2024
Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Indiana PathWays for Aging

Doc#: PMG-20231006-155432

United Healthcare Community Plan

Welcome

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

Click to access different manuals

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

Easily find information in this manual using the following steps

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

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

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

Using this manual

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

This manual will be amended as policies change.

Participation Agreement

Terms and definitions as used in this manual:

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

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

Table of Contents

Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com**	**1-877-610-9785**
Training	**UHCprovider.com/training**	**1-877-610-9785**
Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID. Or go to Provider Portal Self Service: **UHCprovider.com/en/resource-library/provider-portal-resources.html** New users: UHCprovider.com > **New User and User Access**	**1-877-610-9785**
CommunityCare Provider Portal training	**CommunityCare Provider Portal User Guide**	
One Healthcare ID support (formally known as Optum support)	**ProviderTechSupport@uhc.com**	**1-855-819-5909**
Resource library	UHCprovider.com > Resources > **Resource Library**	

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the “what can we help you find?” search bar

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

- Individuals who are 60 years of age and older
- Individuals who are eligible for Medicaid based on age, blindness or disability
- Individuals who have limited income and resources
- Individuals who may be full-benefit dually eligible
- and Individuals in a nursing facility, and those who are receiving long-term services and supports (LTSS) in a home or community-based setting.

The state of Indiana will determine enrollment eligibility.

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com**, or call Provider Services at **1-877-610-9785**

How to join our network

You need to be enrolled in Indiana Medicaid before joining our network. Complete the Indiana Medicaid enrollment and credentialing forms at **in.gov/medicaid**.

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

Already in network and need to make a change?

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

Approach to health care

Care model/care coordination

The UnitedHealthcare care model serves to optimize the health and well-being of members with complex physical, behavioral and functionally limiting conditions that put them at risk for adverse health outcomes. We employ an integrated care model that is person-centered and facilitates collaboration between our members and their health care teams. These programs focus on improving members' active decision-making, providing strong care and service coordination, and encouraging member participation in social determinants of health (SDOH) interventions personalized to their risks and conditions. All members will receive a care coordinator. Members who are nursing facility level of care will receive a care coordinator and service coordinator to assist their integrated care team to provide a seamless member experience.

Care model provides a team that helps increase member engagement, offers resources to fill gaps in care, and develops personalized health goals and service planning 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. The care coordination program provides:

- Medical, behavioral and social care management using community resources
- An extended care team, including a primary medical provider (PMP), pharmacist, medical and behavioral director, and peer specialist
- Options that engage members, connecting them to needed resources, care and services
- Individualized and multidisciplinary care plans
- Assistance making and coordinating appointments
- Education and support with complex conditions
- Tools for helping members engage with care providers, such as appointment reminders and help with transportation
- Foundation to build trust and relationships with hard-to-engage members

The program goals are to:

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

To refer a UnitedHealthcare Community Plan member to the care coordination program, call Member Services at **1-800-832-4643, (**TTY **711)**
You may also call **Provider Services** at: **1-877-610-9785**

Compliance

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

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. The program breaks down linguistic and cultural barriers that can harm health care participation. You must support UnitedHealthcare Community Plan's Cultural Competency Program. For more information, go to UHCprovider.com > Resources > Resource Library > Patient Health and Safety > **Cultural Competency**.

UnitedHealthcare Community Plan offers the following support services:

- **Language interpretation line**
  We provide members with oral interpreter services 24 hours a day, 7 days a week. More than 240 nonEnglish languages and hearing-impaired services are available. If a UnitedHealthcare Community Plan member needs interpreter services, they can call the phone number on their ID card.
  - To reach a professional interpreter during regular business hours, call Provider Services at **1-877-610-9785.** After hours, call Language Line Solutions at **1-877-261-6608**
  - Enter the client ID 209677 (do not hit #). Press 1 for Spanish and 2 for all other languages
- **Materials for limited English-speaking members**
  We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.
- **Indian/Tribal providers,** essential provider type.

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

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual for medical care determinations.

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster.

Learn the differences by viewing our Provider Portal digital guide at UHCprovider.com > Resources > the UnitedHealthcare Provider Portal Resources > **The UnitedHealthcare Provider Portal digital guide**.
Care providers in the UnitedHealthcare network will conduct business with us electronically. This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents. This includes appeals prior authorization requests and decisions. Using electronic transactions is fast, efficient and supports a paperless work environment. Use Application Programming Interface (API), electronic data interchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

Application Programming Interface

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

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

Electronic data interchange

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

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

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

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

Getting started

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

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

Point of Care Assist™

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

UHCprovider.com

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

UnitedHealthcare Provider Portal

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

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

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

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

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

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

- **Specialty pharmacy transactions**
  Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to **UHCprovider.com/pharmacy** for more information.
- **My Practice Profile**
  View and update your provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.
- **Document Library**
  Access reports and claim letters for viewing, printing, or download. For more information, go to **UHCprovider.com/documentlibrary**.

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

Chat support now available

Have a question? Skip the phone and chat with a live service advocate when you sign in to the UnitedHealthcare Provider Portal at **UHCprovider.com**.

Available 7 a.m. -7 p.m. CT, Monday through Friday, Chat support can help with claims, prior authorizations, credentialing and member benefits.

Direct Connect

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

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

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

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

Individual Health Record

The Individual Health Record (IHR) is a digital tool that helps create a more complete picture of a member's health. This supports collaboration between you and other care providers the member visits. The IHR includes each member's care history, including lab results and prescribed medications.

PMPs and behavioral health providers are encouraged to review the IHR for your members at least each quarter. Find out more at **UHCprovider.com/ihr**.

Privileges

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

Provider Services

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

Provider Services can answer your questions about Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more

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

How to contact us

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

Topic	Contact	Information
Behavioral, mental health and substance abuse	Optum **providerexpress.com** **1-800-610-9785**	• Review eligibility, claims, benefits, authorization and appeals • Refer members for behavioral health services. A PMP referral is not required
Benefits	**UHCprovider.com/benefits** **1-877-610-9785** **in.gov/Medicaid**	• Confirm a member's benefits and/or prior authorization
Cardiology prior authorization	**UHCprovider.com/cardiology** **1-877-610-9785**	• Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information
Care Model (care management/ disease management)	**IN_CareManagement@uhc.com** **1-877-610-9785**	• Refer high-risk members (e.g. asthma, diabetes, obesity) and members who need private-duty nursing
Chiropractor care	**myoptumhealthphysicalhealth.com** **1-800-873-4575**	• We provide members older than 21 with up to 6 visits per calendar • year with an in-network chiropractor. • This benefit does not need prior authorization
Claims	**UHCprovider.com/claims** **1-877-610-9785** Mailing address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 1355 S 4700 West, Suite 100 Salt Lake City, UT 84104	• Verify a claim status or get information about proper completion or submission of claims

Topic	Contact	Information
Claim overpayments	Sign in to **UHCprovider.com/claims** to access the Provider Portal **1-877-610-9785** Mailing address: **UnitedHealthcare Community Plan** **ATTN: Recovery Services** P.O. Box 740804 Atlanta, GA 30374-0800	• Ask about claim overpayments • See the **Overpayment section** for requirements before sending your request
Dental services	**uhcdentalproviders.com** **1-844-402-9118**	• Call for details about dental eligibility, benefits, authorizations, claims or other key information
Electronic data intake claim issues	**UHCprovider.com/edi** **1-800-842-1109**	• Ask about EDI claims issues or questions
Electronic data intake log-on issues	**ac_edi_ops@uhc.com** **1-800-210-8315**	• Ask about log-on issues
Eligibility	**UHCprovider.com/eligibility** **1-877-610-9785**	• Confirm member eligibility
Enterprise Voice Portal	**1-877-842-3210**	• The Enterprise Voice Portal provides self-service functionality or call to speak with a contact center agent
Fraud, waste and abuse (payment integrity)	Payment Integrity Information: UHCprovider.com/INcommunityplan > **Integrity of Claims, Reports, and Representations to the Government** Reporting: **uhc.com/fraud** **1-800-455-4521 (NAVEX)** or **1-877-401-9430**	• Learn about our payment integrity policies • Report suspected FWA by a care provider or member by phone or online
Hearing services	**UHChearing.com** **1-877-610-9785**	• The Indiana Health Coverage Programs (IHCP) provides coverage of hearing services for eligible members • UnitedHealthcare Hearing is one provider option offered through Medicaid

Topic	Contact	Information
Laboratory services	UHCprovider.com > Our Network **Preferred Lab Network** LabCorp 1-800-833-3984 Quest Diagnostics 1-866-697-8378	• LabCorp and/or Quest Diagnostics are network laboratories
Medicaid (Indiana Family and Social Services Administration)	**Indiana Office of Medicaid Policy and Planning** **in.gov/medicaid** 1-800-403-0864	• Contact Indiana Medicaid directly
Medical claim, reconsideration and appeal	**UHCprovider.com/claims** **1-877-610-9785** Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240 Appeals mailing address: **UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131-0364	• Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with
Member Services	**myuhc.com** **1-800-832-4643, (**TTY **711**) for help accessing member account	• Helps assist members with issues or concerns • Available 7 a.m.–7 p.m. CT, Monday through Friday
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	**1-800-832-4643 (members)** **1-877-610-9785 (providers)** (TDD **711**)	• Available 8 a.m.–5 p.m. CT, Monday through Friday, except state- designated holidays
National Plan and Provider Enumeration System (NPPES)	**nppes.cms.hhs.gov** 1-800-465-3203	• Apply for a National Provider Identifier (NPI)
Network management	**in_nm_team@uhc.com**	• A team of provider relation advocates. • Ask about contracting and care provider services
Network management resource team (NMRT)	**Networkhelp@uhc.com** **1-877-842-3210**	• Self-service functionality for medical network care providers to update or check credentialing information
NurseLine	**1-866-801-4407**, (TTY **711**)	• Available 24 hours a day, 7 days a week

Topic	Contact	Information
Obstetrics/pregnancy and baby care	Notification of Pregnancy on the Indiana Provider Healthcare Portal: **portal.indianamedicaid.com** Healthy First Steps Pregnancy Notification Form at **UHCprovider.com**, then Sign In for the Provider Portal. **1-800-599-5985** Healthy First Steps Rewards **uhchealthyfirststeps.com**	• Submit the Notification of Pregnancy Form using the Indiana Healthcare Portal • For pregnant members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form • Refer members to **uhchealthyfirststeps.com** to sign up for Healthy First Steps Rewards
One Healthcare ID support center	**ProviderTechSupport@uhc.com** **1-855-819-5909**	• Contact if you have issues with your ID • Available 7 a.m.– 9 p.m. CT, Monday through Friday • 6 a.m.– 6 p.m. CT, Saturday • 9 a.m.– 6 p.m. CT, Sunday
Pharmacy services	**professionals.optumrx.com** **1-877-305-8952** (OptumRx)	• OptumRx oversees and manages our network pharmacies
Prior authorization/notification for pharmacy	UHCprovider.com > Prior Authorization > **Clinical Pharmacy and Specialty Drugs** **1-800-310-6826**	• Request authorization for medications as required • Use the Provider Portal to access the PreCheck MyScript tool • Request prior authorization, receive results and see which prescriptions require prior authorization or are not covered or preferred • Check coverage and price, including lower-cost alternatives
Prior authorization requests/ advanced and admission notification	To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N **UHCprovider.com/paan** Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications." Or call Provider Services at **1-877-610-9785**.	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required • Complete the notification or prior authorization process • Upload medical notes or attachments • Check request status Information and advance notification/ prior authorization lists: UHCprovider.com/INcommunityplan > **Prior Authorization and Notification**

Topic	Contact	Information
Provider Services	**UHCprovider.com/INcommunityplan** **1-877-610-9785**	• Available 8 a.m.– 6 p.m. ET, Monday through Friday.
Reimbursement policy	UHCprovider.com/INcommunityplan > Policies and Clinical Guidelines > **View Current Reimbursement Policies**	• Reimbursement policies that apply to UnitedHealthcare Community Plan members • Visit this site often to view reimbursement policy updates
Technical support	**UHCprovider.com/contact-us/technical-assistance** **ProviderTechSupport@uhc.com** **1-866-209-9320** for Optum support or **1-866-842-3278**, Option 1 for web support	• Call if you have issues logging in to the Provider Portal, you cannot submit a form, etc.
Tobacco cessation (Quit Now Indiana)	1-800-784-8669	• Refer members to Quit Now Indiana for tobacco and vaping cessation services
Transportation	Member Services **1-800-832-4643**	• Call Member Services to schedule transportation or for transportation assistance • To arrange nonemergent transportation, please call at least 48 hours in advance
Utilization management	Provider Services **1-877-610-9785**	• UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. • For UM policies and protocols, go to UHCprovider.com > Resources > **Health Plans, Policies, Protocols and Guides** • Request a copy of our UM guidelines or information about the program

Topic	Contact	Information
Vision services	MARCH Vision Care 1-844-486-2724 MARCH Vision Care Provider Reference Guide: Marchvisioncare.com/providerreferenceguides.aspx	• Contact MARCH® Vision Care's provider relations department for information on benefits, lab order submissions and demographic changes. This includes changes to addresses, phone numbers, office hours, network providers and federal tax identification numbers. • Attend a training session on eyeSynergy®. This web portal gives you 24/7 access to eligibility, benefit, claim and lab order information.
Website for Indiana Community Plan	UHCprovider.com/INcommunityplan	• Access your state-specific Community Plan information on this website

Frequently asked questions

Q: When did the UnitedHealthcare Community Plan Indiana PathWays for Aging program begin?

A: The UnitedHealthcare Community Plan program went live on July 1, 2024.

Q: What are the timely filing requirements?

A: Timely filing requirements are generally 90 days from the date of service. Non-network provider filing limit is 6 months from date of discharge or date of service.

Q: What is UnitedHealthcare PathWays for Aging time frame for processing a care provider's credentialing application?

A: The state of Indiana requires we credential providers within 30 days.

Q: Which member populations are included in the PathWays for Aging program?

A: PathWays covers a variety of individuals who are not eligible for Medicare, including those who:

- Are 60 years of age or older
- Are eligible for Medicaid based on age, blindness or disability
- Have limited income and resources
- May be full-benefit dually eligible

Q: Do I need to enroll with the state of Indiana to become a participating care provider?

A: If you are not an existing Medicaid provider in Indiana, you must enroll with the state of Indiana to provide services to Indiana PathWays to Aging members.

Q: How do care providers access the Provider Healthcare Portal?

A. Use the Provider Healthcare Portal, your online health care portal for eligibility access and other insurance information. The portal is an internet-based solution that offers you reliability, speed, ease of use and security.

It can help you with the following transactions:

- Completing care provider eligibility and enrollment applications
- Verifying member eligibility/identifying a member's plan, including whether the member is in the Right Choices Program
- Confirming any third-party liability (i.e., presence of other health insurance such as commercial or Medicare insurance)
- Managing your care provider profile

Reminder: You may also use the UnitedHealthcare Community Plan web portal for PathWays for Aging transactions, such as claims, remits, prior authorization, adjustments, etc.

See **Online Resources** in **Chapter 1** for more information.

To access the portal, go to **portal.indianamedicaid.com**.

Chapter 2: Care provider standards and policies

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	1-877-610-9785
General provider assistance		1-877-842-3210
Eligibility	UHCprovider.com/eligibility	1-877-610-9785
Provider Directory	UHCprovider.com > Our Network > Find a Provider	1-877-610-9785

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

General care provider responsibilities

Nondiscrimination

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

- Race
- Age
- Ethnicity
- Color
- National origin
- Sexual orientation
- Gender identity
- Genetic information
- Ability (including members with cognitive impairments)
- Visual impairment
- Hearing impairment and/or using sign language or an alternative mode of communication
- Income status
- Those with limited English proficiency

You may only direct the member to another care provider type if that illness or condition may be better treated by someone else.

Communication between care providers and members

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

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

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

Provide official notice

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

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

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

Transition member care following termination of your participation

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

Arrange substitute coverage

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

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

Administrative terminations for inactivity

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

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

Changing an existing TIN or adding a care provider

Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the address listed on the bottom of the form.

- Download the W-9 form at irs.gov > Forms & Instructions > **Form W-9**
- Download the **Care Provider Demographic Information Update Form** using the Provider Portal at **UHCprovider.com** > Sign In > My Practice Profile
- To update your information online, go to the Provider Portal at **UHCprovider.com** > Sign In > My Practice Profile
- To add a PMP, please complete the Indiana Health Coverage Programs (IHCP) MCE Practitioner Enrollment Form located at UHCprovider.com/INcommunityplan > **Provider Forms and References**

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

Updating your practice or facility information

You can update your practice information through the Provider Portal on **UHCprovider.com**. Go to **UHCprovider.com**, then Sign In > My Practice Profile. Or submit your change by:

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

After-hours care

Urgent care can provide quick after-hours treatment and is appropriate for infections, fever, and symptoms of cold or flu. If a member calls you after hours asking about urgent care, and you can't fit them in your schedule, refer them to an urgent care center. For a list of urgent care centers, contact Provider Services.

