healthy First Steps/Obstetrics (OB) Referral | 888-650-3462  
Fax: 877-353-6913 | Refer high-risk OB members. Fax initial prenatal visit form.                                                            |
| Iowa Medicaid Department of Human Services | dhs.iowa.gov  
800-338-7909 | Call Provider Services with questions.                                                                                   |
| LabCorp for Providers                     | 800-833-3984 | LabCorp is the preferred lab provider.                                                                                   |
## Chapter 1: Introduction

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<tr>
<td>Member Services</td>
<td><a href="https://myuhc.com/communityplan">myuhc.com/communityplan</a> 800-464-9484 (TTY 711)</td>
<td>Assist members with issues or concerns. Available 7:30 a.m. – 6 p.m. Central Time, Monday through Friday.</td>
</tr>
<tr>
<td>Non-Emergent Medical Transportation</td>
<td>Medical Transportation Management (MTM) 888-513-1613</td>
<td>Call MTM to schedule transportation or for transportation assistance. To arrange non-urgent transportation, please call two days in advance.</td>
</tr>
<tr>
<td>NurseLine</td>
<td>800-464-9484</td>
<td>Available 24 hours a day, seven days a week.</td>
</tr>
<tr>
<td>Optum Link Support Center</td>
<td><a href="mailto:LinkSupport@optum.com">LinkSupport@optum.com</a> 855-819-5909</td>
<td>Available 7 a.m. – 9 p.m. Central Time, Monday through Friday; 6 a.m. – 6 p.m. Central Time, Saturday; and 9 a.m. – 6 p.m. Central Time, Sunday.</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td><a href="https://uhcprovider.com">UHCprovider.com</a> Pharmacy tab 877-305-8952 (OptumRx)</td>
<td>OptumRx oversees and manages our network pharmacies.</td>
</tr>
<tr>
<td>Prior Authorization/Notification for Pharmacy</td>
<td><a href="https://uhcprovider.com/priorauth">UHCprovider.com/priorauth</a> 800-310-6826 Fax: 866-940-7328</td>
<td>Request authorization for medications as required.</td>
</tr>
<tr>
<td>Provider Services</td>
<td><a href="https://uhcprovider.com/IAprovider">UHCprovider.com/IAprovider</a> 888-650-3462</td>
<td>Available 7:30 a.m. – 6 p.m. Central Time, Monday through Friday.</td>
</tr>
<tr>
<td>Radiology Prior Authorization</td>
<td><a href="https://uhcprovider.com/priorauth">UHCprovider.com/priorauth</a> 866-889-8054</td>
<td>Request prior authorization of the procedures and services outlined in this manual's prior authorization requirements. Complete and current list of prior authorizations.</td>
</tr>
<tr>
<td>Referrals</td>
<td><a href="https://uhcprovider.com">UHCprovider.com</a> &gt; Click Menu on top right, then select Referrals or use LINK Provider Services 888-650-3462</td>
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<td>Topic</td>
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<tr>
<td>Utilization Management</td>
<td>Provider Services 888-650-3462</td>
<td>UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. Request a copy of our UM guidelines or information about the program.</td>
</tr>
<tr>
<td>Vision Services</td>
<td>Superior Vision Provider Services 866-819-4298</td>
<td>Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from Superior Vision.</td>
</tr>
<tr>
<td>Whole Person Care Person-Centered Care Model (Care Management/ Disease Management)</td>
<td><strong><a href="mailto:Iowa_CareManagement@uhc.com">Iowa_CareManagement@uhc.com</a></strong></td>
<td>Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.</td>
</tr>
<tr>
<td>Website for Iowa Community Plan</td>
<td><strong>UHCprovider.com/IAProvider</strong></td>
<td>Access your state-specific Community Plan information on this website.</td>
</tr>
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</table>
Chapter 2: Care Provider Standards & Policies

General Care Provider Responsibilities

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

As such, UnitedHealthcare Community Plan is committed to helping ensure that we, as well as our care providers, treat members with respect and dignity, regardless of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, health status, income status, or physical or mental disability.

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 the most appropriate medical, behavioral health or long-term care treatment options regardless of plan coverage, the risks, benefits and consequences of treatment and non-treatment, 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 on form for demographic changes or update NPI information for care providers in your office. This form is located at UHCprovider.com > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form.

TRANSITION MEMBER CARE FOLLOWING TERMINATION OF YOUR PARTICIPATION
If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This may include providing service(s) for a reasonable time at our in-network rate.
Chapter 2: Care Provider Standards & Policies

Provider Services is available to help you and our members with the transition.

ARRANGE SUBSTITUTE COVERAGE
If you cannot provide care and must find a substitute, arrange for care from other UnitedHealthcare Community Plan care providers 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 > Find Dr.

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

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

CHANGING AN EXISTING TIN OR ADDING A HEALTH CARE PROVIDER
Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the address listed on the bottom of the form. The W-9 form and the Care Provider Demographic Information Update Form are available at UHCprovider.com > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form.

Otherwise, complete detailed information about the change, the effective date of the change and a W-9 on your office letterhead. Email this information to your provider advocate, network manager or the number at the bottom of the Provider Demographic Change Form.

UHCPROVIDER.COM, Go to UHCprovider.com > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form. Or submit your change by:

- Completing the Provider Demographic Change Form and faxing it to the appropriate number listed on the bottom of the form.
- Contacting your provider advocate or network manager. Or call the number at the bottom of the Provider Demographic Change Form.

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 particular 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 or as otherwise specified in the records request notice we send you. We may request you respond sooner (48 hours after the request) for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for six years or longer if required by applicable statutes or regulations.

PERFORMANCE DATA
You must allow the plan to use care provider performance data.
Chapter 2: Care Provider Standards & Policies

COMPLY WITH PROTOCOLS
You must comply with UnitedHealthcare Community Plan’s and Payer’s Protocols, including those contained in this manual.

You may view protocols at UHCprovider.com.

OFFICE HOURS
Provide the same office hours of operation to UnitedHealthcare Community Plan members as those offered to commercial members.

PROTECT CONFIDENTIALITY OF MEMBER DATA
UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members’ health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and associated regulations. In addition, you will comply with applicable state laws and regulations. UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to stop unintentional disclosure of protected health information (PHI). This includes passwords, screen savers, firewalls and other computer protection. It also includes shredding information with PHI and all confidential conversations. All staff is trained on HIPAA and confidentiality requirements.

FOLLOW MEDICAL RECORD STANDARDS
Please reference Chapter 9 for Medical Record Standards.

INFORM MEMBERS OF ADVANCE DIRECTIVES
The federal Patient Self-determination Act (PSDA) gives members the legal right to make choices about their medical care before incapacitating illness or injury through an advance directive.

We expect network care providers to comply with federal laws (OBRA 1990, Sections 4206 and 4751) about advance directives. Provide written information to every adult member receiving medical care. The information includes the right to:

• Make decisions concerning their own medical care.
• Accept or refuse medical or surgical treatment.
• Make advanced directives.
• Have those advanced directives honored.

You must adhere to charting standards that reflect the member’s advance directive. (See Chapter 10.) UnitedHealthcare Community Plan of Iowa also informs members about advance directives through Member Handbooks and other communications.

Appointment Standards (Iowa DHS Access and Availability Standards)
Comply with the following appointment availability standards:

PRIMARY CARE
PCPs should arrange appointments for:
• After-hours care phone number: 24 hours, 7 days a week
• Emergency care: Immediately or referred to an emergency facility
• Urgent care appointment: within 24 hours
• Routine care appointment: within six weeks of the request date or 48 hours for persistent symptoms
• Non-urgent, symptomatic (i.e., routine care) office visits: within three weeks from the request date.
• Non-symptomatic/preventive care office visits: within three weeks from the request date of a patient’s request.
• Transitional health care for clinical assessment and care planning: within seven calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.

SPECIALTY CARE
Arrange appointments for:
• Routine care: within 30 days
• Urgent care: within one day from request
• Non-urgent “sick” visit: within 48–72 hours of request, as clinically indicated
• Non-urgent care: within 30 days of request
VISION SERVICES
Arrange appointments for:
• Routine optometry: within three weeks
• Urgent optometry: within 48 hours

LABORATORY AND X-RAY
Arrange appointments for:
• Routine laboratory and X-ray services: within three weeks
• Urgent laboratory and X-ray services: within 48 hours

BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE USE DISORDERS)
Arrange appointments for:
Mental Health
• Post-stabilization services: within one hour
• Emergent appointments: within three hours
• Urgent: within 24 hours
• Planned IP psychiatric: within five working days
• Routine outpatient services: within nine working days
• Routine care: within three weeks
• Persistent symptoms: within 48 hours

Substance Use Disorders
• Emergent appointments: immediately
• Urgent: within 24 hours
• Routine: within 14 days
• Substance use disorder and pregnancy: admitted within 48 hours

IV Drug Users
• Admitted: no later than 14 days after making request for admission OR 120 days after date of request if no program has the capacity to admit the individual on the date of request and if interim services are made available to the individual not later than 48 hours after request

PRENATAL CARE
Arrange appointments for the initial prenatal visit:
• First trimester: within three weeks of request
• Second trimester: within two weeks of request
• Third trimester: within one week of request

ALLOWABLE OFFICE WAITING TIMES
Members should not be regularly made to wait longer than:
• Routine appointments: 45 minutes after arrival
• Emergency: 15 minutes after arrival
• Mobile crisis: one hour after arrival or request
• Urgent non-emergency: one hour after arrival

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

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

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

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

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

To help ensure we have your most current provider directory information, submit applicable changes to:
For Delegated providers, email your changes to 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 Link or by calling Provider Services. If you have received the upgraded My Practice Profile and have editing rights, access Link’s My Practice Profile App to make many of the updates required in this section.

Prior Authorization Request

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 Link at UHCprovider.com/eligibility or by calling Provider Services. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- Get prior authorization from Link:
  1. To access the Prior Authorization app, go to UHCprovider.com, then click Link.
  2. Select the Prior Authorization and Notification app on Link.
  3. View notification requirements.
- Identify and bill other insurance carriers when appropriate.

Timeliness Standards for Notifying Members of Test Results

After receiving results, notify members within:

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

Requirements for PCP and Specialists Serving in PCP Role

SPECIALISTS INCLUDE: INTERNAL MEDICINE, PEDIATRICS OR OBSTETRICIAN/GYNECOLOGY

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

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

Medical doctors (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
- Obstetrics/gynecology
Nurse practitioners may enroll with the state as solo providers, but physician assistants cannot; they 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 7 a.m. - 7 p.m., Monday through Friday.

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

You may print a monthly Primary Care Provider Panel Roster by visiting UHCprovider.com. Sign in to UHCprovider.com > select the UnitedHealthcare Online application on Link > select Reports from the Tools & Resources. From the Report Search page, select the Report Type (PCP Panel Roster) from the pull-down menu > complete additional fields as required > click on the available report you want to view.

The PCP Panel Roster provides a list of UnitedHealthcare Community Plan members currently assigned to a care provider.

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

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

UnitedHealthcare Community Plan has no network limitation on referrals to any in-network care provider. If the member accesses care through a non-contracted care provider without prior authorization, the services may not be reimbursed. Exceptions are if the service is an emergency, urgently needed, post-stabilization, family planning or out-of-area renal dialysis.

To help ensure compliance with federal and state requirements, UnitedHealthcare Community Plan performs monthly screenings of the Office of Inspector General (OIG) (oig.hhs.gov/fraud/exclusions.asp), the Excluded Parties List System (EPLS), and other databases for individuals or entities that have been “excluded” or “debarred” from federal programs. Individuals or entities identified as excluded or debarred as a result of these screenings will be terminated from participation in the plan, immediately, upon discovery. Payments made to “excluded” or “debarred” providers will be recovered retroactive to the date of exclusion.

UnitedHealthcare Community Plan of Iowa expects all physicians involved in the member’s care to coordinate with each other. This includes communicating significant findings and recommendations for continuing care.

- 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 16 hours per week.
- Be available to members by telephone any time.
- Tell members about appropriate use of emergency services.
- Discuss available treatment options and alternative course of care with members.
Responsibilities of PCPs and Specialists Serving in PCP Role

SPECIALISTS INCLUDE INTERNAL MEDICINE, PEDIATRICS, AND/OR OBSTETRICIAN/GYNECOLOGY

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards and Appointment Scheduling sections of this guide.
- Conduct a baseline examination during the UnitedHealthcare Community Plan member’s first appointment.
- Help ensure the integration of clinical and non-clinical care and services in the overall plan of care for special needs members.
- Be available to accept UnitedHealthcare Community Plan members at each office location at least 16 hours a week.
- Respond to after-hour patient calls within 30–45 minutes for non-emergent symptomatic conditions and within 15 minutes for emergency situations.
- Provide culturally competent care and services. All care providers must have a cultural competency program that trains staff to handle cultural and language barriers to the delivery of health care services to members of all cultures.
- Treat UnitedHealthcare Community Plan members’ general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to the Prior Authorization Department, UnitedHealthcare Community Plan Clinical or Pharmacy Department as appropriate.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members’ advance directives. Document in a prominent place in the medical record whether or not 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 Iowa DHS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.

Rural Health Clinic, Federally Qualified Health Center or Primary Care Clinic

Members must select a practitioner within the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as their PCP. They cannot select the group as their PCP.

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

Take the following steps when providing services to UnitedHealthcare Community Plan members:

- Verify eligibility using Link at UHCprovider.com/eligibility or by calling Provider Services.
- Verify member identity with photo identification, if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/priorauth to locate and view the current prior authorization information and notification requirements.
- Refer to UnitedHealthcare Community Plan participating specialists unless we authorize otherwise.
- Identify and bill other insurance carriers when appropriate.
- See Chapter 11 for more information on submitting claims.

Specialist Care Providers Responsibilities

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

- Contact the PCP to coordinate the care/services.
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer.
- Verify the eligibility of the member before providing covered specialty care services.
- Provide only those covered specialty care services, unless otherwise authorized.
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist’s care.
- Note all findings and recommendations in the member’s medical record. Share this information in writing with the PCP.
- Maintain staff privileges at one UnitedHealthcare Community Plan participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the Iowa DHS Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, seven days a week. Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

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

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

Prenatal Care Responsibilities

Pregnant UnitedHealthcare Community Plan members should only receive care from UnitedHealthcare Community Plan participating providers.

Notify UnitedHealthcare Community Plan as soon as a member confirms pregnancy. This helps ensure appropriate follow-up and coordination by the UnitedHealthcare Healthy First Steps coordinator.

If you have questions, call Healthy First Steps. To begin patient outreach and the required notification process, fax the prenatal assessment form to 877-353-6913.

An obstetrician does not need approval from the member’s care provider for prenatal care, testing or obstetrical procedures. Obstetricians may give the pregnant member a written prescription at any UnitedHealthcare Community Plan participating radiology and imaging facility listed in the care provider directory.
Ancillary Care Provider Responsibilities

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

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

Ancillary Care Provider Checklist

Take the following steps when providing services to UnitedHealthcare Community Plan members:

• Verify the member’s enrollment before rendering services. Go to Link at UHCprovider.com or contact Provider Services. Failure to verify member enrollment and assignment may result in claim denial.

• Check the member’s ID card each time the member has services. Verify against photo ID if this is your office practice.

• Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/priorauth.