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

Participate in quality initiatives

You must help our quality assessment and improvement You must also follow our clinical guidelines, member safety (risk reduction) efforts and data confidentiality procedures. UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for diseases and conditions. This is determined by the state's government agencies and professional specialty societies. See **Chapter 10** for more details on the initiatives.

Provide access to your records

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Medical records shall be legible, signed (manually or electronically) and dated and maintained for at least 7 years as required by state and federal regulations.

Performance data

You must allow the plan to use care provider performance data

Comply with protocols

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

You may view protocols at UHCprovider.com > Resources > **Health Plans, Policies, Protocols and Guides**

Office hours

You must provide the same office hours of operation to UnitedHealthcare Community Plan members as those o 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. The safeguards include shredding information with PHI and all confidential conversations. All staff is trained on HIPAA and confidentiality requirements.

Follow medical record standards

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

Inform members of advance directives

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

Your Agreement

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

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

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

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

Appointment standards (Indiana access and availability standards)

Comply with the appointment availability standards shown in the following table.

Service type	Condition description	Time frame
Aftercare/follow-up	Aftercare appointment after hospital discharge	• Within 7 calendar days
	Outpatient in-person follow-up appointment after inpatient behavioral health hospitalization	• Within 7 calendar days
Consultative clinical and therapeutic services	For informal caregivers	• Within 60 business days from the time of the service order
Durable medical equipment	Excluding hearing aids, prosthetics and family planning supplies	• Within 30 business days from the time of the service order
	Highly specialized equipment and supplies	• Within 120 business days from the time of the service order
Emergency	A condition with acute symptoms the severity of could cause serious impairment of body or organ functions, in whole or in part Includes mental health or substance use disorder (SUD) crisis	• Immediately, upon presentation
Environmental accessibility adaptations	Includes home modifications	• Within 90 business days from the time of the service approval.
Routine care	Routine care with physical or behavioral symptoms. Examples include recurring high-grade temperature, persistent rash, nonspecific pain and fever.	• Within 1 week or 5 days, whichever is earlier
	Routine care without physical or behavioral symptoms. Includes routine physical exams.	• Within 30 calendar days
Urgent	A condition with acute symptoms the severity of could cause serious impairment of body or organ functions, in whole or in part, but do not constitute emergencies. Includes mental health or SUD crisis, high temperature, persistent vomiting or diarrhea, and symptoms which are of sudden or severe onset but no not require emergency room services.	• Within 24 hours

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

Provider Directory

You are required to tell us, within 10 business days, if you can no longer accept new patients to prevent any Provider Directory inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional help finding a care provider.

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

We allow you up to 45 business days to contact us. If you don't, we notify you that if you continue to be nonresponsive, we will remove you from our directory after 10 business days.
If we receive notification the information is inaccurate, you may be subject to corrective action. In addition to outreach for annual or bi-annual attestations, we reach out if we receive a report of incorrect care provider information. We are required to confirm your information.

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

- **Delegated care providers** – email your changes to Pacific_DelProv@uhc.com or delprov@uhc.com
- **Nondelegated care providers** – visit UHCprovider.com for the Care Provider Demographic Change Submission Form and further instructions
- In addition to updating UnitedHealthcare Community Plan, you are required to submit a profile update to the IHCP Provider Healthcare Portal at portal.indianamedicaid.com within 10 business days. Profile updates must be submitted electronically using the IHCP Provider Healthcare Portal or by mail, using the appropriate paper forms.

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

Care provider attestation

Confirm your data every quarter through the Provider Portal at UHCprovider.com or by calling Provider Services. Access the Provider Portal for My Practice Profile to make many of the updates required in this section.

Prior authorization request

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

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

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

- Verify eligibility using the Provider Portal at UHCprovider.com/eligibility or by calling Provider Services. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- Get prior authorization from the Provider Portal:
    1. To access the Prior Authorization app, go to UHCprovider.com
    2. Sign In Select the **Prior Authorization and Notification app**
    1. View notification requirements

Identify and bill other insurance carriers when appropriate. Find the IHCP Prior Authorization Form at in.gov/medicaid.

Obtaining an approved prior authorization does not guarantee payment. You must follow all applicable state and PathWays for Aging billing guidelines and verify eligibility requirements.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

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

Requirements for PMP and specialists serving in PMP role

PMP access standards

PMPs must arrange for service coverage 24 hours a day, 7 days a week (anytime). They must also offer members direct contact with the care provider, or the care provider's qualified clinical staff person, through a toll-free telephone number anytime. Each care provider must be available to see members at least 3 days per week for a minimum of 20 hours per week at any combination of no more than 2 locations. They must ensure the PathWays for Aging population is receiving accessible services equally with the provider's non-PathWays for Aging population.

They must provide "live voice" coverage after normal business hours. After-hours coverage may include an answering service or a shared-call system with other medical providers. Members must have telephone access to their provider (or appropriate designee such as a covering care provider) in English and Spanish anytime.

Specialists include gynecologists and endocrinologists (if primarily engaged in internal medicine)

PMPs are an important partner in the delivery of care, and UnitedHealthcare Community Plan PathWays for Aging members may seek services from any participating care provider. The UnitedHealthcare Community Plan PathWays for Aging program requires members be assigned to PMPs. We encourage members to develop a relationship with a PMP who can maintain all their medical records and provide overall medical management. The PMP plays a vital role as a case manager in the UnitedHealthcare Community Plan system by improving health care delivery in 4 critical areas: access, coordination, continuity and prevention.

As such, the PMP 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 PMP must provide 24 hours a day, 7 days a week coverage and backup coverage when they are not available.

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

- Geriatricians
- Internal medicine
- Physicians
- Gynecologists
- General practitioners
- Family medicine physicians
- Endocrinologists (if primarily engaged in internal medicine)
- Physician extenders

Members may change their assigned PMP by contacting **Member Services**. Customer service is available 7 a.m.–7 p.m., Monday through Friday.

UnitedHealthcare Community Plan may auto-assign a PMP to members who don't select a PMP during enrollment to complete the enrollment process within 30 days.

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

Members have direct access (without a referral or authorization) to 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 PMP.

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support and benefit from the primary care case management system. This includes PMP availability of 24 hours a day, 7 days a week.

During nonoffice hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PMP's nurse triage) will immediately page an on-call medical professional so referrals can be made for nonemergency services. **Recorded messages are not acceptable.**

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

- Use lists supplied by the UnitedHealthcare Community Plan to identify members who may need preventive health procedures or testing
- Submit all accurately coded claims or encounters in a timely manner
- If the member has other insurance, file first. Then submit the Medicaid claim to us with a copy of the paid claim EOB.
- Coordinate each UnitedHealthcare Community Plan member's overall course of care
- Accept UnitedHealthcare Community Plan members for each practice location up to 2 locations per health plan/managed care entity
- Be available to members by telephone any time
- Tell members about appropriate use of emergency services
- Discuss available treatment options with members

Responsibilities of PMPs and specialists serving in PMP role

Specialists include gynecologists and endocrinologists (if primarily engaged in internal medicine)

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

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

Appointment standards are covered in this **chapter**.

Rural health clinic and federally qualified health clinic

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

- **RHC**
  The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be in rural, underserved areas.

- **FQHC**
  An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a P.A., N.P., social worker and/or another care provider
  - Mental health services
  - Immunizations (shots)
  - Home nurse visits

PMP checklist

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

Specialist responsibilities

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

- Contact the PMP to coordinate the care/services
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PMP or who self-refer
- Verify the eligibility of the member before providing wcovered specialty care services
- Provide only those covered specialty care services, unless otherwise authorized
- Provide the PMP 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, to be shared information in writing with the PMP
- Maintain staff privileges at 1 UnitedHealthcare Community Plan participating hospital at a minimum
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws
- Comply with the state of Indiana Access and Availability standards for scheduling routine visits. Appointment standards are covered in this **chapter**.
- Provide anytime coverage. PMPs and specialists serving in the PMP role must be available to members by phone 24 hours a day, 7 days a week Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating care provider. UnitedHealthcare Community Plan tracks and follows up on all instances of care provider unavailability.
- Remember to maintain enrollment with the IHCP

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. PMPs and obstetricians serving in the PMP role must take part in all survey-related activities.

Ancillary care provider responsibilities

Ancillary care providers include:

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

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

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

Ancillary care provider checklist

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

Chapter 3: Care provider office procedures and member benefits

Key contacts

Topic	Link	Phone Number
Member benefits	in.gov/medicaid UHCCommunityPlan.com/IN	**1-800-832-4643**
Member handbook	UHCCommunityPlan.com/IN > Plan Details > Member Resources > View Available Resources	**1-800-832-4643**
Provider Services	UHCprovider.com	**1-877-610-9785**
Prior authorization	UHCprovider.com/paan	**1-877-610-9785**
D-SNP	UHCprovider.com/IN > Medicare > Indiana Dual Complete Special Needs Plan	**1-877-610-9785**
Indiana Department of Health	in.gov/health	1-800-457-8283

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

Benefits

Go to UHCprovider.com/INcommunityplan or UHCprovider.com > Eligibility for more information

See Appendix A for the list of member benefits.

Assignment to PMP panel roster

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

Each month, PMP panel size is monitored by reviewing PMP to member ratio reports. When a PMP's panel approaches the max limit, we remove it from auto- assignment. To update the PMP panel limits, send a written request. PMPs serving in the UnitedHealthcare PathWays for Aging provider network must accept a minimum panel size of 150 members.

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

The Community Care Roster has member contact information, clinical information to include HEDIS measures/Gaps in Care, is in an Excel format with customizable field export options and can be pulled at the individual practitioner or TIN level. You may also use sign into the Provider Portal and then select Documents & Reporting > UnitedHealthcare Reports for member contact information in a PDF at the individual practitioner level.

You may also use the Access Electronic Reports self-paced user guide at UHCprovider.com > Resources > Resource Library > Healthcare Professional Education and Training > Digital Solutions Training and Guides.

Choosing a PMP

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

Depending on the member's age, medical condition and location, the choice of PMP may cover a variety of practice areas, such as:

- Family practice
- General practice
- Internal medicine

- Geriatrics
- Physician extenders
- Endocrinology
- Obstetrics

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

PMP reassignment form

The purpose of this form is to add a member to a PMP panel either at full capacity status or approved by us for a "hold" status. The PMP or office manager may complete the from if the member or the member's family member is an established patient. Established patients must have been treated in the past 24 months from today's date. You may also use this form if you would like to begin providing primary care services to that member. Find the form at UHCprovider.com/INcommunityplan > **Provider Forms and References**.

Deductibles/copayments

Check the medical ID card for copayment amounts. You may also call **Provider Services** for more information.

Self-referral services and coverage

Based on state and federal requirements, UnitedHealthcare Community Plan covers benefits available to members on a self-referral basis. These services do not require a physician's referral or other network authorization from us.

We may direct members to seek self-referral care from care providers contracted in our network. However, except for behavioral health and routine dental services, we cannot require the members to receive services from network care providers. UnitedHealthcare Community Plan members may self-refer to any IHCP-qualified care provider to provide the services. When members choose to receive self-referral services from care providers who do not have contractual relationships with us, UnitedHealthcare Community Plan is responsible for payment to these care providers up to the applicable benefit limits and at 98% of Indiana Medicaid fee for service (FFS) rates.

- **Chiropractic services**
  May be provided by a licensed chiropractor, enrolled with IHCP within the scope of the chiropractic practice
- **Eye care services**
  Except surgical services, may be provided by any IHCP licensed care provider under D.M. or D.O. optometrist
- **Podiatric services**
  May be provided by any IHCP-licensed care provider under D.M., D.O. or doctor of podiatric medicine
- **Psychiatric services**
  Provided by any IHCP licensed care provider under D.M. or D.O.
- **Behavioral health services**
  Self-referral for in-network IHCP care provider. Members may self-refer within the UnitedHealthcare Community Plan's network for behavioral health services not provided by a psychiatrist. This includes behavioral health, substance abuse and chemical dependency services by behavioral health specialty providers.
- **Family planning services**
  Requires freedom of choice of care providers and access to family planning services and supplies. Abortions and abortifacients are not covered family planning services, except as allowable under the federal Hyde Amendment. Members may self-refer to any IHCP care provider qualified to provide the family planning service(s), including care providers not in UnitedHealthcare Community Plan's network. Members may not be restricted in choice of a family planning service if the care provider is an IHCP provider.
- **Emergency services**
  Covered without the need for or the existence of a contract with the emergency care provider. Emergency services must be available 24 hours a day, 7 days a week and are subject to the "prudent layperson" standard of an emergency medical condition. ER services are reimbursed at 100% of the Indiana fee schedule for noncontracted care providers.

- **Immunizations**
  Self-referral to any IHCP-enrolled care provider. Immunizations are covered regardless of where they are received.
- **Diabetes self-management services**
  Available on a self-referral basis to any IHCP care provider when the member obtains the services from an IHCP self-referral care provider. The state expects to include diabetes prevention programs as a self-referral service in the future.
- **Routine dental services**
  May be provided by any in-network licensed IHCP dental provider

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

You must document all services requiring medical necessity in the member's medical record.

A medically necessary service is a covered service required for the care or well-being of the patient and is provided based on generally accepted standards of medical or professional practice.

Member assignment

Assignment to UnitedHealthcare Community Plan

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

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

Download a copy of the member handbook online by contacting **UHCCommunityPlan.com/IN**. Go to Plan Details > Member Resources > View Available Resources

Immediate enrollment changes

Immediate enrollment into managed care means the responsible payer for members may change from FFS to Medicaid managed care during hospitalization. To avoid delays in claims processing and payment, check eligibility daily.

Get eligibility information by calling **the Medicaid inquiry line**

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 Indiana's Medicaid program. The state of Indiana determines program eligibility. An individual who becomes eligible for the state of Indiana program either chooses or is assigned to one of the Indiana health plans.

Member ID card

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

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

The member's ID card will not include the PMP assignment on the front of the card. If a member does not bring their card, call **Provider Services**. Also document the call in the member's chart.

Member identification numbers

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

Health member ID card

(insert image here once provided) New placeholder card pending, PathWays logo not expected from State until late August 2023.

PMP-initiated transfers

A PMP may transfer a UnitedHealthcare Community Plan member due to an inability to start or maintain a professional relationship or if the member is noncompliant. The PMP must provide care for the member until a transfer is complete.

1. To transfer the member, complete the online form at **1-877-610-9785**, call the Member Services number on the back of the member's card, 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
   P.O. Box 5240
   Kingston, NY 12402-5240
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 PMP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PMP member issue, we work with the member to find another PMP. 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 PMP) stating they have 5 business days to contact us to select a new PMP. If they do not choose a PMP, we will choose one for them. A new ID card will be sent to the member with the new PMP information.

Verifying member enrollment

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

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

UnitedHealthcare Dual Complete

Dual Complete Special Needs Plans (D-SNP) is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid.

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

For information about D-SNP, please see the Medicare Products chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) at **UHCprovider.com/guides**. For state-specific information, go to UHCprovider.com/IN > Medicare > **Dual Complete Special Needs Plans**.

Chapter 4: Medical management

Key contacts

Topic	Link	Phone Number
Prior authorization	UHCprovider.com/paan	1-877-610-9785
Provider-administered drugs	UHCprovider.com/priorauth > Clinical Pharmacy and Specialty Drugs	1-877-610-9785
Dental	uhcdentalproviders.com	1-844-402-9118
Healthy First Steps	uhchealthyfirststeps.com	1-800-599-5985

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the “what can we help you find?” search bar

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

Nonemergent air ambulance requires prior authorization.

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

Emergency ambulance transportation

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

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

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

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

Nonemergent ambulance transportation

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

Nonemergency medical transportation

Nonemergency medical transportation (NEMT) services are arranged by LCP Transportation. Transportation is provided by taxi, van, bus or public transit, depending on a member’s medical needs. Wheelchair service is provided if required by medical necessity.

NEMT requests are accepted between 8 a.m.- 8 p.m. ET, Monday through Friday, to schedule transportation. If they have questions about their order, they may call **Member Services**.

Nonemergent transportation must be requested at least 48 hours in advance.

Cardiology

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

You must obtain prior authorization for the following cardiology procedures:

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

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

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

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

Request prior authorization online or by phone:

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

Make sure the medical record is available.

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

Chiropractic services

Evidence-based medicine supports chiropractic care to help lower back pain. In some cases, a visit to the chiropractor can reduce or eliminate the need for pain medication. It can even help combat opioid addiction and overuse. We provide members with up to 50 units per member per calendar year with an in- or out-of-network chiropractor.

The 50 units can be a combination of office visits, spinal manipulation, or physical medicine services. Up to 5 of the 50 units can be office visits. Some chiropractic service require a prior authorization. Use the following steps to access the fee schedules online:

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

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

Chronic condition management

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

Members at highest risk with conditions such as asthma, congestive heart failure, diabetes, chronic obstructive pulmonary disease and coronary artery disease receive more intense health coaching. Resources and tools are available to support members and caregivers with conditions common to children with special health care needs and help them manage their illness.