• Identify and bill other insurance carriers, when appropriate.
Assignment to PCP

Panel Roster

Once a member is assigned a PCP, view the panel rosters electronically on the Link portal on UHCprovider.com. 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.

Sign in to UHCprovider.com > select Link > select the UnitedHealthcare Online application on Link > select Reports from the Tools & Resources. From the Report Search page, select the Report Type (PCP Panel Roster) from the pull-down menu > complete additional fields as required > click on the available report you want to view.

Choosing a Primary Care Provider

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

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

Copayments

Iowa Hawki members in the state’s CHIP plan may have copayments. All other members may have copayments as outlined in the state plan. Members may state they cannot pay the copayment. You may not deny care or services to any members because of this inability.

Medically Necessary Service

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

Member Assignment

ASSIGNMENT TO UNITEDHEALTHCARE COMMUNITY PLAN

Iowa DHS assigns eligible members to UnitedHealthcare Community Plan. We manage the member’s care on the date the member is enrolled until the member is disenrolled from UnitedHealthcare Community Plan. Iowa DHS makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month’s end, but at times may occur mid-month.
At enrollment time, each member receives a welcome packet that includes a copy of the UnitedHealthcare Community Plan Member Handbook. The handbook explains the member’s health care rights and responsibilities through UnitedHealthcare Community Plan.

Obtain copies of the Community Plan Member Handbook online by contacting Provider Services.

**MEMBER CHOICE**

If the member would like to change their Managed Care Organization (MCO), they may do so during the first 90 days after their initial enrollment in an MCO. The member may also change their MCO during the open enrollment period.

To change their MCO, members should call Iowa Medicaid Member Services at 800-338-8366. Or they can call Iowa Medicaid Enterprise Member Services at 515-256-4606 Monday through Friday, 8 a.m. – 5 p.m., Central Time. Hawki members should call the Hawki program at 800-257-8563 8 a.m. – 6 p.m., Central Time. Members may also email Iowa Medicaid Member Services at IMEMemberServices@dhs.state.ia.us.

**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 the Medicaid Inquiry line.

**UNBORN ENROLLMENT CHANGES:**

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

Members may call the Iowa DHS at 855-889-7985.

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 Iowa’s Medicaid and Hawki program. The Iowa DHS determines program eligibility. An individual who becomes eligible for the Iowa DHS program either chooses or is assigned to one of the Iowa DHS-contracted health plans.

**Member ID Card**

Check the member’s ID card at each visit, and copy both sides for your files. Verify the identity of the person presenting the ID card against some form of photo ID, such as a driver’s license, if this is your office practice. 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 or check Link. Also document the call in the member’s chart.
MEMBER IDENTIFICATION NUMBERS
Each member receives an eight-digit UnitedHealthcare Community Plan member identification number (1234567A) Iowa Medicaid assigns. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member.

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

1. To transfer the member, fax the Request for a Change of Primary Care Provider form to 866-888-1129, or mail with the specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider’s name.
   Mailing address:
   UnitedHealthcare Community Plan
   Attn: Health Services
   1089 Jordan Creek Parkway, Ste. 320
   West Des Moines, IA 50266

2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.

3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.

4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have five business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

Limited Medicaid Benefits During Incarceration
The Iowa DHS is required to follow federal guidelines for incarcerated people. When a Medicaid member is placed in a jail setting, they do not lose Medicaid eligibility. Rather, their benefits are limited. They are dis-enrolled from their health plan to prevent improper Medicaid payments. However, they continue receiving benefits if they enter an inpatient situation while in jail. DHS determines the member’s incarceration status.

Medicaid is not available to inmates of public, nonmedical institutions like halfway houses and community residential settings. People on probation or on parole are not considered inmates. People on work release are considered inmates.

LIMITED MEDICAID BENEFITS
When one of the following occurs, limited Medicaid benefits are restored. Inmates are then re-enrolled with their health plan:
- The inmate is released from jail.
- The inmate loses Medicaid eligibility due to other factors (age, end of pregnancy, no longer has earnings, etc.).
- Benefits have been limited for a maximum of 12 months.

RELEASE FROM JAIL
Upon release, the jail shares the inmate’s release date with UnitedHealthcare Community Plan and DHS to put into their systems. DHS re-enrolls the inmate with their health plan.

If the inmate is released within 12 months of being incarcerated and had been placed on limited Medicaid benefits during incarceration, they don’t need to reapply for Medicaid. Their Medicaid benefits will be restored.

TRANSITION FROM JAIL TO UNITEDHEALTHCARE COMMUNITY PLAN
All Medicaid-eligible inmates are considered FFS in their first two months of receiving benefits. During this time, refer billing and claims questions to Iowa Medicaid Enterprise.
Inmates receive UnitedHealthcare Community Plan enrollment information up to two months after enrolling with Iowa Medicaid. Inmates are eligible for Medicaid benefits during this transition.

Inmates with questions about their benefits, services, or eligibility before transitioning to UnitedHealthcare Community Plan can contact Iowa Medicaid Member Services at 888-338-8366.

Sample Health Member ID Card

IOWA MEDICAID AND HAWKI ID CARD

UnitedHealthcare Community Plan

Health Plan/Plan de salud (80840) 911-87726-04
Member ID/ID del Miembro: 9999999 Group/rango: IAQHP
Member/Miembro: REISSUE M ENGLISH MEDICAID
PCP Name/Nombre del PCP: DOUGLAS GETWELL
PCP Phone/Teléfono del PCP: (999) 999-9999
DOB: 07/06/1999

UnitedHealthcare Community Plan

Health Plan/Plan de salud (80840) 911-87726-04
Member ID/ID del Miembro: 999999992010 Group/rango: IAQHP
Member/Miembro: REISSUE M ENGLISH HAWKI
PCP Name/Nombre del PCP: DOUGLAS GETWELL
PCP Phone/Teléfono del PCP: (999) 999-9999
DOB: 07/06/1999

En caso de emergencia, acuda a la sala de emergencia más cercana o llame al 911. In an emergency, go to the nearest emergency room or call 911. Unauthorized use of non-plan providers may result in benefits denial. www.MyUHC.com/communityplan

For Members/Para Miembros: 800-464-9484 TDD 711

For Providers / Para Proveedores: UHCprovider.com 888-650-3462
Claims Address: PO Box 5220, Kingston, NY, 12402-5220
For Pharmacists: 877-405-2272
Pharmacy Claims: OptumRx, PO Box 26044, Hot Springs, AR 71903
Verifying Member Enrollment

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

- Provider Portal: access the Link portal through [UHCprovider.com/eligibility](http://UHCprovider.com/eligibility)
- **UnitedHealthcare Provider Service** is available from 7:30 a.m. – 6 p.m. Central Time, Monday through Friday.
- **Iowa Medicaid Eligibility and Verification Information System (ELVS)**

Benefit Information

UnitedHealthcare Community Plan provides a benefit package which includes services currently covered under the Iowa Medicaid program as well as long-term care and home- and community-based services (HCBS) (See Chapter 4) plus value-added services (See Chapter 6). Services for members are limited to those medically necessary and appropriate, and which conform to professionally accepted standards of care.

Refer to [UHCprovider.com/IAprovider](http://UHCprovider.com/IAprovider) for more information on covered benefits for Iowa Medicaid, Iowa Health and Wellness Plan, Hawki and HCBS.

Please refer to the current Iowa Medicaid Provider Manual located at dhs.iowa.gov for more information about Iowa and Medicaid Plan, Hawki, and HCBS services.

UnitedHealthcare Dual Complete (HMO SNP)

For information about UnitedHealthcare Dual Complete, please see Chapter 4 of the Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for Commercial and Medicare Advantage Products. For state-specific information, go to [UHCprovider.com](http://UHCprovider.com) > Menu > Health Plans by State.
Chapter 4: Medical Management

Medical management improves the quality and outcome of health care 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.

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 MEDICAL TRANSPORTATION (NEMT)
UnitedHealthcare Community Plan members may get non-emergent transportation services through MTM for covered services. Covered transportation includes sedan, taxi, wheelchair-equipped vehicle, public transit, mileage reimbursement and shared rides. Members may get transportation when they need transportation:
- From the member’s home to the doctor’s office.
- To outpatient hospital services.
- To a pharmacy.

We contract with MTM to provide transportation to eligible members. Schedule this service up to 30 days in advance. Overnight hotel stays required with trips may be covered with prior approval.

Visits over 75 miles may require prior approval. Routine visits require 48-hour advance scheduling.

Ambulance services for a member receiving inpatient hospital services are not included in the payment to the hospital.

To make a non-emergent transportation appointment, members must call between 7:30 a.m. – 6 p.m. Central Time, Monday through Friday, to schedule transportation. If they have questions about their order, they may call Member Services at 800-464-9484, TTY 711.

To schedule a ride for a member, call at least 2 business days before the appointment. We will ask for:
- The member’s full name, ID number, current address and phone number.
- The appointment and ride date.
- The name, address and phone number of where the member is going.
• The reason for your transportation request.
• The appointment type.
• The assistance type or mobility aid(s) needed, if any.

Bus transportation will also be available if the member:
• Can access and use public transportation.
• Lives less than half a mile from a bus stop.
• Has an appointment less than half a mile from the bus stop.

Emergency/Urgent Care Services

Hospital emergency rooms offer emergency treatment for trauma, serious injury and life-threatening symptoms. Reasons to go to the ER include:
• Serious illness
• Broken bones
• Serious breathing problems
• Poisoning
• Severe cuts or burns

UnitedHealthcare Community Plan covers any emergency care throughout the United States and its territories. Follow-up care in the ER is not covered.

Urgent care clinics help members with a non-life-threatening condition when their PCP isn’t available or the office is closed. Common urgent care concerns include:
• Sore throat
• Ear infection
• Minor cuts or burns
• Flu
• Low-grade fever
• Sprains

While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about appropriate emergency room use. A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fever, cough and 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, air and water transportation.
• Emergency dental services, limited to broken or dislocated jaw, severe teeth damage and cyst removal.

We pay out-of-network care providers at 80% for emergency services at the current program rates at the time of service. We try to negotiate acceptable payment rates with out-of-network care providers for covered post-stabilization care services for which we must pay.

EMERGENCY ROOM CARE

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

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, please provide notification to us of an admission by 5 p.m. the following business day. We review emergency admissions within one working day of notification. If UnitedHealthcare Community Plan does not respond within one hour or cannot be reached, or if the health plan and attending care provider do not agree on the member’s care, UnitedHealthcare Community Plan lets the treating care provider talk with the health plan’s medical director. The treating care provider may continue with care until the health plan’s medical care provider is reached, or when one of these guidelines is met:

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

Depending on the need, the member may be treated in the ER, in an inpatient hospital room or in another setting. This is called Post Stabilization Services.

Post-stabilization services relate to an emergency medical condition and are provided to help keep the member stabilized and maintain or improve their condition. We cover post-stabilization care when:

1. A member has an approved prior authorization from a network care provider.
2. UnitedHealthcare Community Plan does not respond within one hour to a request for prior authorization from an out-of-network care provider.
3. UnitedHealthcare Community Plan could not be reached during normal business hours for prior authorization.
4. UnitedHealthcare Community Plan and the treating physician cannot reach an agreement about care, and a network care provider is not available to review.

Post-stabilization care services with an out-of-network care provider are covered until one of the following occurs:

1. The member is discharged.
2. A network care provider with privileges at the treating hospital takes responsibility for the member’s care.
3. The out-of-network care provider and UnitedHealthcare Community Plan reach an agreement about the member’s care.
4. A network care provider assumes responsibility for the member’s care until transferred to a network facility.

A member will not pay more than any applicable copayment or cost-share for post-stabilization services. Any cost-sharing for post-stabilization services begins on the date of inpatient admission.

**Urgent Care (Non-Emergent)**

Urgent care services are covered.

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

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**Emergency Care Resulting in Admissions**

Prior authorization is not required for emergency services. Nurses in the Health Services Department review emergency admissions within one business day of notification.

Emergency care should be delivered without delay. Notify UnitedHealth Community Plan about admission. Use Link through UHCprovider.com, call Provider Services at 888-650-3462 or fax forms to 888-899-1680. Fax forms are located at UHCprovider.com/IAProvider > Prior Authorization and Notification > Prior Authorization Paper Fax Forms.

**Authorization Notification Requirements**

Include the following for emergency room admission authorizations/notification:

- Member name and health plan member ID number
- Facility name and tax identification number (TIN) or National Provider Identification (NPI)
- Admitting/attending physician name and TIN/NPI
- Description for admitting diagnosis or ICD-10, or its successor, diagnosis code
- Admission date (Admission starts when the physician writes the order that a member’s condition meets an acute inpatient level of stay.)
- Anticipated date(s) of service
- Service (primary and secondary) procedure code(s) and volume of service, when applicable
- Service setting

For behavioral health and substance use disorder authorizations, please see the current Network Manual and the Manual Addendum available on providerexpress.com.

If you are a non-network care provider, a participating UnitedHealthcare Community Plan network care provider services must refer services to you. You must have prior authorization for all services, except family planning services, emergency services, and approved prior authorized services.

UnitedHealthcare Community Plan makes decisions about utilization management based on appropriateness of care and benefit coverage. We also use evidence-based,
nationally recognized or internal clinical criteria. We do not reward you or reviewers for giving coverage denials. We also do not give financial incentives to Utilization Management staff to support lower utilization. Contact the Prior Authorization Department for more information.

The criteria are available in writing upon request or by calling the Prior Authorization Department.

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

Durable Medical Equipment

You may provide DME to members who need it for life support, lower-cost care or employment. DME is:

1. Able to withstand repeated use.
2. Used for a medical purpose.
3. Appropriate for use in the member’s home.
4. Not useful to a person without illness or injury.

You must check member eligibility and get necessary prior authorizations.


DISPENSING/PRESCRIBING REQUIREMENTS

For ongoing prescriptions with limitations, bill with the usage date. Follow all limitations for the individual supply. You cannot bill future dates. To receive payment when billing a date range, file the claim on or after the last date on the claim.

DELIVERY, REPAIR, MAINTENANCE AND INSTALLATION

We cover DME delivery only when the equipment is first purchased or rented, and the supplier makes a separate charge for delivery. We require proof of delivery. Only a member may sign for the item.

You may also use a return postage-paid delivery invoice from the member or another person receiving the delivery as proof of delivery. Include the member’s name, item quantity, detailed description, brand name, and serial number as well as the required signatures from either the member or the member’s designee on this invoice.

Rental equipment (testing, cleaning, regulating and checking equipment) maintenance is up to the supplier. The supplier may bill extensive maintenance on purchased equipment requiring an authorized technician as a repair.

DME installation requires an invoice. If charges are greater than $25, we require prior authorization.

BENEFITS AND LIMITATIONS

We do not pay care providers for DME when members:

- Receive inpatient or outpatient care in a hospital.
- Receive skilled nursing care payment, except for orthotic and prosthetic services, orthopedic shoes, and therapeutic shoes for diabetics, and the facility is receiving payment.
- Are in an Intermediate Care Facility for theIntellectually Disabled (ICF/ID) or a facility receiving nursing facility payments except for:
  - Assistive technology
  - Catheter (indwelling Foley)
  - Colostomy and ileostomy appliances
  - Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape
  - Diabetic supplies
  - Disposable catheterization trays or sets (sterile)
  - Disposable bladder irrigation trays or sets (sterile)
  - Disposable saline enemas
  - Hearing aid batteries
  - Orthotic and prosthetic services, including augmentative communication devices
  - Orthopedic shoes
  - Repair of member-owned equipment
  - Oxygen services (nursing facility only; no payment is made for oxygen in an ICF/ID)
  - Therapeutic shoes for diabetics
  - Wheelchairs for members in a nursing facility (except when the wheelchair is customized)

We replace items for members in nursing facilities who have their own equipment as long as:

- Cost does not exceed two-thirds the cost of a new item.
- Replacement is not due to change in size or condition of the member.

If the member must receive more than the medically necessary amount, document the reason on a Certificate of Medical Necessity form and attach to your claim.
Family Planning

We cover family planning services to members who choose to delay or prevent pregnancy. Covered services include giving accurate information and counseling to help members make informed decisions about family planning methods. Members may self-refer to any Medicaid care provider, a local health department or family planning clinic, including those not in the UnitedHealthcare network. Members do not need a referral for these services.

Care Coordination/Health Education

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

The program goals are to:

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

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

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

Health Home Program

We use a health home model, which builds on the PCP-led medical home model. Health homes help Medicaid members with chronic, complex conditions who need more care management to live in their community. We contract with medical practices willing to use this person-centered approach to support care coordination. This helps:

- Improve medical, social and behavioral health issues related to the member’s complex conditions.
- Encourage quality of life while respecting member dignity, culture, and personal choice.
- Nurture members’ relationships with you.
- Improve access to services.
- Coordinate care through online tools the care team and the member may use.
- Use education and planning to lower emergency room visits and admissions.
- Accommodate any necessary transitions between you and levels of care.

Our health homes help children and adults with two or more of the following chronic conditions or have one chronic condition and are at risk of developing a second:

- Mental health condition
- Substance abuse disorder
• Asthma
• Diabetes
• High blood pressure
• Overweight
  - BMI over 25
  - BMI over 85 percentile for pediatric population

To learn about health homes, visit UHCprovider.com. You can also read more at dhs.iowa.gov/ime/providers/enrollment/healthhome.

**Integrated Health Home Program**

The Integrated Health Homes program helps health care professionals coordinate the medical, social, and behavioral health care needs for members with serious mental illness (SMI) or serious emotional disturbance (SED).

SMI includes:
- Psychotic disorders
- Schizophrenia
- Schizoaffective disorder
- Major depression
- Bipolar depression
- Delusional disorder
- Obsessive-compulsive disorder

SED is a mental, behavioral or emotional disorder that meets current Diagnostic and Statistical Manual diagnostic criteria for mental disorders. SED also refers to the most recent International Classification of Diseases that cause functional impairment. SED may co-occur with substance use disorders, learning disorders or intellectual disorders that may need clinical attention.

**Home Health Services Program**

The Home Health Services program includes:
- Skilled nursing care
- Home health aide services
- Occupational therapy
- Physical therapy
- Speech-language pathology
- Medical social services

Medicaid members do not require skilled care before they may receive home health services. We cover services delivered in the member’s home. We pay for member services used for stabilized conditions that require nurse observation after stabilization.

Bill claims on a UB-04 form. Home health services have established revenue codes. A unit of service is one visit. Claims submitted without a revenue code and an applicable diagnosis code are denied.

- Revenue Code 551 Skilled Nursing Care
- Revenue Code 421 Physical Therapy
- Revenue Code 441 Speech Therapy
- Revenue Code 431 Occupational Therapy
- Revenue Code 571 Home Health Aide
- Revenue Code 561 Medical Social Worker

**PRIOR AUTHORIZATIONS**

We require prior authorization for PDN/PC services as defined on UHCprovider.com/priorauth.

If members need PDN/PC services outside of normal business hours, request prior authorization within 24 hours or by 5 p.m. Central Time the next business day. You may backdate prior authorizations for medically necessary PDN/PC services up to two calendar days from the receipt date. After we complete the initial assessment, request prior authorization for the medically necessary services. Submit a written treatment plan with the PDN/PC services request. We may require a plan review for continued skilled care needs and progress toward goals.

Include the following information with the prior authorization request:
- Services requested
- Letter of medical necessity that details the member’s skilled needs
- Documentation of caregiver availability, the current nursing assessment, and the POC. This includes verification of the caregiver’s work hours.
- Number of visits and weekly frequency
- Diagnosis codes
- Revenue codes or HCPCS codes
• Start and end dates of care POC. More information on a POC is available at dhs.iowa.gov > Policy Manual > Medicaid Provider > Home Health Services.

Hearing Services

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

Home and Community-Based Services and Long-Term Services and Supports

The Home and Community Based Services (HCBS) Program is a Medicaid long-term delivery system that combines physical and behavioral health with nursing facility-based services. It helps meet the needs of members who would otherwise require care in a medical institution. In addition, HCBS provides members with an advocate who helps them gain knowledge of services and alternatives to make the most informed health care decisions.

All HCBS services require prior authorization through the plan of care (POC) process.

The collective goals of the HCBS Program include:
• Integrated, whole-person care.
• Preserving or creating a path to independence.
• Alternative access models and an emphasis on home and community based services.

DISABILITY SENSITIVITY

Each health plan and its care providers must comply with the Americans with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its members. You can show compliance with the ADA by conducting an independent survey/site review of facilities for both physical and programmatic accessibility. The health plan must reasonably accommodate individuals and will help ensure that the programs and services are as accessible to an individual with disabilities as they are to an individual without disabilities. This is accomplished with written policies and procedures to help ensure compliance while ensuring that physical, communication, and programmatic barriers do not prevent individuals with disabilities from obtaining all covered services.

HCBS PROGRAM DETAILS

UnitedHealthcare Community Plan integrates the HCBS for the AIDS/HIV, Brain Injury, Children’s Mental Health, Elderly, Health and Disability, Intellectual Disability, and Physical Disability Waivers. Eligibility for all of the HCBS programs is determined by the state or state designees. For information on these programs, refer to the Iowa HCBS Manual available at dhs.iowa.gov.

1915(I) STATE PLAN – HABILITATION SERVICES

The 1915 (i) Habilitation Services for Members with Chronic Mental Illness State Plan provides home and community-based services for members with chronic mental illnesses. Habilitation Services assist members develop the self-help, socialization and adaptive skills needed to live in home- and community-based settings.

CONSUMER CHOICES OPTION

The Consumer Choices Option is available under most of the HCBS waivers. It gives members Medicaid dollars they can use to make a budget as well as hire employees and/or buy goods and services to meet their assessed needs. Members using CCO self-direct their services. If needed, members may choose an Independent Support Broker to help them.

HCBS CARE PROVIDER RESPONSIBILITIES

• HCBS care providers provide services according to the plan of care including the amount, frequency, duration and scope of each service along with the member’s service schedule.
• HCBS care providers using EVV should monitor and immediately address service gaps to include backup staff.
Chapter 4: Medical Management

ELECTRONIC VISIT VERIFICATION REQUIREMENTS

The EVV system is an external scheduling and tracking system that helps HCBS providers manage their work based on authorizations UnitedHealthcare Community Plan has approved. EVV monitors the delivery and utilization of personal care and home health services in non-traditional settings. It provides visit verification with location information and a time stamp. EVV also helps ensure quality and program integrity (PI).

HOME AND COMMUNITY BASED SERVICES

Read a summary of the HCBS services, including benefit limitations, unit definitions and billing codes, in the Iowa HCBS Manual on dhs.iowa.gov.

HCBS SETTINGS GUIDELINES

Members may Choose the Setting for their HCBS

Members may choose from a variety of settings, including non-disability specific settings and a private unit in a residential setting. The setting should maximize their freedom to choose their daily activities, environment and interactions. Regardless of the setting, care providers help make sure the setting encourages the greatest possible independence and upholds the member’s rights to privacy, dignity, respect and freedom.

Community Integration

All HCBS settings must be integrated into the community and enable the member to:

- Seek employment with the ability to earn competitive pay in settings with coworkers who do not receive HCBS.
- Engage in the community, such as attending cultural events and recreational activities.
- Control their resources, including personal belongings and money.
- Access services equal to what people who do not receive HCBS may access.

To review the complete guidelines for outpatient settings for Long-Term Service and Supports, please visit EFCR.gov > Libraries > The Public > Catalog of U.S. Government Publications > GPO’s Federal Digital System: Searching and Finding tool > CFR 441.301.

NURSING FACILITIES SERVICES

The facility’s coordinator checks that members are eligible for long-term care (custodial) services upon member enrollment. They also confirm the ongoing MCO census quarterly at a minimum. Long-term care (custodial) members residing in nursing facilities do NOT require prior authorization for the custodial stay. Facilities do not need to submit any prior authorization information when submitting claims.

Services or supplies included in the per diem rate (e.g., oxygen) do not require separate prior authorization.

PATIENT CLIENT PARTICIPATION

Some members have a patient liability, also referred to as client participation. This must be met before Medicaid reimbursement is available. Client participation is the amount of a member’s income, as determined by IDHS, to be collected each month. This includes a portion of members eligible for Medicaid on the following bases:

- Members in an institutional setting
- 1915(c) HCBS waiver members

For HCBS waiver enrollees, the client participation amount is applied on a “first in/first out” basis. For example, it is applied to the first claim that we receive in a month. If there is client participation responsibility remaining after that claim is processed, the amount will be applied to the next claim UnitedHealthcare Community Plan receives until the total amount is exhausted for the month.

For members residing in an institutional facility, the client participation amount is applied to the facility room and board claims. A notice of decision is issued to the member with the amount to pay each facility. Facilities are notified of the amount via the Iowa Medicaid Portal Access (IMPA).

Care providers will be notified of the applied client participation in their provider remittance advice.

Members will be notified of their client participation responsibility in their explanations of benefits. They can work with their community-based case manager to address questions.

Client participation amounts can change retrospectively as determined by the Iowa Medicaid Enterprise. If client participation amounts change, UnitedHealthcare Community Plan automatically adjusts affected claims to reflect the new amount.
Expect to collect patient client participation amounts from the members, including veteran’s aid and attendance, or a medical assistance income trust, and use appropriate legal actions to collect these amounts.

If a member fails to pay their patient client participation, you may refuse to provide services. You must demonstrate to UnitedHealthcare Community Plan you made a good faith effort to collect payment and notify the member’s community-based case manager before discharging them. The member should receive appropriate notice and education about the consequences of non-payment of patient liability, including potential program disenrollment.

COMMUNITY-BASED CASE MANAGEMENT

Community-based case managers:
- Complete a comprehensive assessment that includes the member’s functional ability, physical and behavioral health conditions, available informal supports, environmental considerations, social assessment as well as member and family preferences
- Complete the initial assessment and care/service plan development within 30 days of member assignment, contacts monthly and with significant changes, annual reassessments
- Assist with transition management following inpatient admissions
- Provide information about chronic condition management
- Facilitate community resource linkages
- Submit the authorization for HCBS services.
- Contact HCBS members quarterly and with significant changes in condition

Hospice

Hospice is a complete set of services a hospice interdisciplinary team (IDT) identifies and coordinates to meet the physical, psychosocial, spiritual, and emotional needs of a terminally ill member and family members. The hospice organizes, manages and administers resources to provide the hospice care and services to members, caregivers, and families necessary to manage the terminal illness and related conditions.

ADVANCE DIRECTIVES

We expect network care providers to comply with federal laws (OBRA 1990, Sections 4206 and 4751) about advance directives.

Incapacitated Members

A member may be admitted to a facility and be unable to receive information about an advance directive. In these cases, families or other concerned persons must be given the information. If the incapacitated member recovers, the facility must provide the information directly to them even though the family, surrogate or other concerned person received it first. If a member cannot prove whether they have an advance directive, note this in the medical record.

Mandatory Compliance with the Terms of the Advanced Directive

When a member, relative, surrogate, or other concerned person shows a copy of the member’s advance directive to the facility, the facility must comply with the terms to the extent allowed under state law. This includes recognizing powers of attorney.

HOSPICE PHYSICIAN CERTIFICATION

Hospice must get a physician’s certification that the member is terminally ill. A terminally ill member has a life expectancy of six months or less if the illness runs its normal course. The certification must be signed by the:
- Hospital medical director,
- Hospice interdisciplinary group physician, and
- Member’s attending physician (if the member has one). The attending physician is a doctor of medicine or osteopathy and is identified when the member elects to receive hospice care as having the biggest role in determining and delivering the member’s care.

HOSPICE PLAN OF CARE

A hospice plan of care (POC) must be completed for each hospice member to meet the member and family’s assessed needs. The POC falls under the hospice IDT’s direction and in collaboration with other non-duplicative care providers.

MEDICAID SERVICES

Review, revise and document the hospice POC at least every 15 days, or less if the member’s condition changes.
FACE-TO-FACE ENCOUNTER
A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice member whose total hospice support is expected to be more than 180 calendar days or the two initial hospice benefit periods or 90 days each. This encounter must occur before, but no more than, 30 calendar days to the 180th day or the beginning day of the third benefit period recertification. It must also happen in every benefit period recertification thereafter.

ELECTION STATEMENT
This revocable statement must be signed by a member or their legal representative filed with a hospice. It includes:

- Identification of the hospice selected to provide the member’s care,
- Acknowledgment the member has a full explanation of hospice and the nature of hospice care, and
- Member acknowledgement that our service payments, other than those stated and related to the terminal illness or conditions, are waived by choosing hospice care. The member may still receive HCBS waiver services if the services are not duplicated under the hospice benefit and are medically necessary due to side effects.

Hospice providers must coordinate all services and communication with our community-based case manager. Evidence of coordination must be reflected in the POC.

PALLIATIVE CARE
Hospice provides palliative care. This type of member and family-centered care enhances quality of life by anticipating, preventing, and treating suffering. It addresses physical, intellectual, emotional, social, and spiritual needs. It also helps give the member autonomy, access to information, and choice.

This non-curative requirement for hospice care does not include terminally ill children younger than age 21. Children may receive the hospice benefit and curative care.

HOSPICE ELECTION PERIODS
A physician must certify hospice coverage. Coverage includes:

- An initial 90-day period,
- The following 90-day period, and
- An unlimited number of additional 60-day periods based on continued hospice eligibility.

The hospice provider must complete the following forms according to the purpose for each one:

- Election of Medicaid Hospice Benefit
- Case Activity Report (CAR)
- Revocation of Medicaid Hospice Benefit

Keep the originals in the member’s case file. Complete, date, and sign the forms on the day that the action is effective.

DISCHARGE FROM HOSPICE
A member is discharged from hospice if the:

- Member moves out of the hospice provider’s service area,
- Member transfers to another hospice provider,
- Hospice physician determines the member is no longer terminally ill, or
- Member’s (or other persons in the member’s home) behavior is disruptive, abusive, or uncooperative, and the member’s care is seriously impaired. This is based on written and approved policy developed by the hospice provider.

HOSPICE COVERED SERVICES
The hospice program includes the following services. Any of them may be combined by duration or frequency to meet the member and family’s daily needs.

- **Nursing care.** Hospice must provide nursing care directly unless you submit a waiver CMS approves. Nursing care must help ensure the member’s nursing needs are met based on their initial assessment, comprehensive assessment, and updated assessments.

- **Medical social services.** Social work services must be based on the member’s psychosocial assessment and the member’s and family’s needs and acceptance of these services.