Identification

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

Dental services

Covered

A dental provider manual is available for detailed coverage information.

UnitedHealthcare Community Plan covers the facility and anesthesia for medically necessary outpatient dental services for adults ages 21 and older. If the member is older than 21, we do not provide coverage without the presence of trauma or cases where treatment is needed for serious medical conditions.

Facility services require a prior authorization.

The following services are covered for children younger than 20 years, pregnant members, the blind and nursing facility residents:

- Diagnostic
- Periodontics
- Preventive
- Prosthodontics (includes dentures, implants, crowns and bridges)
- Restorative
- Oral and maxillofacial surgery
- Endodontics

Standard ADA coding guidelines apply to all claims.

Refer to the Dental Provider Manual for applicable exclusions, limitations and requirements at **uhcdentalproviders.com** or to find a dental care provider, go to UHCprovider.com > Our Network > Find a Provider > **Dental Directory**

Durable medical equipment

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

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

See our Coverage Determination Guidelines at UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > **Medical & Drug Policies and Coverage Determination Guidelines for Community Plan**

Emergency/urgent care services

Emergency services do not require prior authorization and are a self-referral service.

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

Covered services include:

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

ER services are subject to diagnosis review against Indiana's state ER autopay list. If a diagnosis billed on the claim does not appear on the emergency department autopay list, then the claim may be adjudicated nonemergent and paid at the contracted screening fee rate.

If the claim is paid at a contracted screening fee rate, submit the medical records for review. If you would like to submit medical records for prudent lay review, submit within 120 calendar days from day of adjudication. See **Claims reconsideration** section of this manual for more information.

If the prudent lay review determines the service was emergent, then the claim will be adjusted to reimburse at a higher emergent contracted rate.

If the member was referred to the ER by the 24-hour NurseLine, crisis line or a PMP, the facility and professional claim will be reimbursed at 100% of the Indiana Medicaid fee schedule or specific contract rate. A copay will not be applied.

We pay out-of-network care providers for emergency services at the current program rates at the time of

service. We try to negotiate acceptable payment rates with out-of-network care providers for covered post-stabilization care services for which we must pay. An Indiana Medicaid provider who is out of network for UnitedHealthcare Community Plan will be paid at 100% of the Medicaid fee schedule for ER services only.

Emergency room care

For an emergency, the member should seek immediate care at the closest ER. If the member needs help getting to the ER, they may call 911. No prior authorization is needed.

Members have been told to call their PMP as soon as possible after receiving emergency care. Members have been told to call their PMP as soon as possible after receiving emergency care.

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

After the member has received emergency care, the hospital must seek approval within 1 hour for pre-approval for more care to make sure the member remains stable. If the hospital needs to appeal the decision or if does not receive a decision within 1 hour and/or they need to speak with a peer (medical director), call **1-800-599-5985**. The treating care provider may continue with care until the health plan's medical care provider is reached, or when 1 of these guidelines is met:

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

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

Urgent care (nonemergent)

Urgent care services are covered.

For a list of urgent care centers available during the week and after hours, contact **Provider Services 1-877-610-9785**

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

Nurses in the Health Services Department review emergency admissions within 1 business day of notification.

Deliver emergency care without delay. Notify UnitedHealthcare Community Plan about admission within 24 hours, unless otherwise indicated. Use the Prior Authorization and Notification tool on the Provider Portal at **UHCprovider.com/paan**, EDI 278N transaction at **UHCprovider.com/edi**, or call Provider Services **1-877-610-9785**

UnitedHealthcare Community Plan makes utilization management (UM) determinations based on appropriateness of care and benefit coverage existence using evidence-based nationally recognized or internally developed clinical criteria. This includes IHCP medical policies to: management (UM) determinations based on appropriateness of care and benefit coverage existence, using IHCP medical polices, and evidence-based, nationally recognized or internally developed clinical criteria. Care determination criteria is available upon request by contacting Provider Services, UM Department.

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

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

Family planning

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

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

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

Noncovered items include:

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

Parenting/childbirth education programs

- Childbirth education is covered
- Parenting education is not covered

Voluntary sterilization

In-network treatment with consent is covered. Before a member can get a tubal ligation or vasectomy, they first must give consent 30 days before surgery, be mentally competent and be at least 21 years old at the time of consent.

Out-of-network services require prior authorization.

View the state of Indiana regulations at **in.gov** for more information on sterilization.

Care coordination/ health education

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

The program goals are to:

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

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

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

Facility admission notification requirements

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

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

Hearing services

Monaural and binaural hearing aids are covered (except for in-the-canal [ITC] hearing aids) for members with a unilateral pure tone average greater than 30 decibels. For more information, please visit the Indiana Hearing Services module at **in.gov/medicaid/providers/files/modules/hearing-services.pdf**. You may also call Provider Services at **1-877-610-9785**.

Home Health program

Home health services are covered on a part-time and intermittent basis to Medicaid members of any age in the member's place of residence. A "place of residence" for home health services does not include a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) or any setting where payment is, or could be, made under inpatient services including room and board. Members may receive home health services in any setting where normal life activities take place. Home health services cannot be limited to members who are homebound.

Home health services include skilled nursing, home health aide services and skilled therapies (physical therapy, occupational therapy and speech-language pathology).

Home health services are available to IHCP members of any age when the services are:

- Medically necessary
- Ordered in writing by a care provider
- Performed on a part-time and intermittent basis based on a written plan of treatment

The qualifying treating care provider must certify the medical necessity for home health services. Home health services require prior authorization.

IHCP home health benefits include covered services performed by practitioners such as the following:

- Registered nurses (RNs)
- Licensed practical nurses (LPNs)
- Physical therapists

For more information about home health call **Provider Services**.

Hospice

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

Home hospice

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

Respite hospice

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

Inpatient hospice

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

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

Laboratory

LabCorp and Quest are the preferred lab care provider, contact **them** directly

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

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

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

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

Maternity/pregnancy/ well-child care

Notification of pregnancy

The Notification of Pregnancy (NOP) was developed to help identify pregnancy earlier with the goal of better health and birth outcomes for mothers and babies. The online form simplifies the process of completing paperwork to document pregnancies and evaluate any risks. If you electronically complete and submit the NOP to comply with IHCP guidelines and use the Provider Portal, you may be eligible for a $60 incentive payment. Just answer 4 questions online with first OB visit once member is effective with Medicaid.

Bill the managed care entity (MCE) for the NOP incentive payment using CPT code 99354 with modifier TH. The date of service on the NOP claim should be the date of the office visit on which the information on the NOP is based.

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.

Call Healthy First Steps at **1-800-599-5985** and complete the Notification of Pregnancy form at the first prenatal visit, located on **portal.indianamedicaid.com**

Healthy First Steps strives to:

- Identify expectant members early and enroll them in case management
- 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 members 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 nonemergent settings
- Encourage members to stop smoking with the Indiana tobacco cessation program
- Help identify and build the member's support system, including referrals to community resources and pregnancy support programs

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

Pregnancy/maternity

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

Medicaid does not consider ultrasounds medically necessary if they are done only to determine the fetal sex or provide parents with a photograph of the fetus. We allow the first 3 obstetrical ultrasounds per pregnancy.

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

For OB billing, refer to the OB billing section in the **Indiana Reference Module.**

For prior authorization maternity care, including out-of-plan and continuity of care, call **1-877-610-9785** or at **UHCprovider.com/paan** or for information about prior authorization requirements, go to UHCprovider.com/INcommunityplan > **Prior Authorization and Notification**

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

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

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

A UnitedHealthcare Community Plan member does not need a referral from their PMP 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 Caesarean section require clinical information and medical necessity review.

Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, the online Prior Authorization and Notification tool at **UHCprovider.com/paan**, or call **1-877-610-9785**

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

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

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

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

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

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

Furnish obstetrical maternity services on an outpatient basis. This can be done under a physician's supervision through a N.P., P.A. or LPN. 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 member and their newborn. Post-discharge care is based on accepted maternal and neonatal physical assessments and consists of a minimum of 2 visits. At least 1 visit is in the home. These visits must be conducted by a registered professional nurse with experience in maternal and child health nursing or a care provider. The first post-discharge visit should occur within 24 to 48 hours after the member's discharge date. Prior authorization is required for home health care visits for postpartum follow-up. The attending care provider decides the location and post-discharge visit schedule.

Home care and all prior authorization services

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

Hysterectomies

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

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

Find the form on the Indiana Medicaid website **in.gov/medicaid/providers/provider-references/forms**

See **"Sterilization consent form"** section for more information.

Exception: The state of Indiana does not require informed consent if:

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

UnitedHealthcare Community Plan requires, along with your claim, a copy of the signed medical assistance hysterectomy statement. Mail the claim and documentation to claims administration identified on the back of the member's ID card. Reimbursement is made upon completion of documentation requirements and UnitedHealthcare Community Plan review. You cannot bill members if you do not submit consent forms.

Pregnancy termination services

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

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

Sterilization and hysterectomy procedures

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

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

Sterilization informed consent

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

Sterilization consent form

- Complete all applicable sections of the consent form before submitting it with the billing form. The IHCP cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.
- Complete your statement section after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.
- 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.

Have 3 copies of the consent form:

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

You may also find the form on the Indiana Family and Social Services Administration website **in.gov/fssa**

Inhaled nitric oxide

Use the NRS guideline for inhaled nitric oxide (iNO) therapy at UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > **Clinical Guidelines**.

Pharmacy

Pharmacy Preferred Drug List

UnitedHealthcare Community Plan determines and maintains its Preferred Drug List (PDL) of covered medications in accordance with Indiana's Statewide Uniform Preferred Drug List (SUPDL) for covered medications, including prescription drugs, select over-the-counter (OTC) drugs and pharmacy supplements.

This comprehensive list applies to all UnitedHealthcare Community Plan of Indiana members. Specialty drugs on the PDL are identified by a “SP” in the “Requirements and Limits” section of each page.

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

In addition, you may use CoverMyMeds or Surescripts to submit a medication authorization request at UHCprovider.com > Prior Authorization > **Clinical Pharmacy and Specialty Drugs** > Forms and Additional Resources.

We provide you PDL updates before the changes go into effect. Change summaries are posted on **UHCprovider.com**.

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

Pharmacy prior authorization

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

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

Specialty pharmacy medications

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

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

Specialty pharmacy medications are available through our specialty pharmacy network, see **UHCprovider.com/priorauth** for more information

Radiology

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

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

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

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

- ER
- Observation unit
- Urgent care
- Inpatient stay

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

Request prior authorization online or by phone at:

- **Online** – **UHCprovider.com/Radiology** > Prior Authorization and Notification Tool
- **Phone** – **1-866-889-8054** from 8 a.m.– 5 p.m. CT, Monday through Friday, ensuring the medical record is available

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

Right Choices Program

The Right Choices Program helps members who may have inappropriate or unnecessary use of Medicaid benefits. The goal is to provide quality health care management by helping ensure the right service is delivered at the right time and place for each member. Members are identified based on their behavior patterns and utilization practices compared to their peers. The initiative is to reduce inappropriate and unnecessary use of pharmacy and other services.

The member will have a care coordination team led by their PMP and include a care/case manager, lock-in PMP, lock-in pharmacy and any other approved specialty care providers. Members can be locked in to both a PMP and pharmacy or just one, depending on their needs and goals. PMPs must make referrals to any nonlocked-in care providers. Add care providers by logging into the **IHCP Provider Healthcare Portal**, or call **Provider Services**.

The Right Choices Program PMP can add care providers to the member's lock-in file on the IHCP Provider Healthcare Portal website at **IHCPportal.indianamedicaid.com** or contact the UnitedHealthcare Right Choices Program administrator so they can be added to the member's lock-in file.

If the Right Choices Program member initiates the PMP change, a new PMP may be selected only in one or more of the following conditions:

- Access to care
- Continuity of care
- Quality of care or service

If the member is auto-assigned a PMP because of failure to respond to their initial PMP selection notification, the member is allowed to change primary lock-in care providers 1 time during tenure in the Right Choices Program. Members are required to submit a written request to the program administrator detailing the reasons for the requested changes. If there is a change in the member's lock-in care providers, they receive a letter with the new care providers' information. The new lock-in care providers also receive letters.

To make a referral to Right Choices Program, find the referral form on UHCprovider.com/INcommunityplan > **Provider Forms and References**
Fax: 1-888-843-6007 or
Email: **In_rcp@uhc.com**

Please review the IHCP provider manual outlining the requirements and details about the program: in.gov/medicaid/providers > Provider References > Provider Reference Materials > IHCP Provider Reference Modules > **Right Choices Program**

Screening, brief interventions and referral to treatment services

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

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

What is included in SBIRT?

Screening

With just a few questions on a questionnaire or in an interview, you can identify members who have alcohol or other drug/substance use problems and determine 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 SUD. **This includes coordinating with the alcohol and drug program in the county where the member resides for treatment.**

SBIRT services will be covered when all are met:

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

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

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

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

Medication-assisted treatment

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

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

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

To find a medical MAT care provider in Indiana:

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

For more SAMHSA waiver information:
Physicians — **samhsa.gov**
N.P.s and P.A.s — **samhsa.gov**

If you have questions about MAT, please call Provider Services at **1-877-610-9785**, and enter your TIN

- Say "Representative," and "Representative" a second time
- Then say "Something Else" to speak to a representative

Telehealth and telemedicine

You may use telemedicine to facilitate access to needed services in a clinically appropriate way.

For more information regarding telemedicine, please refer to **Provider Services**.

Tuberculosis screening and treatment

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

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

Vision

Vision services are covered by MARCH Vision Care. Please see the reference guide at **marchvisioncare.com** for information such as compliance, electronic payment information, safety resources and training. Contact MARCH directly either through their eyeSynergy web portal or fax to refer a member. Call 1-844-486-2724 for more information.

To access eyeSynergy, log onto our website at **marchvisioncare.com** and click on the orange and blue eyeSynergy® link located at the top of the page.

IMPORTANT: If you choose not to submit lab orders through eyeSynergy, you **must** fax your order to March Vision Customer Service Center at 1-855-640-6737.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

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

For behavioral health and substance use disorder authorizations, please contact **Provider Services**

If you have questions, go to Indiana's prior authorization page at UHCprovider.com/INcommunityplan > **Prior Authorization and Notification**

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

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Nonurgent pre-service	Within 5 business days of receipt. May suspend request if additional information is required but must adjudicate within 14 days of suspense date.	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/expedited pre-service	Within 48 hours of request receipt	Within 48 hours of the request	Within 48 hours of the request
Concurrent review	Within 24 hours or next business day following	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within 2 business days
Retrospective review	Within 30 calendar days of receiving all pertinent clinical information	Within 24 hours of determination	Within 24 hours of determination and member notification within 2 business days

Concurrent review guidelines

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

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

Concurrent review details

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

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

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

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

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

UnitedHealthcare Community Plan uses MCG (formally Milliman Care Guidelines), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes:

- Acute and sub-acute medical
- Long-term acute care
- Acute rehabilitation
- Skilled nursing facilities
- Home health care
- Ambulatory facilities

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

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

We don't consider experimental treatments medically necessary.

Determination process

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

Evidence-based clinical guidelines

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

Medical and drug policies and coverage determination guidelines

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

Referral guidelines

We do not require a written referral. However, you must document in the member's medical record the referrals for medically necessary services beyond the scope of your practice. Monitor the referred member's progress and help ensure they are returned to your care as soon as appropriate.

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

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

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

Reimbursement

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

- Determine if the member is eligible on the date of service by using the Provider Portal on **UHCprovider.com**, contacting UnitedHealthcare Community Plan's Provider Services department or the IHCP Provider Healthcare Portal at **portal.indianamedicaid.com**
- 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
- Submit claims using Indiana Medicaid and UnitedHealthcare Community Plan guidelines
- Bill using revenue codes and/or procedure codes required by the IHCP and/or UnitedHealthcare Community Plan

UnitedHealthcare Community Plan will not reimburse:

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

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the state of Indiana. 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 PMP refers the member to an in-network care provider for a second opinion. Care providers will forward a copy of all relevant records to the second opinion care provider before the

appointment. The care provider giving the second opinion will then forward their report to the member's PMP and treating care provider, if different. The member may help the PMP select the care provider.

- If an in-network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a nonparticipating care provider. The participating care provider should contact UnitedHealthcare Community Plan at **1-877-610-9785**.
- Once the second opinion has been given, the member and the PMP discuss information from both evaluations
- If follow-up care is recommended, the member meets with the PMP before receiving treatment

Services not covered by UnitedHealthcare Community Plan

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

- Any health care not given by a doctor from our list (except emergency treatment and self-referral services, excluding behavioral health and dental)
  - Visit **UHCCommunityPlan.com/IN** for current member plan information including sample member ID cards, provider directories, dental plans and vision plans
  - For a list of in-network providers, see our directory at UHCprovider.com > Our Network > **Find a Provider**
- Any care covered by Medicaid but not through managed care:
  - Prescription drugs covered only by FFS Medicaid
  - Long-term care services in a nursing home not to exceed 30 days
  - Nursing facility services in a skilled nursing facility stay of up to 30 days
  - Encourage additional review by health plan for non-covered services for this population
  - Intermediate care facilities for members with intellectual and developmental disabilities
  - Home- and community-based waiver (HCBS) services
- Sunglasses and photo-gray lenses
- Infertility services

Services requiring prior authorization

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

Direct access services – Native Americans

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

Seek prior authorization within the following time frames

- **Emergency or urgent facility admission –** 2 business days
- **Inpatient admissions; after ambulatory surgery –** 2 business days
- **Nonemergency admissions and/or outpatient services (except maternity) –** at least 14 business days beforehand; if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time

Utilization management guidelines

Call **1-877-610-9785** to discuss the guidelines and utilization management

Utilization management (UM) is based on a member' medical condition and is not influenced by monetary incentives. UnitedHealthcare Community Plan pays its in-network PMPs and specialists on a FFS basis. We also pay in-network hospitals and other types of care providers in the UnitedHealthcare Community Plan network on an FFS basis.

The plan's UM staff works with care providers to help ensure members receive the most appropriate care in the place best suited for the needed services. Our staff encourages appropriate use and discourages underuse. The UM staff does not receive incentives for UM decisions.

UM appeals

UM appeals are considered medically necessary appeals. They contest UnitedHealthcare Community Plan's UM decisions. This includes such things as UnitedHealthcare Community Plan's admission, extension of stay, level of care or other health care services determination. They do not include benefit appeals, which are appeals for noncovered services. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal.

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

Chapter 5: Home- and community-based services

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

Home- and community-based services (HCBS) are services that are provided, pursuant to the Indiana Section 1915(c) waiver, as an alternative to long-term care institutional services in an NF or an intermediate care facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility.

Find an HCBS list and definitions of services in the HCBS Waiver Provider Manual posted on the Indiana Family and Social Services Administration (FSSA) Medicaid HCBS webpage: **in.gov/fssa/da/medicaid-hcbs**. Find more about HCBS benefits on **UHCCommunityPlan.com/IN**.

HCBS waiver services

HCBS waiver benefits are available to members who meet a specified level of care. HCBS waiver services and definitions included in the Indiana PathWays for Aging program are as follows:

- **Adult day health service**

Adult day services (ADS) are community-based group programs designed to help individuals who need structured, social integration through a comprehensive and nonresidential program. ADS provides the following support:

- Health
- Social
- Recreational
- Supervision
- Support services
- Personal care

Members attend ADS on a planned basis. The 3 levels of adult day services are basic, enhanced and intensive.

- **Assisted living facility**

An assisted living facility is a licensed facility where members can live, have access to and receive the services they need to be as independent as possible

- **Attendant care**

Attendants provide direct, hands-on care to members for the functional needs with activities of daily living. Services include assistance with:

- Bathing
- Grooming
- Dressing
- Walking
- Toileting
- Eating
- Medication reminders

- **Community transition services**

Services include reasonable setup expenses for members who make the transition from an institution to their own home, where the person is directly responsible for their own living expenses

- **Environmental modification**

Home modifications are physical adaptations to the home, as required by the member's service plan, which are necessary to help ensure the health, welfare and safety of the member. They enable the member to function with greater independence in their home. Without these home modifications, the member would require institutionalization.

- **Home and community assistance**

Homemaker services provide general household activities such as meal preparation, housekeeping

and running errands. Homemakers do not provide any hands-on personal care. Allowable services include:

- Grocery shopping
- Meal preparation
- Limited general housecleaning
- Escort services (not transportation) for medical appointments
- Running care-related errands such as picking up medication or mailing utility payments

- **Health care coordination**
  Integrated health care coordination:
  - Promotes improved health status and quality of life
  - Delays/prevents deterioration of health status
  - Manages chronic conditions in collaboration with physicians
  - Integrates medical and social services
- **Community transportation**
  Nonmedical transportation services enable members to gain access nonmedical community services, activities and resources specified by the service plan
- **Home-delivered meals**
  This service helps prevent institutionalization through good nutrition, as the absence of proper nutrition in individuals with frail and disabling conditions presents a severe risk to health. No more than 2 meals per day are reimbursed under the waiver.
- **Nutritional supplements**
  Dietary supplements include liquid supplements, such as Boost or Ensure, to maintain a member's health, so they can remain in the community. Supplements must be ordered by a physician, P.A. or N.P.
- **Pest control**
  Pest control services prevent, suppress or eliminate anything that:
  - Competes with humans for food and water
  - Injures humans
  - Spreads disease to humans or annoys humans
  - Causes or is expected to cause more harm than is reasonable to accept
- **Respite**
  Pathways services provide temporary or periodical relief in the place of the usual caregiver. Respite can occur in home- and community-based settings.
- **Specialized medical equipment**
  The specialized medical equipment and supplies service includes medically prescribed items required by the member's service plan. These items assist the member in maintaining their health, welfare and safety. They also enable the member to function with greater independence in the home.
- **Structured family caregiving**
  In this caregiving arrangement, a member lives with a principal caregiver, who provides daily care and support to the member based on the member's daily care needs. The principal caregiver may be a nonfamily member or a family member who lives with the member in the private home of the member or the principal caregiver.
- **Vehicle modification**
  Vehicle modifications are additional adaptive equipment or structural changes to a motor vehicle that empower a member to have safe transportation in a motor vehicle

Self-direction care services

Member-directed attendant care

This program allows members receiving care, or representatives acting on their behalf, to select, schedule, train, supervise and (if necessary) terminate their own personal attendants. The member directing care, or their representative takes on all the responsibilities of being an employer except for payroll management, which is handled by the fiscal intermediary.

Member-directed home care attendant

This pilot program offers a health-related service that can be performed by either licensed or trained nonmedical personnel. The attendant helps the member meet chronic medical needs and maintain a level of function to help them avoid unnecessary institutionalization. In conjunction with state plan services, member-directed home care can be provided 24 hours a day, 7 days a week.

HCBS certification

Participation in the HCBS provider network requires care providers to submit the following documents to confirm HCBS certification and Medicaid enrollment with the state:

- Completed Indiana Ancillary Community Support Services Demographic form sent by care provider
- Copy of DA Waiver Service Certification letter. This letter will be sent in by care provider
- W-9 form to be sent by care provider

To request participation in HCBS provider network see, **HCBS Provider Network link** or email UnitedHealthcare Community Plan at **hcbsprovidernetwork@uhc.com**

Electronic visit verification system

Electronic visit verification system (EVV) is a system that electronically captures details of home visits and services provided by caregivers while helping ensure members receive the support they required, and the rendered services are billed accurately.

Benefits of an EVV system

It captures individual caregiver's activity (i.e., check-in, check-out and services performed), which reduces the likelihood for error or fraud. It increases efficiency because reporting is automated, and claims submission is cleaner. It improves quality of care by making workers' activities transparent and measurable.

Do you have to use EVV?

All Medicaid-enrolled service care providers who provide in-home assistance through a personal care assistant or skilled/certified care are required to use EVV to track the time in the member's home. If you do not use this system, claims submitted outside of this system will be denied.

Authorization for HCBS services

The authorization process begins when a care manager assesses the member's needs and then works with the member as well as their family and care providers to create a plan of care and services that specifies supports their ongoing needs. The care manager then arranges for the services by contacting the care providers and entering an authorization into our system.

Sometimes a plan of care may need to be adjusted during the year to accommodate a change in the member's condition. A change in condition means a significant change in a member's health, informal support or functional status that will not normally resolve itself without further intervention. It requires review and revision to the current person-centered care plan. At that time, a service may be added, changed or deleted from the plan of care. The member can initiate this by calling call care management at **1-855-409-7073**.

Before providing services, please make sure the services you provide are authorized. Confirm the authorization is for the correct enrollment and includes the correct billing codes with modifiers and units. Please also verify the member's eligibility on the Provider Portal through UHCprovider.com > **Eligibility** or by calling **1-888-350-5608**.

Compliance with critical incident and adverse event reporting

Every care provider must follow the critical incident and adverse event reporting and related requirements listed in your long-term services and supports contract.

HCBS care providers are required to submit an incident report for any reportable incident within 48 hours of the time of the incident or becoming aware of it. However, if an initial report involves a member death or an allegation or suspicion of abuse, neglect or exploitation, the report must be submitted within 24 hours of first knowledge of the incident.

Report and submit critical incidents and adverse events and death. Report to the FSSA's Division of Disability and Rehabilitative Services/Division of Aging Incident Reporting System (also known as IFUR) at **ddrsprovider.fssa.in.gov/IFUR/.**

Any of the following people may report critical incidents:

- Care provider
- Care provider staff
- Case manager
- Member representative
- UnitedHealthcare employee

Examples of critical incidents include:

- Mistreatment or allegation of mistreatment of a member, including:
  - Abuse
  - Neglect
  - Emotional harm
  - Sexual or financial exploitation
  - Any other mistreatment
- Physical threats to staff, patients or others
- Suicide threats or death of a member from nonnatural cause, including suicide, homicide or other unexpected cause for death
- Serious physical injury, including a self-inflicted injury and injuries where the cause or origin is unknown and where the member requires medical treatment beyond basic first aid
- Natural disaster such as fire, serious flooding or incidents causing displacement in which the member is harmed or in danger of being harmed due to displacement
- Exposure to hazardous material (including blood-borne pathogens)
- Medication error (requiring medical intervention)
- Person missing from scheduled care
- Unexplained deaths
- Witnessed or un-witnessed falls requiring ER treatment or hospitalization
- Member-to-member, other residents-to-member, staff-to-member or other encounters or assaults that have adverse consequences requiring ER treatment or hospital admission

HCBS provider advocate roles and responsibilities

- Serves as primary contact for provider with UnitedHealthcare Community Plan
- Keeps providers advised on new and amended programs and processes
- Specializes in issue resolution
- Answers a dedicated mailbox **IN_Providerservices@uhc.com**

Chapter 5: Home- and community-based services

Looking for something else?

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- In web view, type your keyword in the "what can we help you find?" search bar

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com**	**1-877-610-9785**
Provider Advocate	**UnitedHealthcare Community Plan of Indiana Homepage | UHCprovider.com**, then Contact us	
Training	**UHCprovider.com/training**	**1-877-610-9785**
Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID. Or go to Provider Portal Self Service: **UHCprovider.com/en/resource-library/provider-portal-resources.html** New users: UHCprovider.com > **New User and User Access**	**1-877-610-9785**
CommunityCare Provider Portal training	**CommunityCare Provider Portal User Guide**	
One Healthcare ID support (formally known as Optum support)	**ProviderTechSupport@uhc.com**	**1-855-819-5909**
Resource library	UHCprovider.com > Resources > **Resource Library**	
Fraud, waste and abuse (payment integrity)	**uhc.com/fraud**	**1-800-455-4521 (NAVEX)**

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

- Individuals who are 60 years of age and older
- Individuals who are eligible for Medicaid based on age, blindness or disability
- Individuals who have limited income and resources
- Individuals who may be full-benefit dually eligible
- and Individuals in a nursing facility, and those who are receiving long-term services and supports (LTSS) in a home or community-based setting.

The state of Indiana will determine enrollment eligibility.

Home and Community Based Services

Home- and community-based services (HCBS) are services that are provided, pursuant to the Indiana Section 1915(c) waiver, as an alternative to long-term care institutional services in an NF or to delay or prevent placement in a nursing facility.

Indiana PathWays for Aging HCBS services are available for Medicaid-eligible persons age 60 and older and persons of all ages with disabilities by providing supports to complement and supplement informal supports for persons who would require care in an NF if HCBS services or other supports were not available.

The HCBS Waiver Provider Manual posted on the Indiana Family and Social Services Administration (FSSA) Medicaid HCBS webpage: **in.gov/fssa/da/medicaid-hcbs**. Find more about HCBS benefits on **UHCCommunityPlan.com/IN**.

HCBS certification

Participation in the HCBS provider network requires care providers to submit the following documents to confirm HCBS certification and Medicaid enrollment with the state:

- Completed Indiana Ancillary Community Support Services Demographic form sent by care provider
- Copy of DA Waiver Service Certification letter. This letter will be sent in by care provider
- W-9 form to be sent by care provider

How to join our network

To request participation in HCBS provider network see, **HCBS Provider Network link** or email UnitedHealthcare Community Plan at **hcbsprovidernetwork@uhc.com**

HCBS waiver services

HCBS waiver benefits are available to members who meet a specified level of care. HCBS waiver services and definitions included in the Indiana PathWays for Aging program are as follows:

Adult day health service

Adult day services (ADS) are community-based group programs designed to help individuals who need structured, social integration through a comprehensive and nonresidential program. ADS provides the following support:

- Health
- Social
- Recreational
- Supervision
- Support services
- Personal care
- Transportation add on

Members attend ADS on a planned basis. The 3 levels of adult day services are basic, enhanced and intensive with Category 1 and Category 2 as modifiers to meet the program requirements.

Basic Adult Day Services (Level 1) - include:

Monitoring of all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating,

- walking and toileting with hands-on assistance provided as needed
- Comprehensive, therapeutic activities for those with cognitive impairment in a safe environment
- Initial health assessment conducted by a registered nurse (RN) consultant prior to beginning services at the adult day, and intermittent monitoring of health status.
- Monitoring of medication or medication administration
- Minimum staff ratio: One staff for each eight individuals
- RN consultant available

Enhanced Adult Day Services (Level 2) - Level 1 service requirements must be met. Additional services include:

- Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care
- Initial health assessment conducted by RN consultant prior to beginning services as well as regular monitoring or intervention with health status
- Medication assistance
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers
- Therapeutic structure and intervention for participants with mild to moderate cognitive impairments in a safe environment
- Minimum staff ratio: One staff for each six individuals
- RN Consultant available
- Minimum of one full-time licensed practical nurse (LPN) staff person with monthly RN supervision

Intensive Adult Day Services (Level 3) - Level 1 & Level 2 service requirements must be met. Additional services include:

- Hands-on assistance or monitoring with all ADLs and personal care

- One or more direct health intervention(s) required
- Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy (coordinated or available)
- Therapeutic intervention to address dynamic psychosocial needs, such as depression or family issues affecting care.
- Therapeutic interventions for those with moderate to severe cognitive impairments
- Minimum staff ratio: One staff for each four individuals
- RN consultant available
- Minimum of one full-time LPN staff person with monthly RN supervision
- Minimum of one qualified full-time staff person to address participants' psychosocial needs.

Adult Family Care

Adult family Care (AFC) is a comprehensive service in which a participant resides with an unrelated caregiver. The participant and up to three other participants who have physical and/or cognitive disabilities and are not members of the care provider's or primary caregiver's family, and/or reside in a home that is owned, rented or managed by the AFC provider.

A tiered service (3 levels). Common activities: assistance with bathing, dressing, eating. Home and Community Assistance. Medication oversite.

Participants selecting AFC service may also receive care management service, adult day service, specialized medical equipment and supplies, and healthcare coordination through the waiver.

Assisted living facility

An assisted living facility is a licensed facility where members can live, have access to meals and receive the services they need to be as independent as possible.

The Assisted Living (AL) service is a tiered service (3 levels) defined as personal care and services, home and community assistance, chore, attendant care and companion services, medication oversight (to the extent permitted under state law), therapeutic social and recreational programming provided in a congregate residential setting in conjunction with the provision of participant-paid room and board. This service includes 24-hour, on-site response staff to meet scheduled and unpredictable needs. The participant retains the right to assume risk.

Attendant care

Attendant care services (ATTC) are provided to participants with nursing facility level of care needs. Attendant care services provide direct, hands-on care to participants for the functional needs with ADLs. The participant is the employer for Participant-Directed Attendant Care or appoints a representative to be the employer on their behalf.

Services include assistance with:

- Bathing
- Grooming
- Dressing
- Walking
- Toileting
- Eating
- Medication reminders
- Transportation of individuals to medical and non-medical community activities

Caregiver Coaching and Behavior Management

The purpose of Caregiver Coaching and Behavior Management is to enable the stabilization and continued community tenure of a waiver participant by equipping the participant's lay caregiver(s) with the necessary skills to manage the participant's chronic medical conditions and associated behavioral health needs related to a cognitive impairment and/or dementia.

The following services are covered under Caregiver Coaching and Behavior Management:

- Initial consultation for assessment of the caregiver to determine initial coaching needs, and understand the caregiver's goals, values, needs and strengths.
- Caregiver Coaching and Behavior Management provided in the home of the participant, virtually or telephonically and through Health Insurance Portability and Accountability Act (HIPAA) secure communication platforms that allow for real time and asynchronous communication between caregivers and caregiver coaches and collaboration with waiver care managers.

Community transition services

Community transition services include reasonable setup expenses for participants who make the transition from an institution to their own home where the person is directly responsible for their own living expenses in the community. Community transition services will not be reimbursable on any subsequent move.