- **Physician services.** A physician or nurse practitioner performs these services, with the exception of the hospice medical director or the physician member of the hospice IDT. The hospice medical director or IDT physician must be a doctor of medicine or osteopathy. The hospice medical director, physician employees, and contracted physicians of the hospice — along with the member’s attending physician — manage the terminal illness and conditions related to the terminal illness.
All physician employees and physicians under contract are under the supervision of the hospice medical director. All hospice physicians coordinate care with the attending physician if the member chooses an attending physician outside the hospice network. If the attending physician is unavailable, the hospice medical director, hospice physician or contracted physician coordinate care.

- **Spiritual counseling.** Spiritual counseling must:
  - Assess the member’s and family’s spiritual needs.
  - Meet member’s needs and family’s acceptance of this service in a manner consistent with their beliefs and desires.
  - Help facilitate visits by local clergy, pastoral counselors, or others who can support the member’s spiritual needs.
  - Advise the member and family of this service.

- **Dietary counseling.** A qualified professional addresses the hospice member’s identified dietary needs and assures they are met.

- **Bereavement counseling.** Bereavement counseling is required but not reimbursable. Qualified professionals with experience or education in grief or loss counseling must provide services. Bereavement services are available to the family and other individuals in the bereavement POC up to one year following the member’s death. Bereavement counseling may also be provided to residents of:
  - A skilled nursing facility (SNF)
  - A nursing facility (NF)

- **Hospice aide.** Hospice aides provide personal care and household services to maintain a safe and sanitary home environment. This includes bed changing, light cleaning and laundering needed for the member’s comfort and cleanliness. Hospice aide services must be provided under the general supervision of a registered nurse.

- **Physical therapy, occupational therapy, and speech language pathology.** These services are provided for symptom control. They can also help the member maintain daily living activities and basic functional skills.

- **Volunteer services.** Volunteers provide day-to-day administrative or direct member care services that equal up to 5 percent of the total member care hours of all paid hospice employees and contract staff. The hospice must maintain volunteer records for member care and administrative services, including the type of services and time worked.

- **Short-term inpatient care.** Hospice must notify UnitedHealthcare Community Plan of any hospital admission. Short-term inpatient care is provided in a participating hospital. Services provided in an inpatient setting must follow the written hospice POC. General inpatient care may be required for procedures necessary for pain control, acute or chronic symptom management, which cannot be provided in other settings. Inpatient care may also provide respite for the member’s family or other persons caring for the member at home. Respite care is the only type of inpatient care provided in a NF when the member is otherwise receiving hospice services at home.

- **Medical supplies and medical equipment.** Medical supplies include drugs and biologicals. Only drugs used primarily for terminal illness pain relief and symptom control are covered. Medical equipment includes DME and other self-help and personal comfort items for member’s terminal illness management. Hospice provides the equipment for use in the member’s home while the member is under hospice care. Medical supplies include the written hospice POC.

- **Other services.** Any other service medically necessary for the member’s comfort, management, and related conditions are covered under the hospice program.

- **Non-covered services:**
  - Medicaid-covered services, including direct physician care unrelated to the terminal illness or related conditions. The respective care providers bill these separately.
  - Service costs not covered by the health maintenance organization (HMO) when the member is enrolled in an HMO and elects hospice.
  - AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency...
HOSPICE LIMITATION AUDITS

- Limitation audits help ensure accurate payment of hospice services do not allow reimbursement to exceed one unit per day for the following per diem hospice level of care codes: T2042 T2044 T2045 T2046
- Reimbursement of hospice level of care code combinations that are billable on the same date of service remain unchanged.
- Reimbursement for level of care code T2043 is billable when a minimum of eight hours of continuous care is provided in a 24-hour period. Reimbursement will not exceed 24 hours of care per day.

TRANSPORTATION SERVICES FOR HOSPICE BENEFICIARIES

The hospice provider handles transportation to hospice-related services. Medical services unrelated to hospice treatment or diagnosis may be covered if medical criteria are met.

HOSPICE CARE FOR CHILDREN IN MEDICAID

Members receiving services reimbursed by Medicaid and Hawki may receive medically necessary curative services, even after the election of the hospice benefit by or on behalf of children receiving services. Section 2302 of the Affordable Care Act, titled “Concurrent Care for Children,” allows curative treatment upon the election of the hospice benefit by or on behalf of children enrolled in Medicaid or Hawki.

The Affordable Care Act does not change the criteria for receiving hospice services. This provision requires states to make hospice services available to children eligible for Medicaid and Hawki programs without terminating any other service that the child is entitled to under Medicaid to treat the terminal condition.

MEDICAL SERVICES AND CONCURRENT CARE FOR CHILDREN RECEIVING HOSPICE SERVICES

Children receiving hospice services may receive other reasonable and necessary medical services, including curative treatment for the terminal hospice condition.
- Prior authorization is only required if the services rendered are on the UnitedHealthcare Community Plan prior authorization list.
- Hospice providers coordinate all services related to the hospice diagnosis and help non-hospice care providers get authorization when required.
on UnitedHealthcare Community Plan’s prior authorization list.

- Hospice providers are responsible for all DME, supplies, and services related to the hospice diagnosis.
- Non-hospice care providers must first coordinate with hospice providers about needed services or procedures before rendering concurrent care for children.
- Non-hospice care providers must bill hospice first to receive a payment or denial for the service provided.
- If hospice denies payment, non-hospice care providers may submit the claim to UnitedHealthcare Community Plan.

Hospice patients (0 through 20 years of age) can receive the following services as long as the services are not duplicative of those the hospice provides:
- Case management services when an ARNP provides and bills
- Technology Assisted (TA) waiver program attendant care services

**BASIS OF PAYMENT**

**Non-Reimbursable Diagnosis for Hospice**

The hospice provider reports diagnosis coding on the hospice claim required by ICD-10 guidelines. The principal diagnosis reported on the claim is the one that contributes most to the terminal prognosis. A non-reimbursable ICD-10 diagnosis code list is in the Iowa Medicaid Hospice Provider Manual available at dhs.iowa.gov > Home > Policy Manual > Medicaid Provider.

**Revenue Codes**
- Revenue Code 651 Routine Home Care
- Revenue Code 652 Continuous Home Care
- Revenue Code 655 Inpatient Respite Care
- Revenue Code 656 General Inpatient Care
- Revenue Code 657 Direct Physician Care
- Revenue Code 658 Hospice Nursing Facility Room and Board

**Payment for Physician Services**
- **Physicians Employed by or Under Contract with the Hospice:** The basic payment rate for hospice reimbursement reflects the costs of covered services related to the member’s terminal illness treatment.

This includes the administrative and general supervisory activities performed by the medical director, physicians, if employed by the hospice, or consulting physician.

- **Attending Physician Services:** When the designated attending physician is not a hospice employee or volunteer, the reimbursement of an independent physician is made according to the usual Medicaid reimbursement. The physician bills UnitedHealthcare Community Plan directly. The only services the attending physician bills are their personal professional services. Costs for services such as lab or X-rays are included on the attending physician’s bill.

- **Direct Physician Care:** Direct physician member care provided by a hospice employee or any contracted physician other than the attending physician is billed by the hospice agency. Reimbursement will be in accordance with the care provider’s contract. When billing on the UB-04 for physician services, use the CPT-4 code.

- **Voluntary Physician Care:** Physician services furnished on a volunteer basis are excluded from reimbursement.

**Laboratory, X-rays, Imaging Procedures**

**ADVANCED OUTPATIENT IMAGING PROCEDURES**

Advanced outpatient imaging procedures must be prior authorized by UnitedHealthcare Community Plan Clinical.

- Find a list of imaging procedures on the Radiology tab on UHCprovider.com. To get prior authorization, go to UHCprovider.com/priorauth > click on the Radiology tab > Online Portal link.

Reference the Medical Management chapter for more information on the Radiology Prior Authorization Program.

**LAB SERVICES**

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

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

Maternity/Pregnancy/Well-Child Care

PREGNANCY/MATERNITY

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

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


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

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

UnitedHealthcare Community Plan must approve all out-of-plan maternity care. Care providers should call 866-604-3267 to obtain prior approval for continuity of care.

Care providers should 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.

To notify UnitedHealthcare Community Plan of pregnancies, care providers should call Healthy First Steps at 800-599-5985 or fax the notification to 877-353-6913.

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

MATERNITY ADMISSIONS

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

If the UnitedHealthcare Community Plan member is inpatient longer than the federal requirements, a prior notification is needed. Please go to UHCprovider.com/priorauth or call the Prior Authorization Department.

To notify UnitedHealthcare Community Plan of deliveries, call 866-604-3267 or fax to 800-897-8317. Provide the following information within one business day of the admission:

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

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

- Date of delivery.
- Gender.
- Birth weight.
- Gestational age.
- Baby name.
Non-routine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires prior authorization. Infants remaining in the hospital after mother’s discharge require separate notification and will be subject to medical necessity review. The midwife (CNM) must be a licensed registered nurse recognized by the Board of Nurse Examiners as an advanced practice nurse (APN) in nurse-midwifery and certified by the American College of Nurse-Midwives. A CNM must identify a licensed care provider or group of care providers with whom they have arranged for referral and consultation if complications arise.

Furnish obstetrical maternity services on an outpatient basis. This can be done under a physician’s supervision through a nurse practitioner, physician’s assistant 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.

POST MATERNITY CARE

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

NEWBORN ENROLLMENT

The hospital must report the birth to the Income Maintenance Customer Service Center (IMCSC) at 877-347-5678 by submitting a Newborn Notification form to IMCSC. A Medicaid-eligible mother is required to report the birth of the newborn to IMCSC within 10 days of the birth. The Medicaid-eligible mother’s newborn will automatically be enrolled as long as the newborn stays in the mother’s custody during the month of birth. A newborn child born to a Hawki eligible mother is not automatically covered either through Hawki or Medicaid.

BRIGHT FUTURES ASSESSMENT

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics and supported by the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). The Bright Futures Guidelines provide guidance for all preventive care screenings and well-child visits. You may incorporate Bright Futures into health programs such as home visiting, child care, school-based health clinics, and many others. Materials developed for families are also available.

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

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 Iowa DHS website dhs.iowa.gov.
Chapter 4: Medical Management

Exception: Iowa DHS does not require informed consent if:

1. As the care provider performing the hysterectomy, you certify in writing the member was sterile before the procedure. You must also state the cause of the sterility.
2. You certify, in writing, the hysterectomy was performed under a life-threatening emergency situation in which prior acknowledgment was not possible. Include a description of the emergency.
3. If the hysterectomy may be a result of abdominal exploratory surgery or biopsy. Tell the member about this possibility and let them document in writing they received this information.

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.

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 72 hours before the expected delivery date.

Document that the expected delivery date was at least 30 days after the member signed the informed consent. 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 Iowa Department of Human Services Consent for Sterilization Form 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 Iowa Medicaid Enterprise 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 Iowa DHS website, dhs.iowa.gov

Have three copies of the consent form:

1. For the member.
2. To submit with the Request for Payment form.
3. For your records.
Neonatal Resource Services (NICU Case Management)

Our Neonatal Resource Services program manages inpatient and post-discharge NICU cases to improve outcomes and lower costs. Our dedicated team of NICU nurse case managers, social workers and medical directors offer both clinical care and psychological services.

NEONATAL RESOURCE SERVICES

The Neonatal Resource Services (NRS) program helps ensure NICU babies get quality of care and efficiency in treatment. Newborns placed in the NICU are eligible upon birth (including babies who are transferred from PICU) and/or any infants readmitted within their first 30 days of life and previously managed in the NICU. All babies brought to the NICU are followed by NRS.

NRS neonatologists and NICU case managers and social workers manage NICU members through evidence-based medicine and care plan use.

The NRS case manager will:

• Work with the family, the care providers, and the facility discharge planner to help ensure timely discharge and service delivery.
• Develop care management strategies and interventions based on infant and family needs.
• Coordinate services prior to discharge and after discharge if the member is under NRS case management.

The NRS case manager’s role includes:

• Planning and arranging the discharge.
• Coordinating care options and prior authorization, including home care, equipment and skilled nursing.
• Arranging post-discharge support for a minimum of 30 days and up to 15 months based on infant ongoing acuity
• Educating parents and families about available local resources and support services.
• Coordination with the Whole Person Care Team for additional case management needs and services.

Case managers provide benefit solutions to help families get the right services for the baby.

Nursing Facility Care Coordination

Care coordinators:

• Complete a comprehensive assessment. This includes the member’s functional ability, physical and behavioral health conditions, available informal supports, environmental considerations, social assessment as well as member and family preferences.
• Provide initial assessment and care/service plan development within 30 days of member assignment and with significant changes, and/or reassessments
• Assist with transition management following inpatient admissions
• Facilitate integration with Optum Behavioral Health as needed to support the member and family

NURSING FACILITY ADMISSION/DISCHARGE

Nursing facilities must follow the IDHS process for submitting a Case Activity Report (CAR). In-state facilities enter all residents into the PathTracker system. The system then creates a CAR and sends it to the IDHS Centralized Facility Eligibility Unit (CFEU). If you are with an out-of-state facility, complete a paper CAR (Form 470-0042 CAR is available at [dhs.iowa.gov](http://dhs.iowa.gov) and submit to the IDHS CFEU.

Action should be completed within two business days of when:

• A current resident applies for Medicaid
• A Medicaid-eligible resident:
  - Enters the facility
  - Changes level of care
  - Is discharged from facility
  - Dies
  - Transfers to another facility

Notify CBCMs immediately when a member has transitioned.

ADMISSION, TRANSFER, AND DISCHARGE RIGHTS OF RESIDENTS IN ADULT CARE HOMES

Each licensee, administrator, or operator will comply with the state regulation in the admission, transfer and discharge rights of residents in adult care homes.
NURSING FACILITY PROVIDER REQUIREMENTS

• Tell UnitedHealthcare Community Plan of a member’s admission or request for admission to the nursing facility as soon as the nursing facility knows about the admission or request.

• Notify UnitedHealthcare Community Plan immediately if the nursing facility is considering discharging a member and consult with the member’s care coordinator.

• Notify the member and/or member’s representative, if applicable, in writing before discharge according to state and federal requirements.

• Notify UnitedHealthcare Community Plan of any change in a member’s medical or functional condition that could impact the member’s level of care eligibility for the currently authorized level of nursing facility services.

• Comply with federal Preadmission Screening and Resident Review (PASRR) requirements to arrange to provide specialized services and all applicable Iowa law governing admission, transfer and discharge policies.

• If the nursing facility is involuntarily decertified by the state or CMS, the Agreement is terminated in accordance with federal requirements.

Radiology Prior Authorization Program

We use a Radiology Prior Authorization Program to improve compliance with evidence-based and professional society guidance for radiology procedures. You must obtain a prior authorization before ordering CT scans, MRIs, MRAs, PET scans, nuclear medicine and nuclear cardiology studies in an office or outpatient setting.

The following images do not require prior authorization:

• Ordered through ER visit.
• While in an observation unit.
• When performed at an urgent care facility.
• During an inpatient stay.

Not getting this prior authorization approval results in an administrative denial. Claims denied for this reason may not be balance-billed.

To get or verify prior authorization:

• Online: UHCprovider.com/priorauth > Radiology > Online Portal link.
• Phone: 866-889-8054 from 8 a.m. - 5 p.m. Central Time, Monday through Friday. Make sure the medical record is available. An authorization number is required for each CPT code. Each authorization number is CPT-code specific.

• For a list of Advanced Outpatient Imaging Procedures that require prior authorization, a prior authorization crosswalk, and/or the evidence-based clinical guidelines, use Link through UHCprovider.com or use the search option at UHCprovider.com.

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

WHAT IS INCLUDED IN SBIRT?

Screening: With just a few questions on a questionnaire or in an interview, you can identify members who have alcohol or other drug (substance) use problems and determine how severe those problems already are. Three of the most widely used screening tools are the Alcohol Use Disorders Identification Test (AUDIT), the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and the Drug Abuse Screening Test (DAST).
**Brief intervention:** If screening results indicate at risk behavior, individuals receive brief interventions. The intervention educates them about their substance use, alerts them to possible consequences and motivates them to change their behavior.

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

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

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

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

- Office
- Urgent care facility
- Outpatient hospital
- Emergency room – hospital
- Federally qualified health center (FQHC)
- Community mental health center
- Indian health service – free standing facility
- Tribal 638 free standing facility
- Homeless shelter

**MEDICATION-ASSISTED TREATMENT (MAT)**

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

To prescribe Buprenorphine, you must complete the waiver through the Substance Abuse and Mental Health Services Administration (SAMHSA) and obtain a unique identification number from the United States Drug Enforcement Administration (DEA).

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

To find a medical MAT provider in Iowa:

1. Go to UHCprovider.com
2. Select “Find a Care Provider” from the menu on the home page
4. Click on “Medical Directory”
5. Click on “Medical Plans”
6. Click on applicable state
7. Select applicable plan
8. Refine the search by selecting “Medication Assisted Treatment”

**For more SAMHSA waiver information:**

Physicians — samhsa.gov
Nurse Practitioners (NPs) and Physician Assistants (PAs) — samhsa.gov

If you have questions about MAT, please call Provider Services at 877-842-3210, enter your Tax Identification Number (TIN) then enter ‘0’ to speak to a representative.
Medical Management Guidelines

ADMISSION AUTHORIZATION AND PRIOR AUTHORIZATION GUIDELINES

All prior authorizations must have the following:

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

For behavioral health and substance use disorder authorizations, call 888-650-3462. Locate the Prior Authorization Fax Request Form at UHCprovider.com/priorauth. If you have questions, please call Prior Authorization Intake.

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision TAT</th>
<th>Practitioner notification of approval</th>
<th>Written practitioner/member notification of denial</th>
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</thead>
<tbody>
<tr>
<td>Non-urgent Pre-service</td>
<td>Within five working days of receipt of medical record information required but no longer 14 calendar days of receipt</td>
<td>Within 24 hours of the decision</td>
<td>Within two business days of the decision</td>
</tr>
<tr>
<td>Urgent/Expedited Pre-service</td>
<td>Within three days of request receipt</td>
<td>Within three days of the request</td>
<td>Within three days of the request</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>Within 24 hours or next business day following</td>
<td>Notified within 24 hours of determination</td>
<td>Notified within 24 hours of determination and member notification within two business days</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>Within 30 calendar days of receiving all pertinent clinical information</td>
<td>Within 24 hours of determination</td>
<td>Within 24 hours of determination and member notification within two business days</td>
</tr>
</tbody>
</table>
Chapter 4: Medical Management

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 an on-site facility review or phone review for each day’s stay using 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 one business day of admission. It finds medical necessity clinical information for a continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone or on-site.

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. You must provide all requested and complete clinical information and/or documents as required within four hours of receipt of our request if it is received before 1 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1 p.m. local time (but no later than 12 p.m. local time the next business day).

Determination of Medical Necessity

Medically necessary services or supplies are those necessary to:

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

MCG medical necessity criteria are available at careguidelines.com.

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 talk 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


Pharmacy Lock-In Program

The pharmacy Lock-In Program helps ensure members safely use pharmacy services. Operating like a medical lock-in, the program limits members to one pharmacy. Members with potentially inappropriate patterns of medication utilization are identified using pharmacy and medical claims data.

When a member is enrolled in the Lock-In Program, we send them a written notification that we are restricting their pharmacy usage. The member has 30 days from the mailing of the notification letter to change the pharmacy assigned to them. If they don't respond within 30 days, the member is assigned to the pharmacy as shown in the notification letter. After this time, the member may request a network pharmacy change if it is agreeable to both the member and the health plan. To request a Lock-In pharmacy change, the member should call Member Services at 800-464-9484.

The lock-in will remain in effect until the member uses services appropriately. If the member transfers to another MCO, the member’s lock-In may continue. A one-time 72-hour emergency supply for medications is available at a pharmacy other than the member’s pharmacy on a one-time basis per member, per drug if the pharmacy cannot get the required medication. The member or their representative may request an appeal of this restriction decision within 30 days by calling Member Services at 800-464-9484. They may also send a written appeal to:

Grievance and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364
Fax: 801-994-1082

To refer a member to the program, call Provider Services at 888-650-3462. Include an explanation for your referral, member name, member ID number, and member demographics.

Referral Guidelines

You must coordinate member referrals for medically necessary services beyond the scope of your practice. UnitedHealthcare Community Plan has no network limitation on referrals to any network care provider. Make referrals to care providers, facilities and contractors who are part of the UnitedHealthcare Community Plan. Monitor the referred member’s progress and help ensure they are returned to your care as soon as appropriate.

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

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

If the member accesses care through a non-contracted care provider without prior authorization, we may not reimburse services unless the service is an emergency, urgently needed, post-stabilization or out-of-area renal dialysis.

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

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

- Determine if the member is eligible on the date of service by using Link on UHCprovider.com, contacting UnitedHealthcare Community Plan’s Provider Services Department, or the Iowa 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 as medically necessary and appropriate for their condition, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the Iowa DHS. These access standards are defined in Chapter 2. The care provider giving the second opinion must not be affiliated with the attending care provider.

Criteria:

- The member’s PCP refers the member to an in-network care provider for a second opinion. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward his or her report to the member’s PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact UnitedHealthcare Community Plan at 888-650-3462.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations.
- If follow-up care is recommended, the member meets with the PCP before receiving treatment.

Services Requiring Prior Authorization

For a list of services that require prior authorization, go to UHCprovider.com/priorauth. Also view the Iowa Medicaid Provider Procedures Manual at DHS.Iowa.Gov > Policy Manual > Medicaid Provider.

DIRECT ACCESS SERVICES

Native Americans seeking tribal clinic or Indian Health hospital services do not require prior authorization. Please see page 16 for more information about female members and direct access.

SEEK PRIOR AUTHORIZATION WITHIN THE FOLLOWING TIME FRAMES

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

Telehealth

We cover telehealth services when you provide them based on generally accepted health care practices and standards in line with in-person visits. We recognize the CMS-designated originating sites considered eligible for providing telehealth services through a telecommunications system. A distant site is a care provider’s location at the time the service is furnished.
Utilization Management Guidelines

Call 866-815-5334 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. 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

These appeals contest UnitedHealthcare Community Plan’s UM decisions. They are appeals of UnitedHealthcare Community Plan’s admission, extension of stay, level of care, or other health care services determination. The appeal states it is not medically necessary or is considered experimental or investigational. It may also contest any admission, extension of stay, or other health care service due to late notification, or lack of complete or accurate information. Any member, their designee, or care provider who has the member’s written consent and is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal. Adverse determination decisions may include UnitedHealthcare Community Plan’s decision to deny a service authorization request or to authorize a service in an amount, duration, or scope less than requested. See Appeals in Chapter 12 for more details. Adverse determination decisions may include UnitedHealthcare Community Plan’s decision to deny a service authorization request or to authorize a service in an amount, duration, or scope less than requested.
Chapter 5: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)/Prevention

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

Developmental Disability Services and Coordination with Regional Centers

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

Referral – If you determine supportive services would benefit the member, refer the member to DDS for approval and assignment of a Regional Center Case Manager who is responsible for scheduling an intake assessment.

Determination of eligibility is the responsibility of the Regional Center Interdisciplinary Team. While the Regional Center does not provide overall case management for their clients, they must assure access to health, developmental, social, and educational services from birth throughout the lifespan of individual who has a developmental disability.

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

Early Intervention for Infants and Toddlers

EPSDT 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) through either the RC or LEA. The assigned coordinator will help the local Regional Center 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 with your participation.

**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 10ug/dL. Children with elevated blood lead levels will be offered enrollment in a care coordination program.

**Private-Duty Nursing and Personal Care Services**

The Private-Duty Nursing and Personal Care (PDN/PC) Services for children provides in-home services. Children age 20 and younger may use this program. This benefit is not available to Hawki members. Members are eligible for up to 16 hours per day of PDN/PC services based on medical need.

Bill claims on a UB-04 form using HCPCS codes. We pay based on contracts.

**Vaccines for Children program (VFC)**

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

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

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

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

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

The state mandates childhood immunizations. Immunization information is based on the recommended Advisory Committee schedule on Immunization Practices (ACIP) standards. A copy of the standards is online at [UHCprovider.com](http://UHCprovider.com).

VFC does not provide vaccines for members. You may bill the cost of the vaccine and administration. Bill non-routine immunizations, such as the flu vaccine or tetanus boosters due to injury, the same as other covered services. Any network care provider may administer vaccines.
We offer the following services to our UnitedHealthcare Community Plan members for no added cost to them. Members get information about them in their UnitedHealthcare Community Plan of Iowa welcome packet. Value-added services are highlighted in the member newsletter, listed in the member handbook and at UHCprovider.com. Information about services that are diagnosis-specific, such as diabetes and pregnancy, are mailed to the member’s home.

Members may directly access most of these services. Some services require assistance from your office. All are limited to network care providers. If you have questions or need to refer a member, call Provider Services at 888-650-3462 unless otherwise noted.

Baby Blocks™ Program

Baby Blocks™ is a web-based, mobile tool that reminds and rewards pregnant women and new mothers to get prenatal, postpartum and well-child care. Baby Blocks™ is available to pregnant UnitedHealthcare Community Plan members or their newborns.

BABY BLOCKS™ BENEFIT

Baby Blocks engages members with text and email appointment reminders. Members who enroll early in their pregnancy can earn up to eight rewards by following prenatal and postpartum recommendations.

How it Works

1. Care providers and UnitedHealthcare Community Plan reach out to members to enroll them in Baby Blocks.
2. Members enter information about their pregnancy and upcoming appointments at UHCBabyBlocks.com.
3. Members get reminders of upcoming appointments and record completed visits at UHCBabyBlocks.com.
4. At milestones throughout the program, members choose a reward for themselves or their baby.

How You Can Help

1. Identify UnitedHealthcare Community Plan members during prenatal visits.
2. Share a Baby Blocks brochure with the member and talk about the program.
3. Encourage the member to enroll at UHCBabyBlocks.com.

Members self-enroll on a smartphone or computer. They can go to UHCBaby Blocks.com and click on “Sign Up Here.”

Healthy First Steps

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.

HFS-MATERNAL CARE MODEL

The HFS-Maternal care model strives to:

• Increase early identification of expectant mothers and facilitate case management enrollment
• Assess the member’s risk level and provide member-specific needs that support the care provider’s plan of care
• Help members understand the importance of early and ongoing prenatal care and direct them to receiving it.
• Multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care.
• Increase the member’s understanding of pregnancy and newborn care.
• Encourage pregnancy and lifestyle self-management and informed health care 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-emergency settings.
• Encourage members to stop smoking with our Quit for Life tobacco program.
• Help identify and build the mother’s support system including referrals to community resources and pregnancy support programs
• Program staff act as a liaison between members, care providers, and United Healthcare for care coordination

Tell UnitedHealthcare Community Plan when a member becomes pregnant. Faxing a Prenatal Risk Assessment form to the Healthy First Steps program coordinator. Call 800-599-5985, then fax an American College of Gynecology or other initial prenatal visit form to Healthy First Steps at 877-353-6913.

Makena 17P
An injection for up to delivery or 36 weeks, six days’ gestation. It lowers the risk of pre-term labor.

Mobile Apps
Apps are available at no charge to our members. They include:
• Health4Me enables users to review health benefits, access claims information and locate in-network providers.
• Text4baby is a free mobile information service that helps members through their pregnancy and baby’s first year of life. The weekly text4baby messages give tips about:
  - Keeping healthy.
  - Labor and delivery.
  - Breastfeeding.
  - The importance of immunizations (shots).
  - Exercise and healthy eating.

To sign up for text4baby, members must text the word BABY to 511411.
• Myuhc.com can help members find a care provider, complete a health assessment, read the Member Handbook or see their ID card, wherever they are. Members can register or sign-in at myuhc.com/communityplan.

My HealthLine
(cellphone program)
My HealthLine, our free cellphone program, helps us more closely connect with our members. This is particularly important for high-risk members who need support for their overall health, wellness and access to care. Members can quickly and easily reach us to discuss health-related concerns or to locate a PCP. Our care managers make outbound calls to coordinate care and follow up on important activities to improve a member’s health.

This Federal Lifeline program provides the cellphones. Our members who meet federal eligibility requirements receive 500 minutes per month (depending on the mobile carrier) and unlimited texting, plus a pre-programmed member services number that does not count against the minutes.

NurseLine
NurseLine is available at no cost to our members 24 hours a day, seven days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the emergency room or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call 800-464-9484, TTY 711 to reach a nurse.
UnitedHealthcare OMW™

UnitedHealthcare OMW™ (UnitedHealthcare On My Way) is an interactive website that helps members between ages 14 and 26 get ready for real life. It’s easy and fun and has important information all on one secure site.

- Money: Set up a budget and learn about taxes
- Housing: Understand and compare housing options
- Work: Create a resume, and learn interview tips

Members can go to uhcOMW.com and register.

Weight Watchers

This program enrollment is offered to qualifying members so they may learn valuable skills about healthy eating and weight loss. Upon referral by your PCP, members will receive meeting vouchers. Limited to members older than the age of 12. A parent or guardian must sign the health notice portion of the Weight Watchers registration form for members ages 12 to 16.

Women, Infants and Children Supplemental Nutrition Program (WIC)

This program provides federal grants for supplemental foods, health care referrals, and nutrition education for low-income pregnant, postpartum women. It also covers infants and children up to age 5 who are at nutritional risk.

Eligibility –

- Pregnant women - as soon as there is a positive pregnancy test
- Women who have been pregnant within the previous six months
- Breastfeeding women
- Children younger than 5 years

Referral – Make referrals as a part of the initial health assessment of a pregnant, breastfeeding, or postpartum woman and children younger than 5 years.

A current hemoglobin or hematocrit is required:

- Hemoglobin or hematocrit within 90 days of enrollment
- Hemoglobin or hematocrit within 90 days of each succeeding six-month certification except for a child whose blood value was within normal limits at the previous certification. For these children, the lab tests are required every 12 months
- For infants under nine months of age, height/length and weight dated within 60 days of enrollment and with each six-month recertification
Chapter 7: Mental Health and Substance Use

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

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

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

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

To request an ID number, go to the Department of Social Services website at dhs.iowa.gov > go to the section titled “Apply to be a Medicaid Provider.”

Credentialing

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

Covered Services

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

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

For member resources, go to providerexpress.com. Go to the Live and Work Well (LAWW) clinician center. Locate Health Condition Centers at the Clinical Resources tab. The Provider Express Recovery and Resiliency page includes tools to help members addressing mental health and substance use issues.