The following activities are allowed under community transition services:

- Security deposits and application fees that are required to obtain a lease on an apartment or home
- Essential (not luxury) furnishings and moving expenses required to occupy and use a community domicile, including a bed, table and chairs, assembly of flat-packed furniture when it is not included as part of the furniture purchase cost, window coverings, one land-line telephone, eating utensils, housekeeping supplies, food preparation items, microwave, and bed or bath linens
- Setup fees or deposits for utility or service access including telephone, electricity, heating, internet and water
- Health and safety assurances, including pest eradication, allergen control that would be used in instances where the participant is allergic to certain things that need to be removed from the residence (like animal hair), or one-time cleaning prior to occupancy

Home modifications

Home modifications are physical adaptations to the home, as required by the member's service plan, which are necessary to help ensure the health, welfare and safety of the member. They enable the member to function with greater independence in their home.

Without these home modifications, the member would require institutionalization. Incidental structural repairs to facilitate modifications may be included in this service. Modifications allowed under the home modifications service may include but are not limited to the following:

- Adaptive door openers and locks
- Bathroom modification
    - Removal of existing bathtub, toilet and/or sink
    - Installation of roll-in shower, grab bars, toilet and sink
    - Installation of replacement incidental items (such as flooring, storage space and cabinets) that are necessary due to the bath modification
- Home control units – Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.
- Kitchen modification, including but not limited to:
    - Removal of existing cabinets and sink
    - Installation of sink and cabinet
    - Installation of replacement incidental items (such as flooring, storage space and cabinets) if necessary due to kitchen modification
- Home safety devices such as:
    - Door alarms
    - Anti-scald devices
    - Hand-held shower head
    - Grab bars for the bathroom
- Ramp -including but not limited to portable (considered for rental property only) and permanent
- Single room air or portable conditioner(s)/ single room air purifier(s)
- Vertical lift
- Widening of doorways, including:
    - Exterior or interior bedroom, bathroom, kitchen door or any internal doorway as needed to allow for access. Pocket doors may be requested.

Home Modification Assessment

The service will be used to objectively determine the specifications for a home modification that is safe, appropriate, and feasible to ensure accurate bids and workmanship. All participants must receive a home modification assessment if a provider is available in that county, with a certified waiver provider selected by the participant prior to any subsequent home modifications as well as a home modification inspection upon completion of the work. A home modification will not be reimbursed until the final inspection has been completed.

The home modification assessment will assess the home for physical adaptations to the home, including incidental structural repairs to facilitate modifications that, as indicated by the individual's service plan, are necessary to ensure the health, welfare, and safety of the individual and enable the individual to function with greater independence in the home. Without the modifications, the individual would require institutionalization.

The assessor will be responsible for writing the specifications, review of feasibility and the post-project inspection. The home modification assessment service includes the following activities:

- Evaluation of the current environment, including the identification of barriers underneath the home, electrical and plumbing, which may prevent the completion of desired modifications
- Reimbursement for nonfeasible assessments
- Drafting of specifications
- Preparation and submission of specifications
- Examination of the modification (inspection/approval)
- Contact county code enforcement

Home and community assistance

Homemaker services provide general household activities such as meal preparation, housekeeping and running errands. Homemakers do not provide any hands-on personal care.

Allowable services include:

- Grocery shopping
- Meal preparation
- Limited general housecleaning
- Escort services (not transportation) for medical appointments
- Running care-related errands such as picking up medication or mailing utility payments

Integrated health care coordination

Integrated Health Care Coordination (IHCC) is to promote improved health status and quality of life, delay/prevent deterioration of health status, manage chronic conditions in collaboration with the physicians, and integrate medical and social services.

IHCC may include the following activities:

- Development and oversight of a healthcare support plan that includes coordination of medical care and proactive care management of both chronic diseases and complex conditions such as recurring falls, depression and dementia.
- Physician collaboration
- Medication review
- Transitional Care from hospital or nursing facility to home/assisted living.
- Advance care planning

Community transportation

Nonmedical transportation services enable members to gain access nonmedical community services, activities and resources specified by the service plan.

These service standards must be followed for nonmedical transportation waiver services:

- Transportation services must follow a written service plan addressing specific needs determined by the participant's PCA.
- This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.
- Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be used.

Transportation services are reimbursement as three types of service:

- **Non assisted transportation** – The participant does not require mechanical assistance to transfer in and out of the vehicle.
- **Assisted transportation** – The participant requires mechanical assistance to transfer into and out of the vehicle.
- **Adult day service transportation** – The participant requires round-trip transportation to access adult day services.

Home-delivered meals

This service helps prevent institutionalization through good nutrition, as the absence of proper nutrition in individuals with frail and disabling conditions presents a severe risk to health. No more than 2 meals per day are reimbursed under the waiver.

The home-delivered meals service may include but is not limited to:

- Diet and nutrition counseling provided by a registered dietician.
- Nutritional education based on needs of each participant.
- Diet modification according to a physician's order, as required, meeting the individual's medical and nutritional needs

Nutritional supplements

Dietary supplements include liquid supplements, such as Boost or Ensure, to maintain a member's health, so they can remain in the community. Supplements must be ordered by a physician, physician assistant or nurse practitioner.

Personal Emergency Response System

The Personal Emergency Response System (PERS) is an electronic device that enables certain participants at high risk of institutionalization to secure help in an emergency.

The participant may also wear a portable help button to allow for mobility.

The system is connected to the person's phone and programmed to signal a response center after a button is activated. The response center is staffed 24 hours a day, seven days a week by trained professionals. The following activities are under the PERS service:

- Device installation
- Ongoing monthly maintenance of the device
- Electronic service that is usually a portal help button; however, it can also be an electronic device that includes, but is not limited to GPS or video monitoring service. (Note: Remote monitoring will not be placed in participant bedrooms or bathrooms.)

Pest control

Pest control services prevent, suppress or eliminate anything that:

- Competes with humans for food and water
- Injures humans
- Spreads disease to humans or annoys humans
- Causes or is expected to cause more harm than is reasonable to accept.

Respite

Pathways services provide temporary or periodical relief in the place of the usual caregiver. Respite can occur in home- and community-based settings.

The following activities are allowed under respite services:

- Home health aide services (RHHA)
- Skilled nursing services (RSKNU)

Specialized medical equipment

The specialized medical equipment and supplies service includes medically prescribed items required by the member's service plan. These items assist the member in maintaining their health, welfare and safety. They also enable the member to function with greater independence in the home.

The specialized medical equipment and supplies service provides therapeutic benefits to a participant in need, because of certain medical conditions and/or illnesses. Specialized medical equipment and supplies primarily and customarily are used to serve a medical purpose and are not useful to a person in the absence of illness or injury.

All specialized medical equipment and supplies must be approved by the waiver program prior to the service being rendered. The following are allowable activities under this service:

- Lift chairs – The HCBS program will cover the chair. Medicaid State Plan should be pursued first for prior approval of the lift mechanism.
- Medication dispensers
- Toileting and/or incontinence supplies that do not duplicate Medicaid State Plan Services
- Slip-resistant socks
- Self-help devices – including over-the-bed tables, reachers, adaptive plates, bowls, cups, drinking glasses and eating utensils
- Strollers – when needed because participant's primary mobility device does not fit into the participant's vehicle/mode of transportation, or when the participant does not require the full-time use of a mobility device, but a stroller is needed to meet the mobility needs of the participant outside of the home setting.
- Voice active smart devices
- Interpreter service – provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (such as waiver case conferences or team meetings) and is not available to facilitate communication for other service provision.

Structured family caregiving

In this caregiving arrangement, a member lives with a principal caregiver, who provides daily care and support to the member based on the member's daily care needs. The principal caregiver may be a nonfamily member or a family member who lives with the member in the private home of the member or the principal caregiver.

Structured family caregiving includes the following activities (Levels 1-3):

- Home and community assistance care services related to needed IADLs Attendant care services related to needed ADLs
- Medication oversight (to the extent permitted under state law)
- Escorting to necessary appointments, whenever possible, such as transporting individuals to doctor appointments and community activities that are therapeutic in nature or assists with maintaining natural supports.
- Caregivers not living in the home of the participant if this arrangement began prior to Feb. 1, 2020.
- Unskilled respite for the family caregiver for a maximum of 15 days per calendar year (Note: Funding for this respite is included in the per diem paid to the service provider; the actual respite service may not be billed in addition to the per diem.

Vehicle modifications

Vehicle modifications are additional adaptive equipment or structural changes to a motor vehicle that empower a member to have safe transportation in a motor vehicle.

Justification and documentation are required to demonstrate that the modification is necessary to meet the participant's identified need(s).

The following are allowable under the vehicle modification service:

- Wheelchair lifts
- Wheelchair tie-downs (if not included with lift)
- Wheelchair/scooter hoist
- Wheelchair/scooter carrier for roof or back of vehicle
- Raised roof and raised door openings.
- Power transfer seat base

Self-direction care services

Member-directed attendant care

This program allows members receiving care, or representatives acting on their behalf, to select, schedule, train, supervise and (if necessary) terminate their own personal attendants. The member directing care, or their representative takes on all the responsibilities of being an employer except for payroll management, which is handled by the fiscal intermediary.

Electronic visit verification system

Electronic visit verification system (EVV) is a system that electronically captures details of home visits and services provided by caregivers while helping ensure members receive the support they required, and the rendered services are billed accurately. Indiana PathWays will require EVV for the following care provider types:

- Personal Care Service providers: Homemaker and attendant care
- Home Health Service providers: Home Health (PT, OT, ST, Evals).

Services excluded from EVV include:

- Caregiver Coaching and Behavior Management
- Integrated Healthcare Coordination
- Participant Directed Attendant Care *(self-direction)*

Benefits of an EVV system

It captures individual caregiver's activity (i.e., check-in, check-out and services performed), which reduces the likelihood for error or fraud. It increases efficiency because reporting is automated, and claims submission is cleaner. It improves quality of care by making workers' activities transparent and measurable.

Do you have to use EVV?

All Medicaid-enrolled service care providers who provide in-home assistance through a personal care assistant or skilled/certified care are required to use EVV to track the time in the member's home. If you do not use this system, claims submitted outside of this system will be denied.

Authorization for HCBS services

The authorization process begins when a care coordinator assesses the member's needs and then the service coordinator works with the member as well as their family and care providers to create a plan of care and services that specifies supports their ongoing needs. The service coordinator then arranges for the services by contacting the care providers and entering an authorization into our system.

Sometimes a plan of care may need to be adjusted during the year to accommodate a change in the member's condition. A change in condition means a significant change in a member's health, informal support or functional status that will not normally resolve itself without further intervention. It requires review and revision to the current person-centered care plan. At that time, a service may be added, changed or deleted from the plan of care. The member can initiate this by calling call care management at **1-855-409-7073**.

Before providing services, please make sure the services you provide are authorized. Confirm the authorization is for the correct enrollment and includes the correct billing codes with modifiers and units. Please also verify the member's eligibility on the Provider Portal through UHCprovider.com > **Eligibility** or by calling **1-888-350-5608**.

Billing Instructions, Codes and Rates

Division of Aging (DA) certified providers may begin providing services once they receive a notice of action (NOA) authorizing the provisions of services to a particular member.

A complete list of Indiana's billing codes and rates can be located here: IHCP Fee Schedules **indianamedicaid.com**

The IHCP Fee Schedule is updated each Tuesday. Changes may include rates, limits, and code updates.

For the most current fee schedule please refer to the current Professional Fee Schedule link listed within the IHCP Fee schedule site.

Reimbursement Process

- Care Providers should submit claims for payment after the service is provided.
- HCBS waiver services are billed as professional claims, using the CMS-1500 paper claim form.
- Care Providers must use valid ICD-10 coding.
- All elements of the clean claim requirements must be followed when submitting claims.
- Please continue to bill for HCBS/LTSS services using the Healthcare Common Procedure Coding System (HCPCS) codes, modifiers, and units used for Indiana.

Electronic Payments:

UnitedHealthcare is transitioning from paper checks to electronic payments and will no longer be sending providers paper checks for payment in accordance with applicable laws.

As part of those efforts, we encourage electronic payment signup, specifically Automated Clearing House (ACH)/direct deposit through Optum Pay™. Virtual card payments will be utilized in lieu of electronic payments.

NOTE: EFT is optional and is not required.

Compliance with critical incident and adverse event reporting

Every care provider must follow the critical incident and adverse event reporting and related requirements listed in your long-term services and supports contract.

HCBS care providers are required to submit an incident report for any reportable incident within 48 hours of the time of the incident or becoming aware of it. However, if an initial report involves a member death or an allegation or suspicion of abuse, neglect or exploitation, the report must be submitted within 24 hours of first knowledge of the incident.

Report and submit critical incidents and adverse events and death. Report to the FSSA's Division of Disability and Rehabilitative Services/Division of Aging Incident Reporting System (also known as IFUR) at **ddrsprovider.fssa.in.gov/IFUR/.**

Care providers must report other types of critical incidents directly to the appropriate state entity, in accordance with Indiana law.

You are required to:

- Submit an incident report for any reportable HCBS critical incident within forty-eight (48) hours of the time of the incident or becoming aware of the incident (whichever is sooner).
- Also notify the member's Service Coordinator of all HCBS critical incidents within forty-eight (48) hours of the time of the incident or becoming aware of the incident (whichever is sooner)

Care provider expectations involving critical incidents

- Care providers shall cooperate and follow up with UnitedHealthcare staff on all reported critical incidents.
- Providers are expected to collaborate and cooperate with investigations of critical incidents regarding any necessary follow up to ensure member has no unmet needs.
- Providers are expected to protect the health and welfare of all members and collaborate as well as cooperate in addressing any quality of care or quality of service investigation.

When and how to submit a critical incident

When:

- Report any identified critical incidents within 48 hours.
- If an initial report involves a member death, or an allegation or suspicion of abuse, neglect or exploitation, the report must be submitted within forty-eight (48) hours or sooner of "first knowledge" of the incident.

How:

UnitedHealthcare requires its network providers to submit reports regarding HCBS critical incidents via FSSA's DDRS/DA Incident Reporting System (also known as IFUR) at **https://ddrsprovider.fssa.in.gov/IFUR/.**

Also notify the member's Service Coordinator of all HCBS critical incidents within forty-eight (48) hours of the time of the incident or becoming aware of the incident (whichever is sooner).

Any of the following people may report critical incidents:

- Care provider
- Care provider staff
- Case manager
- Member representative
- UnitedHealthcare employee

Critical incident type are categorized as:

- Home and Community-Based Services (HCBS) critical incidents
- Abuse, Neglect and Exploitation (ANE) critical incidents, and
- All Other Critical Incidents such as:
- Physical threats to staff, patients or others
- Suicide threats or death of a member from nonnatural cause, including suicide, homicide or other unexpected cause for death
- Serious physical injury, including a self-inflicted injury and injuries where the cause or origin is unknown and where the member requires medical treatment beyond basic first aid
- Natural disaster such as fire, serious flooding or incidents causing displacement in which the member is harmed or in danger of being harmed due to displacement
- Exposure to hazardous material (including blood-borne pathogens)
- Medication error (requiring medical intervention)
- Person missing from scheduled care
- Unexplained deaths
- Witnessed or un-witnessed falls requiring ER treatment or hospitalization
- Member-to-member, other residents-to-member, staff-to-member or other encounters or assaults that have adverse consequences requiring ER treatment or hospital admission

HCBS provider advocate roles and responsibilities

HCBS Provider Advocate Overview:

Care providers will be assigned a dedicated HCBS Provider Advocate whose name and contact information will be available on the web site.

The assigned HCBS Provider Advocate is an important resource when you have questions. They are your single point of contact across all lines of business and medical benefit plans to help make your interactions with us easier and more efficient.

The assigned provider advocate will:

- Serves as primary contact for provider with UnitedHealthcare Community Plan
- Keeps providers advised on new and amended programs and processes
- Specializes in issue resolution
- Answers a dedicated mailbox **IN_Providerservices@uhc.com**

If you don't know who your provider advocate is, email **IN_Providerservices@uhc.com** and a care provider advocate will get back to you

HIPAA compliance – your responsibilities

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

Unique identifier

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

Legacy Provider Identifier (LPI)

We encourage all HCBS providers who have both an NPI and LPI to bill using only the LPI. HCBS providers who choose to bill with an NPI must ensure that a taxonomy code is included on the claim.

Provider Enrollment:
Successful IHCP enrollment results in a Medicaid Provider ID/Legacy Provider ID (LPI)
All IHCP providers bill with NPI except for Provider Type 32 (waiver).

Key for data match:

- Taxonomy
- Service location zip code +4

HCBS Provider Claim Tips:

- Bill with the IHCP Provider ID/LPI (rather than NPI)

Member ID card for billing

The member ID card has the UnitedHealthcare Community Plan member ID. The member ID is the same as the members Medicaid ID. UnitedHealthcare Community Plan prefers you bill with the Medicaid ID.

Clean claims and submission requirements

Complete a CMS 1500 form whether you submit an electronic (via EDI or portal) or a paper claim. Clean claims have:

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

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

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.

- 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) guidelines for CMS 1500 forms.

Electronic data interchange

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

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

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

EDI companion documents

UnitedHealthcare Community Plan's companion documents are intended to share information within implementation guides (IG) adopted by HIPAA.