Benefits include:

**Mental Health Services**

- Outpatient therapy provided by a licensed care provider. This includes family therapy and in-home family therapy to address the needs of the child or other members in the family
- Medication management provided by a professional licensed to prescribe medication
- Inpatient hospital psychiatric services, including services in the state mental health institutes
- Services meeting concurrent substance use disorder and mental health needs of individuals with co-occurring condition
- Community-based and facility based sub-acute services;
- Crisis services:
  - 24-hour crisis response
  - Mobile crisis services
  - Crisis assessment
  - Non-hospital facility-based crisis services
  - 23-hour observation in a 24-hour treatment facility
• Care consultation by a psychiatric physician to a non-psychiatric physician
• Integrated health home mental health services and supports
• Intensive psychiatric rehabilitation services
• Peer support services for persons with serious mental illness
• Community support services:
  - Monitoring of mental health symptoms and functioning/reality orientation,
  - Transporting to and from behavioral health services and placements,
  - Establishing and building supportive relationships
  - Communicating with other care providers
  - Helping ensure member attends appointments and obtains medications, crisis intervention and developing a crisis plan
  - Developing and coordinating natural support systems for mental health support
• Habilitation program services
• Children's mental health waiver services
• Stabilization services
• In-home behavioral management services
• Behavioral interventions with child and family, including behavioral health intervention services (BHIS)
• Medicaid and non-Medicaid funded applied behavior analysis (ABA) services for children with autism, including MHDS Autism Support program
• Psychiatric Medical Institutions for Children (PMIC)
• Community-based neurobehavioral rehabilitation services
• Assertive Community Treatment (ACT) Respite

Substance Use Disorder Services
• Outpatient treatment
• Ambulatory detoxification
• Intensive outpatient
• Partial hospitalization (day treatment)
• Clinically managed residential treatment (low, medium and high intensity) and detoxification
• Medically monitored intensive inpatient services, treatment and detoxification
• Detoxification services, including such services by a care provider licensed under chapter 135B
• Peer support and peer counseling
• PMIC substance use disorder services consisting of treatment provided by a substance use disorder-licensed PMIC and consistent with care provided by a PMIC as described in Iowa Code chapter 135H
• Emergency and ambulance services for substance use disorder conditions
• Intake, assessment and diagnosis services, including appropriate physical examinations, urine screening and all necessary medical testing to determine a substance use disorder diagnosis, identification of medical or health problems, and screening for contagious diseases
• Evaluation, treatment planning and service coordination
• Substance use disorder counseling services when provided by approved opioid treatment programs licensed under Iowa Code Chapter 125
• Substance use disorder treatment services determined necessary after an EPSDT screening
• Substance use disorder screening, evaluation and treatment for members convicted of Operating a Motor Vehicle While Intoxicated (OWI), Iowa Code Section 321J.2 and members whose driving licenses or non-resident operating privileges are revoked under Chapter 321J, provided that such treatment service meets the criteria for service necessity
• Court-ordered evaluation for substance use disorder
• Court-ordered testing for alcohol and drugs
• Court-ordered treatment which meets criteria for treatment services
• Second opinion as medically necessary and appropriate for the member's condition and needs identified by a qualified network care provider or arranged for outside the network at no cost to the member

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 Link at UHCprovider.com. You may also verify member eligibility and request a prior authorization by calling 888-650-3462.
Authorizations

Members may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care. Help ensure prior authorizations are in place before rendering non-emergent services. Get prior authorization by going to UHCprovider.com/priorauth, faxing 888-899-1680. MCG guidelines for medical necessity criteria are located at careguidelines.com.

Collaboration with Other Health Care Professionals

COORDINATION OF CARE

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

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

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

Portal Access

Website: UHCprovider.com

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

View the Prior Authorization list, find forms and access the care provider manual. Or call Provider Services at 888-650-3462 to verify eligibility and benefit information (available 8 a.m. - 5 p.m. Central Time, Monday through Friday).

Website: providerexpress.com

Appeals and Grievances

Call Provider Services and a representative will assist you with the Appeals and Grievances process. You may file an appeal with written consent from the member within 60 calendar days of the notice of action.

Send written requests to:

UnitedHealthcare Community Plan
Grievance and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

Claims

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

Monitoring Audits

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

Addressing the Opioid Epidemic

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

BRIEF SUMMARY OF FRAMEWORK

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

INCREASING EDUCATION & AWARENESS OF OPIOIDS

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

Access these resources at UHCprovider.com. Then click “Drug Lists and Pharmacy”. Click Resource Library to find a list of tools and education.

PRESCRIBING OPIOIDS

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

Refer to Chapter 4 for information about Screening, Brief Intervention, and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT) programs.
Chapter 8: Member Rights and Responsibilities

Our Member Handbook has a section on member rights and responsibilities. In it, we emphasize the importance of members understanding their rights and responsibilities.

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 assert 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 us 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 information be changed if they believe it is inaccurate or incomplete. Any request must be in writing and explain why they want the change. This request must be acted on within 60 days. The timing may be extended 30 days with written notice to the member. If the request is denied, members may have a disagreement statement added to their health information.

ACCOUNTING OF DISCLOSURES

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

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

RIGHT TO REQUEST RESTRICTIONS

Members have the right to ask you or us to restrict the use and disclosures of their PHI for treatment, payment and health care operations. This request may be denied. If it is granted, the covered entity is bound by any restriction to which is agreed. Document these restrictions. We must agree to restrict disclosure. Members may request to restrict disclosures to family members or to others who are involved in their care or its payment.

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. 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 under the Member Information tab (English, Spanish).

MEMBER RIGHTS

Members have:

- A right to receive information in an easily understood format and manner about the organization, its services, its practitioners and providers and member rights and responsibilities
- A right to be treated with respect and recognition of
their dignity and right to privacy including a right to fully participate in the community and to work, live and learn to the fullest extent possible

- Receive information on available treatment options and alternatives, including treatment in the least restrictive setting, presented in a manner appropriate to the Member’s condition and ability to understand
- A right to participate with practitioners in making decisions about their health care, including the right to refuse services
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- A right to request and receive a copy of his or her medical records, and request that they be amended or corrected
- A right to be furnished healthcare services in accordance with requirements for access and quality of services
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- A right to voice complaints or appeals about the organization or the care it provides
- A right to make recommendations regarding the organization’s member rights and responsibilities policy
- A right to exercise his/her right and that the exercise of those rights does not adversely affect the way members are treated
- A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

MEMBER RESPONSIBILITIES

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

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

UnitedHealthcare Community Plan requires you to keep current, detailed and organized member medical records. Maintain them in a way that permits effective and confidential patient care and quality review. You are expected to achieve a passing score of 85% or better.

Medical record standards are available through the UnitedHealthcare Community Plan of Iowa page on UHCprovider.com.

Every year, we select a sample of high-volume PCPs and specialty providers for medical record review. We review three charts per care provider to determine compliance with medical record documentation standards. If you receive a score below 85% on your chart audit, we review five more charts to help ensure an accurate chart sample was examined. If you still score below 85%, you will be re-audited in six months. If the re-audit does not receive a passing score, we may require education and counseling, further audits, and recommendation for termination of contract for non-compliance with Medical Record Documentation Standards.

Documentation guidelines can be found at UHCprovider.com/IAProvder > Provider Forms and Reference Guides.

To achieve this score, the medical records should include:

- An initial health assessment (with a baseline medical history, with ongoing physical assessments) within two visits.
- Problem list with:
  - Biographical data with family history.
  - Past and present medical and surgical intervention.
  - Significant illnesses and 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).
- Past medical history. This should include serious illnesses, injuries and operations (for members seen three or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record.
- Tobacco habits, alcohol use and substance abuse (11 years and older).
- Document if adult members have executed an advance directive. Also note whether information about advance directives has been given to members without 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.
- Each encounter must include a note indicating when a return date is recommended and/or other necessary follow-up.
- Consultations, lab, imaging and special studies initiated by PCP to indicate review.
- Consultation and abnormal studies including follow-up plans.

For a list of these medical record documentation standards, please see UHCprovider.com/IAProvder > Provider Forms and Reference Guides.
Member hospitalization records should include, as appropriate:

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

**ANCILLARY MEDICAL RECORDS**

As an ancillary provider, you may undergo periodic medical record review. This may happen whether you are clinical or non-clinical. Ancillary service records include but are not limited to DME, physical, occupational, speech therapy and HCBS providers.

All ancillary service providers must also follow UnitedHealthcare Community Plan’s documentation standards. These can be found at UHCprovider.com/IAprovider > Provider Forms and Reference Guides.

**CHARTING STANDARDS FOR ANCILLARY MEDICAL RECORDS**

As noted in chapter 3, UnitedHealthcare Community Plan of Iowa follows the service documentation guidelines as defined in the Iowa DHS HCBS Provider Manual. This helps ensure that member records follow established general documentation standards and measure performance on care dimensions and services delivered.
Chapter 10: Quality Management (QM) Program and Compliance Information

What is the Quality Improvement Program?

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

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

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

COOPERATION WITH QUALITY-IMPROVEMENT ACTIVITIES

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

- Providing requested timely medical records.
- Cooperation with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.
- Participation 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.
- Requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email, secure email or secure fax.
- Practitioner appointment access and availability surveys.

Care Provider Satisfaction

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

- Annual care provider satisfaction surveys.
- Regular visits.
- Town hall meetings.
Our chief concern with the survey is objectivity. That’s why UnitedHealthcare Community Plan engages independent market research firms to analyze and report findings.

Survey results are presented to the physician advisory committee. It compares the results year over year as well as to other UnitedHealthcare Community Plan plans across the country. The survey results include key strengths and improvement areas. Additionally, we carry out improvement plans as needed.

**Clinical Practice Guidelines**

We review and update our clinical practice guidelines annually to help you make clinical decisions and meet members’ needs. These guidelines describe a range of generally acceptable approaches to the diagnosis, management, and prevention of specific diseases or conditions. The guidelines define practices that meet the needs of most members in most circumstances.

Approved guidelines include, but are not limited to:
- Asthma
- Cardiovascular disease
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Major depression
- Perinatal care

A full list is on UHCprovider.com/IAprovider > Policies and Clinical Guidelines > Clinical Guidelines > View Clinical Practice Guidelines.

**Healthcare Effectiveness Data and Information Set (HEDIS®)**

HEDIS® is a tool United States’ health plans uses to measure performance on important care dimensions and service. This helps meet gaps in care to satisfy wellness criteria. For example, a member gap in care could be a postpartum visit that has not yet occurred. Plans collect data through claims and pharmacy utilization. Measures may change from year to year.

For more information, visit The National Committee for Quality Assurance (NCQA), which publishes HEDIS® at NCQA.org > HEDIS® Quality Measurement.

HEDIS® measures include:
- Adolescent well-care visits
- Adults’ access to preventive/ambulatory health services
- Antidepressant medication management
- Appropriate treatment for children with upper respiratory infection
- Asthma Medication Ratio (AMR)
- Childhood immunizations (We commit to the combo four series.)
- Children’s and adolescents’ access to PCPs
- Diabetes care
- Diabetes monitoring for people with diabetes and schizophrenia
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications
- Follow-up after hospitalization for mental illness
- Follow-up care for children prescribed ADHD medication
- Medication management for people with asthma
- Prenatal and postpartum care
- Well-child visits in the first 15 months of life
- Well-child visits in the third, fourth, fifth and sixth years of life

**Credentialing Standards**

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable Iowa statutes and the National Committee of Quality Assurance (NCQA). The following items are required to begin the credentialing process:
- A completed credentialing application, including Attestation Statement
- Current medical license
- Current Drug Enforcement Administration (DEA) certificate
- Current professional liability insurance
We verify information from primary sources regarding licensure, education and training. We also verify board certification and malpractice claims history.

**Credentialing and Recredentialing Process**

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

**CARE PROVIDERS SUBJECT TO CREDENTIALING AND RECREDENTIALING**

UnitedHealthcare Community Plan evaluates various health care practitioners, such as:

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

Excluded from this process are practitioners who:

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

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

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

First-time applicants may go to [UHCprovider.com](http://UHCprovider.com) for more information.

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

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

**ADVANCE DIRECTIVES**

As part of re-credentialing, we may audit records of PCPs, hospitals, home health agencies, personal care providers and hospices. This process helps us determine whether you are following policies and procedures related to advance directives. These policies include:

- Respecting members’ advance directives, and placing them prominently in medical records.
- Adhering to charting standards that reflect the member’s advance directives.

**Peer Review**

**CREDENTIALING PROCESS**

UnitedHealthcare Community Plan follows the care provider requirement guidelines defined in the Iowa Medicaid Provider Manual to credential nursing facility providers and care providers of HCBS services.

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.

During the initial credentialing process, we verify required documents. You must submit the certificate and/or licensures as applicable to the services you provide. We verify each license with its issuing licensing board. You will provide proof of general liability insurance that meets the minimum required amount Iowa sets as applicable to those services. You will also provide proof of malpractice insurance, as applicable, as state guidelines require.
If you are a HCBS provider, you do not have to keep malpractice insurance unless required per state care provider requirements or applicable care provider licensing requirements.

**RECREDENTIALING PROCESS**

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

If you do not meet our re-credentialing requirements, you will be terminated from our network. We will give you a written termination notice stating the reason for the termination, the effective date, and an explanation of appeal rights, if applicable.

**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. You may call the NCC to correct your information at any time. If the NCC finds erroneous information, a representative will contact you by fax or in writing. You must submit corrections within 30 days of notification by phone, fax or in writing to the number or address the NCC representative provided. You also have the right to receive the status of your credentialing or recredentialing application by calling the NCC (VETTS) number listed in How to Contact Us.

**CONFIDENTIALITY**

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

**Resolving Disputes**

**CONTRACT CONCERNS**

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

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

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

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

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

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

**Critical Incident Reporting**

Related to the state managed care contract and all applicable federal and state regulations, care providers and subcontractors must comply with critical incident reporting requirements. Report critical incidents for members receiving home- and community-based or
habilitation services based on UnitedHealthcare’s critical incident reporting process. See Provider Training for the detailed reporting process at UHCprovider.com/IAprovider > Provider Training > Critical Incident Reporting Process Training.

Any of the following may report critical incidents:

- Care providers
- Office staff
- Case managers
- Member/member representative
- UnitedHealthcare Community Plan employees
- State agency representative

Iowa defines critical incidents as major and minor. They apply to members enrolled in waiver services.

**MAJOR INCIDENT**

A major incident involves the following:

- A person’s death.
- A member’s emergency mental health treatment.
- Physical injury to or by the member that requires physician treatment or admission to a hospital.
- Law enforcement intervention.
- A report of child abuse pursuant to Iowa Code (section 232.69 for children, section 235B.3 for adults). These reports also need to be reported to the appropriate state reporting agency. For more information, see Abuse, Neglect and Exploitation: Recognition and Reporting Quick Reference Guide at UHCprovider.com/IAprovider > Provider Forms and Reference Guides.
- A prescription medication error or a pattern of medication errors that lead to any outcomes on this list.
- A care provider staff member assigned protective oversight not knowing a member’s location.

**MINOR INCIDENT**

A minor incident is not a major incident. It involves:

- The application of basic first aid.
- Bruising.
- Seizure activity.
- Injury to self, to others or to property.
- A prescription medication error.

**WHEN TO REPORT**

- Major incidents: report to UnitedHealthcare Community Plan by the end of the next calendar day from the date of the incident occurred or was discovered.
- Minor incidents: report (in any format the care provider designates) to the network care provider’s supervisor within 72 hours of the incident occurring or being discovered.