The companion documents identify the data content requested when it is electronically transmitted UnitedHealthcare Community Plan uses companion documents to:

- Clarify data content that meets the needs of the health plan's business purposes when the IG allows multiple choices
- Provide values the health plan will return in outbound transactions
- Outline which situational elements the health plan requires
- The companion document provides general information and specific details pertinent to each transaction. Share these documents with your software vendor for any programming and field requirements.

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

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

Clearinghouse and status reports

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

For clearinghouse options, go to UHCprovider.com/EDI > **EDI Clearinghouse Options**

e-Business support

Call Provider Services at **877-440-9946** for help with online billing, claims, electronic remittance advices (ERAs) and electronic funds transfers (EFTs).

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

Billing multiple units

When billing multiple units:

- If the same procedure is repeated on the same date of service, enter the procedure code once with the appropriate number of units.

The total bill charge is the unit charge multiplied by the number of units.

Timely filing

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

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

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

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

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

If we reject a claim and don't receive corrections within 90 days from date of service or close of business from the primary carrier, the claim is considered late billed. It will be denied timely filing.

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

Provider Portal

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

Submitting a Claim Reconsideration

- A claim reconsideration request is the quickest way to address your concerns regarding claim payments.
- Preferred method for submitting a claim reconsideration: the Provider Portal at **UHCprovider.com** > Sign in > Claims tool
- Call Provider Services at **1-877-440-9946** or use the telephone number on the back of the member's ID card.

Submit claim reconsideration form by mailing to:

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

- Access the Single Paper Claim Reconsideration Request Form at **UHCprovider.com/claims** > scroll down to the frequently searched items.
- **3 step process for Indiana –** Claim Reconsideration, Informal Dispute and Formal Appeal.

Balance billing

Do not balance bill members if:

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

Federal and state regulations prohibit you from charging any IHCP member, or a family member, for any amount not paid for covered services following a reimbursement determination by the IHCP.

As a condition of your participation in the IHCP, you must accept the IHCP determination of payment as payment in full, whether the IHCP is the primary or secondary payer. If you disagree with the Medicaid determination of payment, your right of recourse is limited to an adjustment request, administrative review and appeal.

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. The program breaks down linguistic and cultural barriers that can harm health care participation.

You must support UnitedHealthcare Community Plan's Cultural Competency Program. For more information, go to UHCprovider.com > Resources > Resource Library > Patient Health and Safety > **Cultural Competency**.

UnitedHealthcare Community Plan offers the following support services:

Language interpretation line

We provide members with oral interpreter services 24 hours a day, 7 days a week. More than 240 non-English languages and hearing-impaired services are available. If a UnitedHealthcare Community Plan member needs interpreter services, they can call the phone number on their ID card.

- To reach a professional interpreter during regular business hours, call Provider Services at **1-877-610-9785**. After hours, call Language Line Solutions at 1**-877-261-6608**
- Enter the client ID 209677 (do not hit #). Press 1 for Spanish and 2 for all other languages

Materials for limited English-speaking members

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

- **Indian/Tribal providers,** essential provider type.

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

Informal Disputes and Appeals

- If you are not satisfied with the outcome of a claim reconsideration, you can submit an informal dispute. If the outcome of the Informal Dispute is not favorable, a Formal Appeal can be submitted. To submit either an Informal Dispute or Formal Appeal follow the process outlined in the care provider manual.
- The care provider manual is available at **UHCprovider.com/guides**>Community Plan Care Provider Manuals for Medicaid Plans by State>Indiana.
- Informal disputes must be submitted within 90 days of the last denial of the claim.
- Formal appeals must be submitted within 60 days of the denial of an informal dispute or claim denial.
- We generally complete the dispute within thirty (30) calendar days or appeal within forty-five (45) calendar days.

Please allow ten (**10) business days** from the informal dispute/ formal appeal submission date before requesting a status update.

Surveys and care provider satisfaction

UnitedHealthcare Community Plan facilitates surveys the following:

- Members
- Consumer Assessment of Healthcare Providers
- and Systems (CAHPS)
- Health Plan, HCBS and Nursing Home National
- Core Indicators Survey – Aging and Disabilities
- Informal caregivers
- Care provider surveys

We incorporate and address findings from surveys and other analytic activities to assess the quality of care and services provided to members and identify opportunities for improvement.

Frequently asked questions

Q: When did the UnitedHealthcare Community Plan Indiana PathWays for Aging program begin?

A: The UnitedHealthcare Community Plan program went live on July 1, 2024.

Q: What are the timely filing requirements?

A: Timely filing requirements are generally 90 days from the date of service. Non-network provider filing limit is 6 months from date of discharge or date of service.

Q: What is UnitedHealthcare PathWays for Aging time frame for processing a HCBS care provider's network participation request?

A: For HCBS providers, all network participation requests will be processed within 30 days.

Q: Which member populations are included in the PathWays for Aging program?

A: PathWays covers a variety of individuals who are not eligible for Medicare, including those who:

- Are 60 years of age or older
- Are eligible for Medicaid based on age, blindness or disability
- Have limited income and resources
- May be full-benefit dually eligible

Q: Do I need to enroll with the state of Indiana to become a participating care provider?

A: If you are not an existing Medicaid provider in Indiana, you must enroll with the state of Indiana to provide services to Indiana PathWays to Aging members.

Q: How do care providers access the Provider Healthcare Portal?

A. Use the Provider Healthcare Portal, your online health care portal for eligibility access and other insurance information. The portal is an internet-based solution that offers you reliability, speed, ease of use and security.

It can help you with the following transactions:

- Completing care provider eligibility and enrollment applications
- Verifying member eligibility/identifying a member's plan, including whether the member is in the Right Choices Program
- Confirming any third-party liability (i.e., presence of other health insurance such as commercial or Medicare insurance)
- Managing your care provider profile

Reminder: You may also use the UnitedHealthcare Community Plan web portal for PathWays for Aging transactions, such as claims, remits, prior authorization, adjustments, etc.

See Online Resources in **Chapter 1** for more information. To access the portal, go to **portal.indianamedicaid.com**.

Chapter 6: Enhanced services

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the “what can we help you find?” search bar

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call Provider Services at **1-877-610-9785** unless otherwise noted. You may also send an email to **IN_Hpops@uhc.com**. We will respond and facilitate a referral through the member’s assigned care coordinator.

Alternative healing pain relief

We provide $250 annual reimbursement to members for pain management alternatives such as herbal remedies, vitamins, minerals, acupuncture or therapeutic massage. This can be paired with our fitness program to improve health outcomes.

Animatronic pets

Our members with Alzheimer’s and related dementia diagnoses may qualify for participation in our Joy for All companion pet program. This program offers an animatronic pet, which has been shown to improve well-being, sense of purpose, and quality of life for individuals affected by dementia.

Assistive devices

When a member requires an assistive device, the care coordinator can work with the member to obtain these products. These devices include a magnifying tool to enhance vision or a talking scale to support weight management goals. When the item is not covered under the Indiana Medicaid fee schedule, the care coordinator will access other appropriate paths to get the member what is needed to help them improve, maintain or thrive in their preferred setting.

CareBridge remote support

For our highest-risk members, we offer 24/7 virtual care through a tablet-based remote monitoring program. Advanced practice clinicians, physicians and geriatricians assess and treat members virtually to reduce inpatient admissions.

CARES peer support

This informal caregiver program is available in central Indiana through CICOA (AAA for Region 8). It offers:

- Training for coping skills
- Aging and mental health resources
- Acceptance techniques
- Prompts for discussing end-of-life preferences

Dental

PathWays for Aging provide members with enhanced dental coverage. Services include:

- X-rays
- Fluoride
- Nonsurgical periodontics
- Extractions
- Sedation
- Anesthesia
- Teledentistry
- Dental case management

Dispatch health

Members living in the greater Indianapolis area may use this ER diversion program. A multi-disciplinary medical care team is dispatched to the member’s home for procedures, pharmaceuticals, lab testing and diagnostics.

DivvyDose

OptumRx offers a multi-dose packaging solution for members who can benefit from medication synchronization and polypharmacy management. The packaging may contain both prescription and OTC medications in a personalized and pre-sorted roll of medications delivered to the member through the mail every 4 weeks. As part of our support, we work to identify opportunities to conduct comprehensive medication reviews, evaluate polypharmacy risk, and work with members to better understand and manage their medications.

FarmboxRx

Members with nutritional care plan goals associated with the control of diabetes and/or congestive heart failure are eligible for referral into the FarmboxRx program. A Farmbox filled with fresh fruits and vegetables and nutrition education is delivered to members in 3-month periods. The program is renewable through the member's assigned care coordinator based on need.

Fitness programs

Our One Pass program includes many fitness centers across Indiana, including YMCA and Planet Fitness. Members may also access many online fitness sites, such as Yoga Works and Les Mills Studio. D-SNP members with UnitedHealthcare coverage have access to the same benefit, called Renew Active.

HERO Council

We host monthly member and informal caregiver meetings through our Health, Empowerment, Resources, and Opportunities (HERO) Council. These meetings will be in-person and virtual, with a focus on listening to our members and their supports. The goal is to use feedback that changes how managed care programs interact and engage throughout the health care system. Members will receive SDOH-based incentives as they participate. Key stakeholders such as community- and faith-based organizations are also invited to participate during HERO Council events.

Just Plain Clear glossary

The Just Plain Clear® Glossary contains thousands of health care terms defined in plain, clear language to help you make informed decisions. Visit **justplainclear.com** to use this free and helpful tool. This resource is currently available in English, Spanish, Burmese, Chinese and Portuguese. Share this resource with your patients, regardless of their assigned health plan.

Legal assistance

Members in need of legal support may request help with:

- Power of Attorney
- Advance directive form
- Removing a criminal record that makes getting work or housing a challenge

Livongo-Care Angel

This program assists members who are self-managing their diabetes. Available through a referral, this program offers remote monitoring and an app for digital engagement. It also includes 24/7 monitoring that prompts nurse outreach if a member's blood glucose reading is out of range or if a member's interaction with the program is irregular.

Member portal

Member.uhc.com/communityplan offers immediate access to the member's ID card, claims, health record, medication list and health record. It also helps members learn how to access tools and articles on health and well-being, as well as their benefits and enhanced services. Our core member portal content is available in 11 languages, including Spanish and Burmese.

Member rewards

Members can earn rewards for engaging with the health plan and care providers. They may get incentives for activities such as:

- Completing a health needs screening and comprehensive health assessment
- Engaging with a transition coordinator
- Scheduling timely follow-up visits following a hospital-to-home transition due to inpatient stay

UHCCommunityPlan.com/IN lists all applicable member incentives. Incentives are subject to change.

Mobile app

The UnitedHealthcare smartphone app enables members to:

- Complete their health needs screening
- Review health benefits
- Access claims information
- Locate in-network care providers
- Access details about programs and services

Mom's Meals

For members who qualify and are scheduled for or experience an inpatient stay, we offer 2 meals per day for 14 days. This nutritional support is crucial during the recuperation stage and has proven to reduce readmission for up to 55% who have benefited from this program.

NurseLine

NurseLine is available at any time at no cost to our members. Members may call NurseLine to ask if they need to go to the urgent care center, the ER or to schedule an appointment with their PMP. Our nurses also help educate members about staying healthy. Call **1-866-801-4407**, (TTY **711**) to reach a nurse.

Personal emergency response system

A personal emergency response system (PERS) can be an important tool for members and their caregivers. If you have a patient who would benefit from a PERS, make an inquiry. Our care coordinator will review the member's benefits and will help them obtain a PERS that meets their needs.

Pharmacy

Members can earn rewards by having immunization consults at pharmacies. This helps them complete a targeted medication review, an adherence consultation that may help resolve potential and existing barriers to care. From there, members are encouraged to talk to their doctor to address any immunization gaps and obtain a prescription for the vaccine, if necessary.

Postbook

A Postbook creates deeper relationships with a relative or friend. Members choose a Postbook pal and share post cards based on ideas in the journal. We include postage and supplies.

Respite support

If members receive unpaid caregiver support from a friend or family member, we offer a special program to support them. We provide gift cards to help them enjoy their free time. Our care coordinators arrange for member care while the informal caregiver takes a break.

Self-care app

Members and informal caregivers have access to this mobile app. Self-care contains tools and resources to help with self-management of symptoms of stress, anxiety and depression. It is free to members and their informal caregivers. Learn more at **sanvello.com/self-care**.

Smartphone

UnitedHealthcare offers free smartphones with unlimited talk, text and data. This offer is limited to 1 per household. All our web-based programs and services are loaded onto this phone. We also load popular apps like Facebook and WhatsApp Messaging. Members may apply at **mybenefitphone.com**.

Teledental service

We offer a dentist who can consult with a member on the phone or by video chat.

Tobacco cessation

This enhanced tobacco cessation program combines cognitive behavioral therapy and motivational interviewing. It offers:

- Instant rewards
- Biofeedback
- Social supports
- Remote patient monitoring
- Clinical support

Indiana tobacco cessation

Quit Now Indiana 1-800-QUIT-NOW (1-800-784-8669) is a free phone-based counseling service that helps Indiana tobacco users quit. Funded by the Indiana Tobacco Prevention and Cessation Agency, Quit Now Indiana offers experienced professional Quit Coaches® trained in cognitive behavioral therapy.

Quitline staff are skilled in working with people who use all forms of tobacco products, including smokeless tobacco, pipes, cigars, and e-cigarettes.

Refer patients and employees for help with quitting tobacco. Learn more at **quitnowindiana.com**.

Transportation

In addition to standard nonemergency medical transportation benefits, PathWays members are eligible for enhanced transportation benefits through the transportation broker. Members who are eligible for waiver services also qualify for community transportation and member aide transportation. Consult with the member's care coordinator or visit **UHCCommunityPlan.com/IN** for more information.

UHC Doctor Chat— virtual visits

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

Virtual visits can improve access to care, reduce health disparities and reduce avoidable use of the ER. This program highlights our commitment to expand and deliver access to care.

UHC Healthier Lives

Visit **UHCHealthierLives.com** to find community-based resources that address social needs. This site can be used by members and is available in more than 60 languages.

Virtual community center

This unique website offers live classes for adults who are older, led by adults who are also older. Join millions of others learning something new every day. Members access this site through **member.uhc.com/communityplan** or by calling Member Services. Live classes include:

- Online banking tips
- Email scams and how to recognize them
- Arts, crafts and hobbies
- Recipes and cooking tips
- Health and well-being sessions like meditation, chair yoga and mindfulness

Vision

Through our enhanced vision benefits, members will receive 1 free eye exam every 12 months with an allowance to cover the cost of frames and lenses or contact lenses.

Government assistance programs

Supplemental Nutritional Assistance Program

Supplemental Nutritional Assistance Program (SNAP) provides food assistance to low- and no-income people and families living in the United States. In Indiana, the FSSA is responsible for ensuring federal regulations are initially implemented and consistently applied in each county. Visit **in.gov/fssa/dfr/snap-food-assistance** for details, including eligibility and application requirements.

Affordable Connectivity Program

This federal program offers monthly discounts on internet service as well as 1-time support toward the purchase of a tablet, laptop or desktop computer. For more information, members may visit or apply visiting **fcc.gov/acp**.

Chapter 7: Mental health and substance use

Key contacts

Topic	Link	Phone Number
Optum Behavioral Health - Clinical	providerexpress.com	**1-800-888-2998** for clinical questions
Optum Provider Services - Network	providerexpress.com	**1-800-614-0484** for network, claims or contract questions
Indiana Community Plan prior authorization	UHCprovider.com/INcommunityplan	**1-877-610-9785**

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

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

The Optum Behavioral Health National Network Manual is located on **providerexpress.com**.

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

The IHCP reimburses care providers for outpatient behavioral health services. This includes group, family and individual psychotherapy.

Behavioral health care providers are required to enroll with Indiana Medicaid as billing or rendering providers. These providers include:

- Community behavioral health centers
- Outpatient behavioral health clinics
- Psychiatrists
- Health service care provider in psychology
- Psychologist
- Licensed Independent practice school psychologist
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed mental health counselor (LMHC)
- Licensed clinical addiction counselor (LCAC)
- An APN who is a licensed, registered nurse holding a master's degree in nursing, with a major in psychiatric or mental health nursing, from an accredited school of nursing

These care providers can be enrolled in Indiana Medicaid if they have an NPI and a valid professional license. They receive direct reimbursement for their services at the applicable current Indiana Medicaid Fee Schedule rate. They can be employed by an outpatient mental health facility, clinic, physician or HSPP enrolled in the IHCP.

The following care providers can supervise the member's treatment plan and certify the diagnosis for outpatient behavioral health or SUD services:

- Psychiatrist or physician
- Health service provider in psychology (HSPP)
- LCSW
- LMFT
- LMHC
- LCAC
- APN

Licensed psychologists and licensed independent school psychologists still require that an eligible practitioner supervise the member's treatment plan and certify the diagnosis. These practitioners can bill for services if they meet Indiana Medicaid's enrollment requirements and are enrolled as providers.

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

To request an ID number, go to **in.gov/medicaid/providers/591.htm** > Provider Enrollment > Become a Provider or check the **Indiana Provider Enrollment Application Process**

How to join our network: Credentialing information is available at **providerexpress.com** > Clinical Resources > Guidelines/Policies & Manuals > Credentialing Plans > Optum

If you have questions about network participation, credentialing, or your provider record, please go to providerexpress.com > **Contact Us**.

Covered services

UnitedHealthcare Community Plan offers covered behavioral health services for mental, emotional and SUDs. We offer care management to help members, clinicians, and PMPs 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 1 place.

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

For member resources regarding mental health and substance use issues., go to **providerexpress.com** > Clinical Resources > Live and Work Well (LAWW) clinician center > Mind & Body > Recovery and Resiliency

Benefits include:

- Crisis stabilization services (includes treatment crisis intervention and mobile crisis)
- Inpatient psychiatric hospital (acute and sub-acute, including SUD)
- Outpatient assessment and treatment
  - - Partial hospitalization Intensive outpatient
  - Medication management
  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)
  - Electroconvulsive therapy
  - Telemental health
- Rehabilitation services
- Low and high-intensity SUD residential
- Long-term institutional care
- HCBS waivers

Excluded services

- Psychiatric treatment in a state hospital
- Intermediate care facilities for individuals with intellectual disabilities
- Traumatic Brain Injury Waiver
- Community Integration and Habilitation Waiver
- Family Supports Waiver

UnitedHealthcare Community Plan will provide care coordination services for transition and discharge planning.

These excluded benefits are available under traditional Medicaid.

Residential SUD services

The health plan covers short-term low-intensity and high-intensity residential treatment for OUD and other SUD in settings of all sizes, including facilities that qualify as institutes of mental disease.

Prior authorization is required for all residential SUD stays. Admission criteria for residential stays for OUD or other SUD treatment is based on the following American Society for Addiction Medicine (ASAM) Patient Placement Criteria:

- ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services
- ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services

When residential services are determined medically necessary for a member, we approve a minimum of 14 days for residential treatment, unless the facility requests fewer than 14 days.

If a facility determines a member requires more time than the initial 14 days, the facility should submit an update request showing the member has made progress but can be expected to show more progress given more treatment time. An additional length of stay can be approved based on documentation of medical necessity.

For more information about ASAM, go to **asam.org**.

Only state-certified SUD residential facilities may provide this service.

Eligibility

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

Authorizations

Members may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care.

Help ensure prior authorizations are in place before rendering nonemergent services. Get prior authorization by going to **UHCprovider.com/INcommunityplan**, calling **1-877-610-9785** or fax 1-844-897-6514.

Notifications

You must notify us within 5 calendar days of the member's visit, and submit information about the treatment plan, member diagnosis, medications and other pertinent information.

Collaboration with other care providers

Coordination of care

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

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

Please talk to your patients about the benefits of sharing their condition.

Go to **UHCprovider.com** then login to the Provider Portal to find the member's PMP, who is the coordinator, or other participating care providers.

No form is required to participate in coordination of care.

Release of information

The Authorization for Release of Information (ROI) form gives you access to the UnitedHealthcare Community Plan medical portal system and allows the treating care providers to share physical, social and behavioral health information about that member.

Find the ROI at **UHCprovider.com/INcommunityplan**. Go to Provider Forms and References and fax to **1-844-386-9286.**

Ask the member to complete the form during the appointment. Member should complete 1 form per care provider. The member may decline to complete the form.

Portal access

Website: **UHCprovider.com**

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

View the prior authorization list, find forms and access the care provider manual. Or call Provider Services at **1-877-610-9785** to verify eligibility and benefit information (available 8 a.m.– 5 p.m. CT, Monday through Friday).

Website: **providerexpress.com**

Update your care provider practice information, review guidelines and policies, and view the national Optum Network Manual. Or call Provider Services at **1-877-610-9785**.

Claims

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

When you submit a CMS 1500 claim form, include the billing group NPI in 33a. Bill the supervising practitioner NPI in block 24J. The supervising practitioner provides the service or oversees the mid-level practitioner providing the member's service.

Monitoring audits

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

Addressing the opioid epidemic

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

Brief summary of framework

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

Increasing education and awareness of opioids

You must be up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep OUD-related trainings and resources available on our Provider Portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free SUDs/OUD assessments and screening resources, and other important state-specific resources.

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

Prescribing opioids

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

Pharmacy lock-In

Pharmacy lock-ins minimize drug abuse. Pharmacy lock-ins identify and manage members who meet criteria indicative of potential prescription medication misuse or abuse, and specific therapeutic categories with the potential for high abuse, (e.g., narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances).

When lock-in is determined appropriate, a member is placed into a lock-in where they can only receive prescriptions from a single pharmacy for at least 1 year.

Indiana handles pharmacy lock-ins through the Right Choices Program. For more information, see the Right Choices Program in **Chapter 4**.

Expanding medication assisted treatment access and capacity

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

Only state-certified opioid treatment programs (OTP) may prescribe and provide methadone. To find a behavioral health MAT care provider in Indiana:

1. Go to **UHCprovider.com**
2. Select “Our Network,” then “Find a Provider”
3. Select under “Specialty Directory and Tools” the option of Optum Behavioral Health, EAP, Work life & Mental Health Services
4. Click on “Search for a Behavioral Health Provider”
5. Enter “(city)” and “(state)” for options
6. If needed, refine the search by selecting “Medication Assisted Treatment”

We contract with OUD Centers of Excellence (where available), which are designated as premier facilities to help ensure people with OUD stay in treatment and receive appropriate follow-up care and supports within their communities.

To find medical MAT care providers, see the MAT section in **Chapter 4**

Mental Health Parity and Addiction Equality Act

By providing behavioral health benefits, you must comply with the Mental Health Parity and Addiction Equality Act (MPAEA). This includes, but is not limited to:

- Ensuring medical management techniques applied to mental health or SUD benefits are comparable to and applied no more stringently than the medical management techniques applied to medical and surgical benefits
- Ensuring compliance with MHPAEA for any benefits you offer PathWays for Aging members beyond those specified in Indiana’s Medicaid state plan
- Making criteria and guidelines available to any current or potential member, or contracting care provider when requested
- Providing a reason for denial of reimbursement or payment benefits to members
- Providing out-of-network medical and surgical benefits for mental health or SUDs
- Coordinating transition of care for members going from a higher to a lower level of care
- Coordinating transition of care to approved lower level of care for patients who are, due to lack of medical necessity, denied a higher level of care

Chapter 8: Member rights and responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	UHCCommunityPlan.com/IN	1-800-832-4643
Member handbook	UHCCommunityPlan.com/in > Community Plan > Member benefits	1-800-832-4643

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

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

Privacy regulations

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

Access to PHI

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

Amendment of PHI

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

Accounting of disclosures

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

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

Right to request restrictions

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

Right to request confidential communications

Members have the right to request communications from you or us be sent to a separate location or other means. You must accommodate reasonable requests, especially if the member states disclosure could endanger them.
Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Member rights and responsibilities

The following information is in the member handbook at the following link under the Member Information tab: **UHCCommunityPlan.com/IN**.

Native American/Alaskan Native access to care

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

UnitedHealthcare member rights

Members have the right to:

- • Be treated with respect, dignity and privacy
- Receive information about us, rights and
- Responsibilities, their benefit plan and which services are not covered
- Know the qualifications of their care provider
- Receive information about in-network care provider and practitioners, and choose a care provider from our network
- Register grievances or complaints concerning the Health plan or the care provided
- Appeal any payment or benefit decision we make
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, and talk with you when making decisions about their care
- Get a second opinion with an in-network care provider
- Expect care providers are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage
- Make suggestions about our member rights and responsibilities policies

PathWays member rights

According to the state of Indiana, members have the right to:

- Be treated with dignity and respect when getting health services
- Be given information on their medical benefits and plan information
- Be given privacy for them and their medical records
- Be given easy-to-understand explanations of their medical problems and treatment choices
- Stay involved in decisions about their treatment choices
- Get care 24 hours a day, 7 days a week
- Get timely answers to their complaints or appeals
- Appeal decisions made about health care they receive
- Use buildings and services that meet the standards of the Americans with Disabilities Act (ADA). This means that persons with disabilities or physical problems can get into medical buildings and use important services.
- Get a second opinion from a different doctor
- Request and receive a copy of their medical records and request that they be changed or corrected
- Say no to treatment or therapy. If they say no, the health care provider or health plan must talk to them about what could happen. A note must be place in their medical record about the treatment refusal.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, in accordance with federal regulations. This means a doctor cannot make them do something they do not want to do. The doctor cannot try to get back at them for something that they may have done.
- Be free from any restrictions on freedom of choice among network providers
- Receive information on available treatment options and alternatives, presented in a way that is right for their condition and that they can understand

Member responsibilities

According to the state of Indiana, members have the right to:

- Tell care providers about their medical conditions to the best of their ability
- Call their personal doctor (PMP) for all their medical care
- Keep all their appointments; if they cannot keep an appointment, call to cancel or reschedule as soon as they can
- Tell their doctor if they do not understand what they are told about their condition, care or what they need to do
- Get all childhood shots for their children
- Call your doctor if they are not sure they are having a true emergency
- Follow the rules of their care provider's office

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

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

Chapter 9: Medical records

Looking for something?

- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the “what can we help you find?” search bar

Medical record charting standards

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

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

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

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

***Critical element**

Member copies

~~A member or their representative is entitled to 1 free copy of their medical record. Additional copies may be available at the member's cost. Medical records must be legible, signed (manually or electronically) and dated and maintained for at least 7 years as required by state and federal regulations.~~

Medical record review

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

- The identity of the individual to whom service was rendered
- The identity of the care provider rendering the service
- The identity, including date signature or initials, and position of the provider employee rendering the service, if applicable
- The date on which the service was rendered
- The diagnosis of the medical condition of the individual to whom service was rendered, relevant to physicians, optometrists and dentists only
- A detailed statement describing services rendered, including duration of services rendered
- The location at which services were rendered
- The amount claimed through Medicaid for each specific service rendered
- Written evidence of physician involvement, including signature or initials and personal patient evaluation will be required to document the acute medical needs, excluding HCBS services
- A current plan of treatment and progress notes, as to the medical necessity and effectiveness of treatment and ongoing evaluations as to assess progress and refine goals, if applicable (e.g. pest control and home modification would not require a treatment plan)
- X-rays, mammograms, electrocardiograms, ultrasounds and other electronic imaging records

Chapter 10: Quality management program and compliance information

Key contacts

Topic	Link	Phone Number
Credentialing	Medical: Network Management Resource Team at Networkhelp@uhc.com Chiropractic: myoptumphysicalhealth.com	1-877-614-0484
Fraud, waste and abuse (payment integrity)	uhc.com/fraud	1-800-455-4521 (NAVEX)

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

What is the Quality Improvement program?

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

The program addresses the following quality goals:

- Developing service plans and delivering services in a manner that is person-centered, member-driven and holistic; involves caregivers; and addresses SDOH
- Helping ensure continuity of care and seamless experiences for members as they transition into the PathWays program or among providers, settings or coverage types
- Assuring timely access to appropriate services and supports to enable members to live in their setting of choice and promote their well-being and quality of life

It also consists of:

- Identifying the scope of care and services given
- Taking appropriate action to address service delivery, provider and other quality management and improvement issues as they are identified
- Developing and implementing targeted strategies to improve health, functional or quality of life outcomes
- Addressing the unique needs of populations and subpopulations served, including a focus on equity across subpopulations
- Following procedures for a provider value-based payment program
- Striving for improvement of member health care and services
- Using mechanisms to understand and assess members' SDOH and promote connections with social services providers to address member and informal caregiver SDOH needs
- Using the results of quality management and improvement program activities to design improvement activities to support the quality of all covered benefits under the program, including long-term services and supports as well as other benefits, with appropriate input from members, informal caregivers and providers. This includes survey data, call center data, complaint and grievance data, and input from the member and informal caregiver advisory committee.
- Developing and maintaining mechanisms, including our member and informal caregiver advisory committee, to solicit feedback and recommendations from key stakeholders, members and family members to monitor service quality and to develop strategies to improve member outcomes and quality improvement activities related to the quality of care and system performance

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

Cooperation with quality-improvement activities

You must comply with all QI activities including:

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

We require your cooperation and compliance to:

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

Surveys and care provider satisfaction

UnitedHealthcare Community Plan facilitates surveys the following:

- Members
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Plan, HCBS and Nursing Home National Core Indicators Survey – Aging and Disabilities
- Informal caregivers
- Care provider surveys

We incorporate and address findings from surveys and other analytic activities to assess the quality of care and services provided to members and identify opportunities for improvement.

Clinical practice guidelines

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

Credentialing standards

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

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

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

Criteria includes:

- IHCP MCE Enrollment Form located at UHCprovider.com/INcommunityplan > **Provider Forms and References**
- Required medical or professional education and training
- Verification of post-graduate education or training and/or board certification
- Current license or certification
- DEA certificate and number, if applicable
- Medicare/Medicaid program participation eligibility
- Work history
- Professional liability insurance
- Malpractice history
- Sanction and limitation on licensure
- Hospital staff privileges
- Office site review on PMPs and OB/GYNs

Credentialing and recredentialing process

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

Meet the credentialing and recredentialing standards and be eligible to enroll with Indiana Medicaid. As a condition of network participation, you must be enrolled with the state as a participating provider in the IHCP.

We credential physicians, health care providers and facilities who want to join our network and be listed in our Provider Directory. We recredential at least every 36 months. Our credentialing program helps us maintain and improve the quality of care and services delivered to our members. Our credentialing standards are fully compliant with the NCQA, CMS and Indiana state requirements. We have a thorough, written credentialing program outlined in our Credentialing Plan on **UHCprovider.com/join**.

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- M.D.s (Doctors of Medicine)
- D.O.s (Doctors of Osteopathy)
- D.D.S.s (Doctors of Dental Surgery)
- D.M.D.s (Doctors of Dental Medicine)
- D.P.M.s (Doctors of Podiatric Surgery)
- D.C.s (Doctors of Chiropractic)
- C.N.M.s (Certified Nurse Midwives)
- C.R.N.P.s (Certified Nurse Practitioners)
- P.A.s (physician assistants)
- 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
- Optum Physical Health outpatient clinic PT, OT and speech language pathology care providers

Health facilities

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

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

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

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

For Optum Physical Health chiropractic and outpatient clinic physical therapy, occupational therapy and speech language pathology care providers credentialing, call **1-800- 873-4575** or **myoptumhealthphysicalhealth.com**

Peer review

Credentialing process

A peer review committee reviews all credentialing applications and makes a final decision. The decisions may not be appealed if they relate to mandatory criteria at the time of credentialing.

Credentialing applications will be completely processed within 30 calendar days of receipt of a complete application by our NCC. Care providers will be notified in writing of their credentialing decision.

Recredentialing process

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

Performance review

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

Applicant rights and notification

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

You also have the right to receive the status of your credentialing application, please email us at **networkhelp@uhc.com**. Include your full name, NPI, TIN and brief description of the request.

A UnitedHealthcare representative will be in touch with you within 2 business days from when we receive your request.

Confidentiality

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

Failure to meet recredentialing requirements

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

Resolving disputes

Contract concerns

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

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

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

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

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

If a member has authorized you in writing to appeal a clinical or coverage determination on their behalf, that appeal follows the member appeals process as outlined in the member handbook at:

UHCCommunityPlan.com/IN and **Chapter 12** of this manual.

HIPAA compliance – your responsibilities

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

Transactions and code sets

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

Unique identifier

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

National Provider Identifier

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

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

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

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

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

Ethics and integrity

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

Compliance program

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

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

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

Reporting and auditing

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

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

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

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

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

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

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the state of Indiana to perform individual and corporate extrapolation audits. This may affect all programs supported by dual funds (state and federal funding) as well as state-funded programs, as requested by the state of Indiana.

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

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

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

You must cooperate with the state or any of its authorized representatives, the state of Indiana, CMS, the Office of Inspector General (OIG), or any other agency prior-approved by the state, at any time during your Provider Agreement.
These entities may, at all reasonable times, enter your premises. You agree to allow access to and the right to audit, monitor and examine any relevant books, documents, papers and records to otherwise evaluate (including periodic information systems testing) your performance and charges.

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 agreement must include all requirements of your applicable Provider Agreement and this manual.