The Critical Incident Reporting Form (for reporting major incidents) is on UHCprovider.com/IAprovider > Provider Forms and Reference Guides.

**HIPAA Compliance — Your Responsibilities**

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**

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

**transactions and code sets**

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

**Unique Identifier**

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

**National Provider Identifier (NPI)**

The National Provider Identifier (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](http://cms.hhs.gov).

Ethics & Integrity

INTRODUCTION

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

COMPLIANCE PROGRAM

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

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

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

REPORTING AND AUDITING

Report any unethical, unlawful or inappropriate activity by a UnitedHealthcare Community Plan employee to a UnitedHealthcare Community Plan senior manager or directly to the Compliance Office.
UnitedHealthcare Community Plan’s Special Investigations Unit (SIU) is an important part of the Compliance program. The SIU focuses on prevention, detection and investigation of potentially fraudulent and abusive acts committed by care providers and members. This department oversees coordination of anti-fraud activities.

To facilitate the reporting process of questionable incidents involving members or care providers, call our Fraud and Abuse line.

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.

**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 Iowa 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 one year after the resolution of all issues that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your Provider Agreement.

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

You must cooperate with the state or any of its authorized representatives, the Iowa DHS, the Centers for Medicare & Medicaid Services, the Office of Inspector General, or any other agency prior-approved by the state, at any time during your Provider Agreement.

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

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

**DELEGATING AND SUBCONTRACTING**

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

**Office Site Quality**

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

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

**CRITERIA FOR SITE VISITS**

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

<table>
<thead>
<tr>
<th>QOS Issue</th>
<th>Criteria</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue may pose a substantive threat to patient’s safety</td>
<td>Access to facility in poor repair to pose a potential risk to patients, needles and other sharps exposed and accessible to patients, drug stocks accessible to patients, other issues determines to pose a risk to patient safety</td>
<td>One complaint</td>
</tr>
<tr>
<td>Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space</td>
<td>Access to facility in poor repair to pose a potential risk to patients, needles and other sharps exposed and accessible to patients, drug stocks accessible to patients, other issues determines to pose a risk to patient safety</td>
<td>Two complaints in six months</td>
</tr>
<tr>
<td>Other</td>
<td>All other complaints concerning the office facilities</td>
<td>Three complaints in six months</td>
</tr>
</tbody>
</table>
Chapter 11: Billing and Submission

Our Claims Process

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

UnitedHealthcare Community Plan follows the same claims process as UnitedHealthcare.

For a complete description of the process, go to UHCprovider.com/guides > View online version > Chapter 9 Our Claims Process.

Claims Billing Procedures

Submit claims (within 180 days of service) and register for electronic fund transfer payments and statements online at UHCprovider.com/claims. Use payer ID 87726.

CLAIMS PROCESSING TIME

Allow 30 days before asking about claims status. The standard turnaround time for clean claims is 30 calendar days, measured from date of receipt. The only exception is if it is otherwise specified in your Agreement.

National Provider Identifier

HIPAA requires you have a unique National Provider Identifier (NPI). The NPI identifies you in all standard transactions.

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

Your clean claims must include your NPI and Federal Tax Identification Number. Also include the Unique Care Provider Identification Number (UPIN) laboratory claims.

If the state has not required a provider NPI, UnitedHealthcare Community Plan will treat those care providers as atypical. If you have an atypical state-assigned NPI (X NPI), leave the NPI fields blank when billing claims electronically.

General Billing Guidelines

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

Fee Schedule

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

Member ID Card for Billing

The member ID card includes the UnitedHealthcare Community Plan member ID assigned by Iowa Medicaid. Please bill with the member ID shown on the UnitedHealthcare Community Plan ID card.
Acceptable Claim Forms

We encourage you to submit claims electronically. However, you may submit paper claims for medical or hospital services using the standard CMS Form 1500, UB-04, 5010 format or respective electronic format. Send claims to:

UnitedHealthcare Community Plan
Attn: Claims
P.O. Box 5220
Kingston, NY 12402-5220


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 nurse practitioners or physician assistants who are part of a collaborative agreement.

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.

- OptumInsight can provide you with clearinghouse connectivity or your software vendor can connect through an entity that uses OptumInsight.
- Our payer ID is 87726.

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

For more information, contact EDI Claims. You can also see enshealth.com or contact Provider Services.

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 > Go to companion guides

Importance and Usage of EDI Acknowledgment/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.
Chapter 11: Billing and Submission

To get your reports, make sure your software vendor has connected to our clearinghouse OptumInsight at enshealth.com.

If you are not yet an OptumInsight client, we will tell you how to receive Clearinghouse Acknowledgment Reports.

e-Business Support

Using EDI for all eligible UnitedHealthcare Community Plan transactions can help your organization improve efficiency, reduce costs and increase cash flow. We encourage you to use the following tools and resources to help you get started with electronic transactions.

For EDI-related inquiries, call UnitedHealthcare EDI Support at 800-210-8315. Or email ac_edi_ops@uhc.com. They can help you with Electronic Remittance Advices (ERAs) and Electronic Funds Transfers (EFTs). To use ERAs, you must enroll through a clearinghouse or entity that uses OptumInsight.

Support is also available for EDI Claims and EDI Log-on Issues at UHCPROVIDER.COM > Resource Library > Electronic Data Interchange.

IMPORTANT EDI PAYER INFORMATION

- Claim Payer ID: 87726
- ERA Payer ID: UFNEP

Completing the CMS 1500 Claim Form

Companion documents for 837 transactions are on UHCPROVIDER.COM/EDI.

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

Completing the UB-04 Form

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

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

Form Reminders

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

Subrogation and Coordination of Benefit

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

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

THIRD-PARTY LIABILITY

If the service code billed is listed on the Medicare non-covered list, or the state’s third-party liability (TPL) policy is defined as Pay and Chase, you don’t need a remittance advice or other documentation from the primary insurance. If the code is not listed as such, either bill the primary carrier to get the primary carrier’s EOB/EOMB or get other documentation the state accepts for TPL.

THIRD-PARTY LIABILITY – BILLING OPTIONS

Applicable liable third parties include:

- Health insurance, including Medicare
- Worker’s compensation
- Homeowner’s insurance
- Automobile liability insurance
- Veteran’s aid and attendance
When a member has primary insurance, you must file TPL information:

- If the service code billed is not listed on the Medicare non-covered list or defined as Pay and Chase:
  - File to the primary insurance. Then submit the claim with the primary carrier EOB/EOMB information to UnitedHealthcare Community Plan or obtain other state-approved documentation in accordance with state policy.
- Bill TPL electronically through EDI and Clearinghouse Connections.
- You may also bill on paper (CMS-1500 or UB-04 form). When billing on paper, attach the primary insurance EOB/EOMB, remittance advice or other state-approved documentation to each claim.
- An occurrence code on the claim does not replace the primary carrier EOB/EOMB requirement.

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.

**Correct Coding Initiative**

The health plan performs coding edit procedures based on the Correct Coding Initiative (CCI) and other nationally recognized and validated sources.

The edits fall into one of two categories:

1. **Comprehensive and Component Codes**
   
   These edits apply when the code pairs in question appear to be inclusive of each other. This category of edits can be broken into subcategories that explain bundling in more detail.

   Some common causes for denials in this category include:

   - Separate procedures. Codes should only be reported separately when performed independently and not when they are an integral part of a more comprehensive procedure.
   - Most extensive procedures. Some procedures can be performed at different complexity levels. Only the most extensive service performed should be reported.

   - With/without services. Do not report code combinations where one code includes and the other excludes certain other services.

   - Standards of medical practice. Services and/or procedures that are integral to a more comprehensive procedure are bundled into the comprehensive procedure.

   - Laboratory panels. Individual components of panels or multichannel tests should not be reported separately.

   - Sequential procedures. When procedures are often performed in sequence, or when an approach is followed by a more invasive one during the same session, only report the procedure that achieves the expected result.

2. **Mutually Exclusive Codes**

   These edits apply to procedures unlikely or impossible to perform at the same time on the same patient, by the same physician. There is a significant difference in the processing of these edits versus the comprehensive and component code edits.

   CCI guidelines are available on paper and in software packages that will edit your claims before submission. Your CPT and ICD-10 vendor may offer a CCI manual. Many specialty organizations have their own publications that address CCI issues within the specialty. CMS’s authorized distributor of CCI information is the U.S. Department of Commerce’s National Technical Information Service (NTIS). Call 800-553-NTIS (6847) or visit [ntis.gov](http://ntis.gov).

**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](http://cms.gov).
Claim Filing Information for HCBS Care Providers

HCBS program codes and limits apply to all HCBS, including non-medical waiver transportation. Covered services, service definitions, units and benefit limitations are consistent with the Iowa DHS HCBS Provider Manual. Reference the IDHS HCBS manual for service definitions.

Use the CMS 1500 claim form, targeted medical claim form or an accepted electronic equivalent when requesting payment for HCBS services. Claims may be received through your EDI vendor and communicated through the OptumInsight clearinghouse (formerly Ingenix) using payer ID 87726. Paper claims may be submitted to the following address.

UnitedHealthcare Community Plan
P.O. Box 5220
Kingston, NY 12402-5220

You may also submit claims on UHCprovider.com.

Date Span Billing (HCBS Providers Only)

You may bill for date spans for codes whose descriptions say per month, per hour or per 15 minutes. Bill codes whose descriptions say per day based on the From-To-Date Reimbursement Policy. The number of units submitted should be equally divisible by the number of days indicated in the from and to dates reported. Read the From-To-Date Policy on UHCprovider.com > Policies and Protocols > Community Plan Policies

- You cannot overlap billed date spans, otherwise the claims may experience possible duplication edits and/or other claim errors.

UnitedHealthcare Community Plan may split an authorization for the month due to a unit limitation in our system. In that case, bill date spans consistent with the authorization date spans.

- You will experience claim payment issues if billing for services across multiple authorization date spans.

Claim Filing Information for Nursing Facilities and ICF/ID

Nursing facilities (NFs) and ICF/ID should use the UB-04 claim form or accepted electronic equivalent when requesting payment for NF services. Submit claims through your EDI vendor and OptumInsight clearinghouse using payer ID 87726. Send paper claims to:

UnitedHealthcare Community Plan
P.O. Box 5220
Kingston, NY 12402-5220

The care coordinator assigned to the facility will validate those members eligible for long-term care (custodial) services with facility staff upon member enrollment. They will confirm the ongoing MCO census quarterly at a minimum. Long-term care (custodial) members residing in NFs will NOT require prior authorization of the custodial stay. NFs do not need to submit any prior authorization information when submitting claims. Services or supplies included in the per diem rate (e.g., oxygen) do NOT require separate prior authorization.

REVENUE CODES

Daily Nursing Facility Care
100, 110, 119, 120, 129 and value code 80, 81.

Ventilator Incentive
100, 110, 119, 120, 129 and value codes 80, 81 along with ICD-10 diagnosis code J95.850, J95.851, J95.859, Z99.11 and Z99.12

Bed Hold Days
183, 185, 189 and value codes 80, 81.

- Bed hold days are only reimbursable for special population facilities

NURSING FACILITY BILL TYPES

Enter the three-digit number specific to the type of claim

1st digit:
2 – Skilled nursing

2nd digit:
If the 1st digit is a 2, the second digit is:
1 – Inpatient
3rd digit:
0 – Nonpayment/zero claim
1 – Admit through discharge claim
2 – Interim – first claim
3 – Interim – continuing claim
4 – Interim – last claim through date to discharge date
7 – Replacement of a prior claim
8 – Void/cancel of a prior claim

Swing-Bed Facility Bill Types
Enter the three-digit number specific to the type of claim

1st digit:
2 – Skilled nursing

2nd digit:
If the 1st digit is a 2, the second digit is:
8 – Swing bed inpatient

3rd digit:
0 – Nonpayment/zero claim
1 – Admit through discharge claim
2 – Interim – first claim
3 – Interim – continuing claim
4 – Interim – last claim through date to discharge date
7 – Replacement of a prior claim
8 – Void/cancel of a prior claim

ICF/ID FACILITY BILL TYPES
Enter the three-digit number specific to the type of claim.

1st digit:
6 – Intermediate care

2nd digit:
5 – Level 1
6 – Level 2

3rd digit:
0 – Nonpayment/zero claim
1 – Admit through discharge claim
2 – Interim – first claim
3 – Interim – continuing claim
4 – Interim – last claim through date to discharge date
7 – Replacement of a prior claim
8 – Void/cancel of a prior claim

FROM AND THROUGH SERVICE DATES BILL BOTH HEADER AND DETAIL
Box 6 of the UB “Statement covers period” from and through dates must equal to the room and board units billed in Box 46. For example, if billing for 30 units in April, the Statement Covers Period must be April 1 to April 30. For those uploading through a billing software, the statement covers from and through date maps to the EDI837I Loop 2300 DTP * 434 * RD8 segment which covers a date range.

Box 45 must be completed if two or more line items are billed on the claim form.

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.
Chapter 11: Billing and Submission

Asking About a Claim

You can ask about claims through UnitedHealthcare Community Plan Provider Service 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 30 days to solve your concern.

UNITEDHEALTHCARE COMMUNITY PLAN PROVIDER PORTAL

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

LINK: YOUR GATEWAY TO UNITEDHEALTHCARE COMMUNITY PLAN ONLINE PROVIDER TOOLS AND RESOURCES

Link lets you move quickly between applications. This helps you:

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

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

Find Link training on UHCprovider.com.

Resolving Claim Issues

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

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 5220
Kingston, NY 12402-5240

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

TIMELY FILING

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

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

If a claim is denied, and corrections are not received within 365 days from date of service or close of business from the primary carrier, the claim is considered late billed. It will be denied timely filing. A rejected claim isn’t the same as a denied claim. A rejected claim hasn’t been accepted and doesn’t enter our claim payment system. Resubmit rejected claims within the 180-day timely filing period if needed.

Timely filing is 180 days from the date of service, unless otherwise stated in your provider Agreement.

Balance Billing

Do not balance bill members if:

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

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

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible members. Therefore, you must bill and obtain an explanation of benefits (EOB) from any other insurance or health care coverage resource before billing UnitedHealthcare Community Plan, as required by contract. Refer to your Agreement for third-party claim submission deadlines. Once you bill the other carrier and receive an EOB, submit the claim to UnitedHealthcare Community Plan. Complete the EOB to understand the paid amount or denial reason.
Chapter 12: Claim Reconsiderations, Appeals and Grievances

There are a number of 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.

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

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

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<tr>
<th>SITUATION</th>
<th>DEFINITION</th>
<th>WHO MAY SUBMIT?</th>
<th>SUBMISSION ADDRESS</th>
<th>ONLINE FORM FOR FAX OR MAIL</th>
<th>CONTACT PHONE NUMBER/FAX</th>
<th>WEBSITE (Care Providers Only) for Online Submissions</th>
<th>CARE PROVIDER FILING TIMEFRAME</th>
<th>UnitedHealthcare Community Plan RESPONSE TIMEFRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Claim Reconsideration</td>
<td>Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.</td>
<td>Provider</td>
<td>UnitedHealthcare Community Plan P.O. Box 5220 Kingston, NY 12402-5220</td>
<td>UHCprovider.com</td>
<td>888-650-3462</td>
<td>Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link</td>
<td>Submit within 12 months from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA), not to exceed two years from the date of service (DOS)</td>
<td>30 business days</td>
</tr>
<tr>
<td>Provider Claim Appeal</td>
<td>The second step following a claim reconsideration.</td>
<td>Provider</td>
<td>UnitedHealthcare Community Plan Attn: Grievance and Appeals Dept. P.O. Box 31364 Salt Lake City, UT 84131-0364</td>
<td>UHCprovider.com</td>
<td>Fax: 801-994-1082</td>
<td>Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link</td>
<td>Submit within 12 months from the date of the EOB or PRA not to exceed two years from the DOS.</td>
<td>60 calendar days</td>
</tr>
</tbody>
</table>
## APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>DEFINITION</th>
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<th>UNITEDHEALTHCARE COMMUNITY PLAN RESPONSE TIMEFRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
<td>Grievance An expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.</td>
<td>• Member&lt;br&gt;• Member’s authorized representative (such as friend or family member) with written member consent&lt;br&gt;• Care provider on behalf of a member with member’s written consent*</td>
<td>UnitedHealthcare Community Plan Grievance and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364</td>
<td>UHCprovider.com</td>
<td>Member Services: 800-464-9484 Fax: 801-994-1082</td>
<td>Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link.</td>
<td>Any time</td>
<td>30 calendar days of receipt of the grievance but may be extended up to 14 calendar days. Expedited grievance: 72 hours but may be extended up to 14 calendar days.</td>
</tr>
</tbody>
</table>

| Member          | Appeal A request to change an adverse benefit determination that we made. | • Member<br>• Member’s authorized representative (such as friend or family member) with written member consent<br>• Care provider on behalf of a member with member’s written consent* | UnitedHealthcare Community Plan Grievance and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364                                                                                                            | UHCprovider.com             | Member Services: 800-464-9484 Fax: 801-994-1082 | Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link. | All Appeals – 60 days from the date on the notice of Action | All appeals: 30 calendar days of receiving the appeal but may be extended up to 14 calendar days. Expedited appeals: 72 hours but may be extended up to 14 calendar days. |

*You must obtain a signed Authorized Representative for Managed Care Appeals form from the member to establish consent. Find this form on [dhs.iowa.gov](http://dhs.iowa.gov).
### APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

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<th>CARE PROVIDER FILING TIMEFRAME</th>
<th>UnitedHealthcare Community Plan RESPONSE TIMEFRAME</th>
</tr>
</thead>
</table>
| State Fair Hearing | An opportunity to share why members think the Iowa Medicaid services should not have been denied, reduced or ended. | • Member  
• Member’s authorized representative (such as friend or family member) with written member consent  
• Care provider on behalf of a member with member’s written consent* | Iowa: DHS Appeals: 515-281-3094  
Department of Human Services Appeals Section, 5th Floor  
1305 E. Walnut Street  
Des Moines, IA 50319-0114 | [UHC provider.com](http://uhcprovider.com) | [Care provider.com](http://careprovider.com) | | 120 calendar days to file request from the date on the notice of UnitedHealthcare Community Plan's appeal decision. | |

*You must obtain a signed Authorized Representative for Managed Care Appeals form from the member to establish consent. This form is on [dhs.iowa.gov](http://dhs.iowa.gov).*
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. The top reasons for claim denial are as follows.

**Medical necessity** – When the level of care billed wasn’t approved as medically necessary.

**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.** Practices should 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 some 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 when your originally submitted claim needs updated information to process. Examples of information that you can update include:

- Number of units for a service
- Dates of service
- Procedure code, modifier or diagnosis code.

**How to use:**

Use the claims reconsideration application on Link. To access Link, sign in to [UHCprovider.com](http://UHCprovider.com) using your Optum 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 5220  
Kingston, NY 12402-5240

**Additional Information:**

When correcting or submitting late charges on 837 institution claims, use bill type xx7: Replacement of Prior Claim or bill type xx8: Void/Cancel of Prior Claim. Do not submit corrected or additional information charges using bill type xx5: Late Charge Claim. For professional claims, use frequency code 7: Replacement of Prior Claim or frequency code 8: Void/Cancel of Prior Claim.

A rejected claim isn’t the same as a denied claim. A denied claim has been accepted by UnitedHealthcare Community Plan and processed. A rejected claim hasn’t been accepted and doesn’t enter our claim payment system. Please don’t resubmit rejected claims as a corrected claim.
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. A rejected claim is one that has not been processed due to problems detected before claim processing. 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. If a claim is rejected, and the health plan does not receive corrections within 180 days from the date of service or EOB from primary carrier, the claim will be considered late billed and denied. To mail your resubmission, provide all claim information to:

UnitedHealthcare Community Plan
P.O. Box 5220
Kingston, NY 12402-5240

Warning! If your claim was denied and you resubmit it, you will receive a duplicate claim rejection. A denied claim has been through claim processing and we determined it cannot be paid. You may appeal a denied claim by submitting the corrected claim information or appealing the decision. See Claim Correction and Reconsideration sections of this chapter for more information.

Claim Reconsideration

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 to use:
Submit a claim reconsideration when you think a claim has not been properly processed. Submit within 12 months from the date of the EOB or Provider Remittance Advice (PRA) not to exceed two years from the DOS.

For administrative denials:
- In your reconsideration request, please ask for a medical necessity review and include all relevant medical records in addition to the expected results of the reconsideration request.

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

How to use:
If you disagree with a claim determination, submit a claim reconsideration request electronically, by phone, mail or fax:
- Electronically: Use the Claim Reconsideration application on Link. Include electronic attachments. You may also check your status using Link.
- Phone: Call Provider Services at 888-650-3462 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 5220
Kingston, NY 12402-5240

This form is available at UHCprovider.com.
Valid Proof of Timely Filing Documentation (Reconsideration)

What is it?
If a claim payment is denied for lack of notification or for untimely filing, the denial will be reversed if you appeal within 12 months after the date of denial. You must show all the following:

- At the time the protocols required notification or at the time the claim was due, you didn’t know and were unable to reasonably determine if the patient is a member.
- You took reasonable steps to learn that the patient is a customer.
- You promptly provided notification or filed the claim after learning that the patient is a member.

Other examples of proof of timely filing include:

- 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, mail or fax with the following information:

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

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

Overpayment

What is it?
An overpayment happens when we overpay a claim.

How to use:
If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your contract.

If 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 Return Overpayment through the Adjustment Request form.

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

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

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

UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0800
Instructions and forms are on UHCprovider.com.

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 PRA. When additional information is needed, we will ask you to provide it.

**Claim Appeal**

**What is it?**

A review of a claim when you do not agree with a reconsideration. It is the second step following a claim reconsideration.

**When to use:**

Submit a dispute to challenge a decision or request an exception. You must submit within 12 months from the date of the EOB or PRA not to exceed two years from the date of service (DOS).

**How to use:**

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

- **Electronic claims:** Use the Claims Management or ClaimsLink application on Link. You may upload attachments.
- **Mail:** Send the appeal to:
  
  UnitedHealthcare Community Plan
  Grievances and Appeals
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

- **Fax:** Send the appeal to 801-994-1082.

**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. If you have questions, call Provider Services.
- 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.

**Member Appeals and Grievances Definitions and Procedures**

UnitedHealthcare Community Plan uses the Centers for Medicare and Medicaid Services (CMS) definitions for appeals and grievances.

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

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

**What is it?**
An expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.

**How to use:**
You may file a grievance as the member’s representative with their written consent. You must obtain a signed Authorized Representative for Managed Care Appeals form from the member to establish consent. This form is on [dhs.iowa.gov](http://dhs.iowa.gov).

**Where to send:**
You or the member may file a grievance by calling Member Services or writing UnitedHealthcare Community Plan. Mail to:

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

We will send an answer within 30 calendar days of receipt. We must resolve an expedited grievance within 72 hours.

We may extend the response up to 14 calendar days if the following conditions apply:
1. Member requests the extension.
2. We request more information and explain the delay is in the member’s interest.

**Member Appeals**

**What is it?**
A request to change an adverse benefit determination.

**When to use:**
You or a member may appeal when the plan:
- Limits or denies a requested service. This includes the type or level of service.
- 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.

You may act on the member’s behalf with their written consent. You may provide medical records and supporting documentation as appropriate. You must obtain a signed Authorized Representative for Managed Care Appeals form from the member to establish consent. This form is on [dhs.iowa.gov](http://dhs.iowa.gov).

**Where to send:**
Call Member Services or mail the information within 60 days from the date on the notice of an adverse benefit determination. Mail to:

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

**How to use:**
Whenever a service is denied, provide the member with UnitedHealthcare Community Plan appeal rights. The member has the right to:
- Receive a copy of the rule used to make the decision.
- Ask someone to help. This may be a family member, friend, lawyer, or health care provider. The member may present evidence and allegations of fact or law in person and in writing.
- The member or representative may review the case file before and during the appeal process. The file includes medical records.
- 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. Provider certification is a written confirmation from you that the expedited request is urgent.
- A member may 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.
- We must resolve a standard appeal 30 calendar days from the day we receive it and an expedited appeal 72 hours from when we receive it.

We may extend the response up to 14 calendar days if the following conditions apply:
1. Member requests the extension.
2. We request more information and explain the delay is in the member’s interest.
State Fair Hearings

What is it?
An opportunity to share why the member thinks the Iowa Medicaid services should not have been denied, reduced or ended.

When to use:
Before requesting a state fair hearing, you must exhaust the UnitedHealthcare appeal process. Members have 120 calendar days to file request from the date on the notice of UnitedHealthcare Community Plan’s appeal decision to ask for a hearing.

Where to send:
To file in writing, either:
- Complete the Appeal and Request for Hearing form electronically at dhs.iowa.gov.
- Write a letter telling DHS why you think a decision is wrong and whether you would like benefits to continue during the state fair hearing.

Mail, fax or take your request to:

Department of Human Services
Appeals Section, 5th Floor
1305 E. Walnut Street
Des Moines, IA 50319-0114
Fax: 515-564-4044

How to use:
- The member may contact the DHS Appeals Section at 515-281-3094 if they want to file a request by phone or need help writing or filing the letter.
- If you’re given a state fair hearing, the member will receive a written notice with the date and time of the hearing.
- Members may present evidence and legal documents at the hearing.
- The member may have someone attend with them. This may be a family member, friend, care provider or lawyer. If the member has a lawyer, write the lawyer’s name on the Appeal and Request for Hearing form. Or call the Appeals Section at 515-281-3094.
- If the state fair hearing reverses a decision to deny, limit, or delay services not provided while the appeal was pending, we authorize or provide the disputed services as quickly as the member’s health condition requires.

• If the decision reverses denied authorization of services, and the disputed services were received pending appeal, we pay for those services as specified in policy and/or regulation.

Fraud, Waste and Abuse

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

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.

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](#)

**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 & Outreach

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

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

Care Provider Websites

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

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

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

- Provider service updates – new tools and initiatives (UHC on Air, PreCheck MyScript, etc.)

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 > Menu > Resource Library > More Resource Topics > Training.

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 Bulletins

UnitedHealthcare Community Plan produces a care provider newsletter to the entire Iowa network at least three times a year. These include the Network Bulletin and Practice Matters. 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

The newsletters also include notifications about changes in laws and regulations. UnitedHealthcare Community Plan posts electronic bulletins on UHCprovider.com, Click Menu, then Resource Library, News to quickly share urgent information that affects the entire network.


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

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

Acute Inpatient Care
Care provided to members sufficiently ill or disabled requiring:
• Constant availability of medical supervision by attending care provider or other medical staff
• Constant availability of licensed nursing personnel
• Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

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

Adverse Benefit Determination
The denial or limited authorization of a requested service, including the type, level or care provider of service; reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

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
Care providers who offer health care services that support the work of a Primary Care Provider (PCP). These services include freestanding radiology and clinical labs, home health, hospice, dialysis, durable medical equipment (DME), infusion care, therapy, ambulatory surgery centers, freestanding sleep centers and other non-care providers.

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.

Case Manager
The individual responsible for coordinating the overall service plan for a member in conjunction with the member, the member’s representative and the member’s PCP.

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

Children’s Health Insurance Plan (CHIP)
A federal- and state-funded health insurance program authorized by Title XXI of the Social Security Administration (SSA) and administered by the Iowa Department of Health Services.
Claim
A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04, or successor, submitted electronically or by mail.

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

Community-Based Case Manager
An individual who helps manage resources effectively and ensure a member’s health, safety, and welfare are met. They help members access appropriate resources.

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

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

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

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

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
A disagreement involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

Dual Coverage
When a member is enrolled with two UnitedHealthcare plans at the same time.

Dual Eligible
When a member has Medicare as the other insurance that is primary to Medicaid.

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

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

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

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

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

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

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

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

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

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

Expedited Appeal
An oral or written request by a member or member’s representative received by UnitedHealthcare Community Plan requesting a faster reconsideration of an action. This speed is necessary when taking the time for a standard resolution could seriously jeopardize the member’s life, health or ability to attain, maintain or regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

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.

Federal Qualified Health Centers (FQHC)
Facilities that primarily provide services typically furnished in an outpatient clinic. FQHCs include community health centers, migrant health centers, health care for the homeless health centers, public housing primary care centers, and health center program “look-alikes.” They also include outpatient health programs or facilities operated by a tribe or tribal organization or by an urban Indian organization.

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

Grievance
An oral or written complaint a member or their representative has and communicates to UnitedHealthcare Community Plan.

Hawki Program
Healthy and Well Kids in Iowa, the Iowa program to provide health care coverage for uninsured children of eligible families as authorized by Title XXI of the federal Social Security Act.

Healthcare Common Procedure Coding System (HCPCS)
A set of health care procedure codes based on the American Medical Association’s CPT code.

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.

**Interdisciplinary Care Team (ICT)**
Medical/professional staff, friends, neighbors, family members, etc. that participate in the development of an individual’s care plan. The ICT assists the individual in identifying and accessing a personalized mix of paid and nonpaid services and supports that will help the member achieve personally-defined outcomes in the most inclusive community setting.

**Long Term Care (LTC) or Long Term Services and Supports (LTSS)**
The services of a nursing facility (NF), an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/ID), State Resource Centers or services funded through 1915(c) home and community based services waivers.

**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 serious 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**
Health care services or supplies that:
- Are appropriate and necessary to diagnose or treat the member’s symptoms.
- Help the member make reasonable progress with their treatment.
- Are within professional practice standards and are given at the right time in the most appropriate setting.
- Are not used primarily for the member’s, physician’s or other care provider’s convenience.
- Deliver the most appropriate level of covered services that can safely be provided.

**Medicare**
The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the SSA.
Medicare has two parts:
- Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- Part B is the supplementary medical insurance benefit (SM B) covering the Medicare provider’s services, outpatient hospital care, outpatient physical therapy and speech pathology services, home healthcare, and other health services and supplies not covered under Part A of Medicare.

**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.

**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.

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.

Women’s Health Care Services
Include but are not limited to maternity care, reproductive health services, gynecological care, general examination, preventive care as medically appropriate, and medically appropriate follow-up visits for these services. General examinations, preventive care, and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations. Women’s health care services also include any appropriate healthcare service for other health problems, discovered and treated during the course of a visit to a women’s healthcare practitioner for a women’s healthcare service, which is within the practitioner’s scope of practice. For purposes of determining a woman’s right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and pregnancy complications.