Office site quality

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

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

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

Criteria for site visits

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

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

Chapter 11: Billing and submission

Key contacts

Topic	Link	Phone Number
Claims	UHCprovider.com/claims	1-866-633-4449
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	1-800-465-3203
EDI	UHCprovider.com/EDI	1-800-210-8315

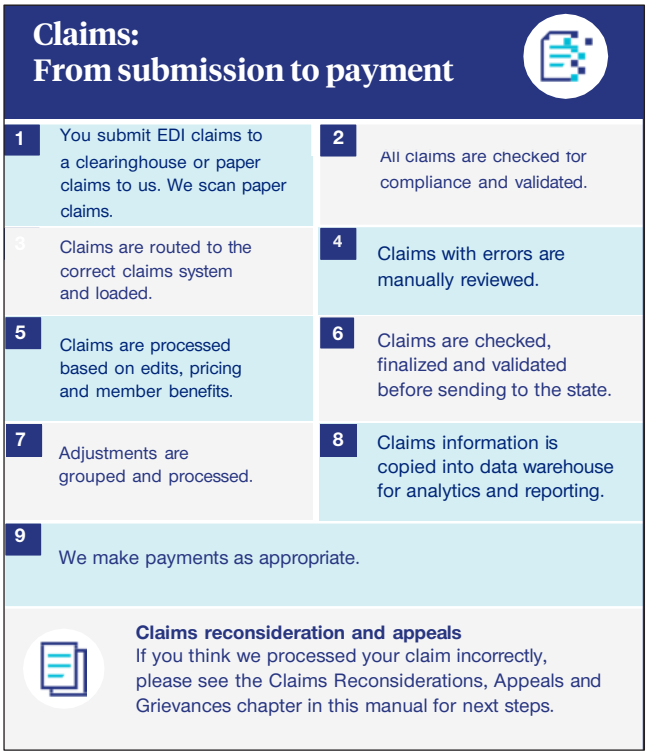
Looking for something else?

- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

Our claims process

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

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



National Provider Identifier

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

If you have not applied for a NPI, contact **National Plan and Provider Enumeration System (NPPES)**

Once you have an identifier, report it to UnitedHealthcare Community Plan. Call **Provider Services**

Your clean claims must include your NPI and federal TIN

General billing guidelines

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

Fee schedule

Reimbursements also depend on the fee schedule and the procedure performed. Refer to your bulletins for correct coding. Refer to the IHCP Fee Schedule for procedure code or revenue code coverage at **in.gov/medicaid**.

Modifier codes

Use the appropriate **modifier codes** on your claim form. The modifier must be used based on the date of service.

Recipient ID card for billing

The recipient ID (RID) card has the state's member identification number. Use the RID when billing UnitedHealthcare Community Plan.

Member ID card for billing

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

Acceptable claim forms

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

- Use the CMS 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services.
- Use the UB-04 form for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other care providers.

Clean claims and submission requirements

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

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

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

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

Care provider coding

Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to find an ICD-9 or ICD-10 code.

For more information about ICD-10 coding and SDOH protocol and how they apply to the members you treat, see the Specific Protocols chapter in the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) at **UHCprovider.com/guides** or visit **UHCprovider.com/en/policies-protocols.html**, Under Additional Resources, choose Protocols > **Social Determinants of Health ICD-10 Coding Protocol**

Electronic claims submission and billing

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

- All claims are set up as "commercial" through the clearinghouse
- Our payer ID is 87726
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for CMS 1500 and UB-04 forms

For more information, see **EDI Claims**

EDI companion documents

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

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

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

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

Clearinghouse and status reports

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

For clearinghouse options, go to UHCprovider.com/EDI > **EDI Clearinghouse Options**

e-Business support

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

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

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

Electronic payment solution: Optum Pay™

~~UnitedHealthcare Community Plan sends electronic care provider payments instead of paper checks. You can sign up for automated clearinghouse (ACH)/direct deposit, our preferred method of payment, or to receive a virtual card payment. The only alternative to a virtual card is direct deposit. Both of these options allow you to get paid quickly and securely.~~

Why choose ACH/direct deposit?

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

What does this mean to you?

- ~~If your practice/health care organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a virtual card will be automatically sent in place of paper checks.~~
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**
- If your practice/health care organization is already enrolled and receiving your claim payments through AHC/direct deposit from Optum Pay™ or receiving virtual cards, you don't need to take action
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and virtual card statement will be available online through Document Library
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

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

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on **UHCprovider.com**, Click Resources, then Resource Library to find the **EDI** section

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

Completing the UB-04 form

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

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

Capitated services

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

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

1. Who have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare Community Plan for such member
2. Who are covered under an applicable benefit plan insured by or receiving administrative services from UnitedHealthcare Community Plan

Additionally, capitated care providers may be subject to any or all delegated activities. Capitated care providers should refer to their delegation grids within their participation agreements to determine which delegated activities the capitated care providers are performing on behalf of UnitedHealthcare Community Plan.

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

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

Form reminders

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

Member cost sharing requirements

During office visits, importance of member education on any deductible, cost share, patient or waiver liability obligation, or transfer penalty period they may need to meet to maintain Medicaid eligibility.

Subrogation and coordination of benefits

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

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

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

Hospital and clinic method of billing professional services

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

Global days

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

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

National Correct Coding Initiative

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

Comprehensive and component codes

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

- **Separate procedures**
  Only report these codes when performed independently
- **Most extensive procedures**
  You can perform some procedures with different complexities. Only report the most extensive service.
- **With/without services**
  Don't report combinations where 1 code includes and the other excludes certain services
- **Medical practice standards**
  Services part of a larger procedure are bundled
- **Laboratory panels**
  Don't report individual components of panels or multichannel tests separately

Clinical laboratory improvements amendments

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

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02.

For more information about the CLIA number, contact the CMS CLIA Central Office at:

Indiana Department of Public Health
Division of Acute Care Services
2 N Meridian Street, Room 4A
Indianapolis, IN 46204
1-317-233-7502
Fax 1-317-233-7157
Email - **IndianaCLIA@isdh.IN.gov** or go to **cms.gov**.

Billing multiple units

When billing multiple units:

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

Billing guidelines for obstetrical services

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

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

Billing guidelines for transplants

The state of Indiana covers medically necessary, nonexperimental transplants. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation.

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

Ambulance claims (emergency)

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

National drug code

Claims must include:

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

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

Medical necessity

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

Place of Service codes

Go to CMS.gov for Place of Service codes.

Asking about a claim

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

Provider Services

Call **1-877-610-9785**. Have the following information ready before you call:

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

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

Provider Portal

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

Resolving claim issues

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

Mail paper claims and adjustment requests to:

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

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

For paper claims

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

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

Timely filing

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

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

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

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

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

If we reject a claim and don't receive corrections within 90 days from date of service or close of business from the primary carrier, the claim is considered late billed. It will be denied timely filing.

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

Balance billing

Do not balance bill members if:

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

Federal and state regulations prohibit you from charging any IHCP member, or a family member, for any amount not paid for covered services following a reimbursement determination by the IHCP.

As a condition of your participation in the IHCP, you must accept the IHCP determination of payment as payment in full, whether the IHCP is the primary or secondary payer. If you disagree with the Medicaid determination of payment, your right of recourse is limited to an adjustment request, administrative review and appeal.

Charging for missed appointments

You may not charge IHCP members for missed appointments. This is based on the reasoning that a missed appointment is not a distinct reimbursable service, but part of your overall cost of doing business. Furthermore, the Medicaid rate covers the cost of doing business, and you may not impose separate charges on members.

If you don't know who your provider advocate is, email **IN_PR_Team@uhc.com** and a care provider advocate will get back to you

Third-party resources

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

Chapter 12: Claims reconsiderations, appeals and grievances

Looking for something?

- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

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

For claims, billing and payment questions, go to **UHCprovider.com/claims**, using our online options or phone number

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

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form for mail	Contact phone number	Website (care providers only) for Online Submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider claim reconsideration	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission.	Care Provider	**UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240	UHCprovider.com/claims	1-877-610-9785	Use Claims on the Provider Portal. UHCprovider.com, then Sign In on top right.	must receive within 60 calendar days from denial paid date	30 business days
Care provider claim informal dispute	The first step to dispute how a claim was paid or to submit a corrected claim. If you disagree with the outcome of the reconsideration, move to a formal appeal process.	Care Provider	**UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240	N/A	1-877-610-9785	Use Claims on the Provider Portal. UHCprovider.com, then Sign In on top right.	must receive within 60 calendar days from denial date	30 calendar days

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form for mail	Contact phone number	Website (care providers only) for Online Submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider claim formal appeal	A second review in which you did not agree with the outcome of the reconsideration	Care Provider	**UnitedHealthcare Community Plan of Indiana** P.O. Box 31364 Salt Lake City, UT 84131-0364	N/A	1-877-610-9785	Use Claims on the Provider Portal UHCprovider.com, Sign In on top right.	60 calendar days	45 calendar days
Member appeal	A request to change an adverse benefit determination that we made	*Member *Member's authorized representative (such as friend or family member) with written member consent *Care provider on behalf of a member with member's written consent	**UnitedHealthcare Community Plan of Indiana** P.O. Box 31364 Salt Lake City, UT 84131-0364	UHCprovider.com/claims *AOR Consent Form on this site for member appeals	1-800-832-4643, (TTY 711)	Use Prior Authorization on the Provider Portal. UHCprovider.com, then Sign In on top right.	60 calendar days from date of denial	Urgent appeals: We will resolve within 48 hours Standard appeals acknowledgement letter sent within 3 business days Resolution of standard appeal within 30 calendar days
Member grievance	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns	*Member *Care provider or authorized representative (such as friend or family member)	**UnitedHealthcare Community Plan of Indiana** P.O. Box 31364 Salt Lake City, UT 84131-0364	N/A	1-800-832-4643, (TTY 711)	Use Prior Authorization on the Provider Portal UHCprovider.com, Sign In on top right	standard grievance is 60 calendar days from date of occurrence	Urgent grievances: We will resolve within 48 hours Standard grievance acknowledgment letter sent within 3 business days Resolution of standard grievance within 30 calendar days

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

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

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

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

Denial

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

- **Administrative denial**
  When we didn't get notification before the service, or the notification came in too late
- **Medical necessity**
  The level of care billed wasn't approved as medically necessary

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

Other top reasons for denial include:

- **Duplicate claim**
  One of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.
- **Claim lacks information**
  Basic information is missing, such as a person's date of birth; or information is incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information.
- **Eligibility expired**
  Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired, and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.
- **Claim not covered by UnitedHealthcare Community Plan**
  Another claim denial you can avoid is when procedures are not covered by us. You can easily avoid this problem by using real-time verification.
- **Time limit expired**
  This is when you don't send the claim in time.

Claim correction

What is it?

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

When to use:

Submit a corrected claim to fix or void one that has already processed.

How to use:

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

Mailing address:

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

Additional information

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

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 you send a reconsideration, please send additional support information.

When to use it:

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

Emergency services:

- Medical records for prudent lay review

For administrative denials:

- In your reconsideration request, please ask for a medical necessity review and include all relevant medical records. For medical necessity denials:
- In your request, please include any additional clinical information that may not have been reviewed with your original claim.

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.

Mailing address:

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

How to use: To resubmit the claim or submit a reconsideration, follow the same submission instructions as a new claim.

Mailing address:

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

Claim informal dispute (step 1 of dispute)

What is it? A claim reconsideration request is the quickest way to address your concern about whether the claim was paid correctly. However, if you are not satisfied with the outcome of the reconsideration an informal dispute can be submitted. Please submit additional supporting information.

When to use:

An informal dispute is a one-time request that that should include new information. Submit an informal dispute when you think a reconsideration has not been properly processed.

For emergency services – Medical records for prudent lay review
For administrative denials – In your reconsideration request, please ask for a medical necessity review and include all relevant medical records.

For medical necessity denials –

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

How to use: if you disagree with a claim determination, submit a claim reconsideration request electronically, by phone or mail.

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

- **Phone –** Call Provider Services at **1-877-610-9785** 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 Informal Dispute Request Form to:

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

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

Tips for successful claims resolution

To help process claim informal disputes:

- Do not let claim issues grow or go unresolved
- Call **Provider Services** if you can't verify a claim is on file
- Do not resubmit validated claims on file unless submitting a corrected claim
- File adjustment requests and claims disputes within contractual time requirements
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity

- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Valid proof of timely filing documentation (reconsideration)

What is it?

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

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

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

How to use:

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

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

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

Overpayment

What is it?

An overpayment happens when we overpay a claim **How to use:**

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

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

If you prefer to mail a refund, send an overpayment return check or the Overpayment Refund/Notification form.

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

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

Where to send:

Mail refunds with an overpayment return check or the Overpayment Refund/Notification form to:

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

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

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

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

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

Sample overpayment report

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

Member ID	Date of service	Original claim #	Date of payment	Paid amount	Amount of overpayment	Reason for overpayment
11111	01/01/14	14A000000001	01/31/14	$115.03	$115.03	Double payment of claim
2222222	02/02/14	14A000000002	03/15/14	$279.34	$27.19	Contract states $50.00, claim paid $77.29
3333333	03/03/14	14A000000003	04/01/14	$131.41	$99.81	You paid 4 units, we billed only 1
44444444	04/04/14	14A000000004	05/02/14	$412.26	$412.26	Member has other insurance
55555555	05/05/14	14A000000005	06/15/14	$332.63	$332.63	Member terminated

Former provider appeal (step 2 of dispute)

What is it?

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

When to use:

If you do not agree with the outcome of the claim informal dispute decision, use the claim appeal process.

How to use:

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

- **Electronic claims:** Use Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims. You may upload attachments.
- **Mail:** Send the appeal to:

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

Questions about your appeal or need a status update?
Call **Provider Services** for questions about your appeal, how to communicate with the appeal reviewer, or if you need a status update. If you filed your appeal online, you should receive a confirmation email or feedback through the secure provider portal.

Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses CMS definitions for appeals and grievances.

Member appeals

What is it?

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

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

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

When to use:

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

Where to send:

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

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

Phone – 1-800-587-5187 (TTY **711**)

As the provider, you may also submit electronically on **UHCprovider.com**. Navigate to Prior Authorization to submit an appeal on a member's behalf.

You must sign an Authorization of Representation form on **UHCprovider.com/claims**. If needed, an appeals representative will provide you with this form.

How to use:

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

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

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

We resolve an expedited appeal 48 hours from when we receive it.

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

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

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

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

Member grievance

What is it?

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

When to use:

You may act on the member's behalf by submitting a grievance

Where to send:

You or the member may call, mail or submit the information electronically anytime to:

Mailing address:

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

Phone – 1-800-587-5187 (TTY **711**)

As the care provider, you may also submit electronically on **UHCprovider.com** and navigate to Prior Authorization to submit a grievance on a member's behalf.

We will send an answer no longer than 30 calendar days from when you filed the grievance or as quickly as the member's health condition requires.

State fair hearings

What is it?

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

When to use:

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

They must exhaust the health plan's appeal process before requesting a State Fair Hearing.

How to use:

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

Office of Administrative Law Proceedings
Attn: Hearing and Appeals
402 W. Washington St. RM E034
Indianapolis, IN 46204

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

External review

An alternative to a state fair hearing is an external review by an independent review organization (IRO). The rules for a state fair hearing also apply to an external review.

Members can share why they think Indiana Medicaid services should not have been denied, reduced or terminated. The member must complete the first-level appeal before asking for an external review. Members have up to 120 calendar days from the receipt of the first-level appeal decision letter to ask for an external review. The IRO will make their decision within 72 hours for an expedited review, or 15 business days for a standard reviews. Whatever the decision is from the IRO, we will comply.

If a member does not agree with the IRO's decision, they may ask for a state fair hearing. The UnitedHealthcare Community Plan member may ask for an external review by writing a letter to:

UnitedHealthcare Community Plan
Attn: Indiana Grievance and Appeal Manager
P.O. Box 31364
Salt Lake City, UT 84131-0364

or

UnitedHealthcare Community Plan
Attn: Indiana Grievance and Appeal Manager
7440 Woodland Drive
Indianapolis, IN 46278

Processes related to reversal of our initial decision

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

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

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

Fraud, waste and abuse

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

UnitedHealthcare Community Plan's anti-fraud, waste and abuse efforts focus on prevention, detection and investigation of false and abusive acts committed by you and plan members. The effort also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer

suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies based on state and federal law. 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 work. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

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

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

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

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

Exclusion checks

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

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

What you need to do for exclusion checks

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

Chapter 13: Care provider communications and outreach

Key contacts

Topic	Link	Phone Number
Provider education	UHCprovider.com > Resources > **Resource Library**	**1-877-610-9785**
News and bulletins	UHCprovider.com > Resources > **News**	**1-877-610-9785**
Provider manuals	**UHCprovider.com/guides**	**1-877-610-9785**

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

Connect with us on social media:

Communication with care providers

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

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

- **UHCprovider.com**
  This public website is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates and quality programs.
- **UHCprovider.com/INcommunityplan**
  The UnitedHealthcare Community Plan of Indiana page has state-specific resources, guidance and rules
- **Policies and protocols**
  UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols
- **Indiana health plans**
  UHCprovider.com/IN is the fastest way to review all the health plans UnitedHealthcare offers in Indiana.
  To review information for another state, use the drop-down menu at UHCprovider.com > Resources > **Health Plans**. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **UnitedHealthcare Provider Portal**
  This secure portal is accessible from **UHCprovider.com**. It allows you to access patient information such as eligibility and benefit information and digital ID cards.
  - You can learn more about the portal in **Chapter 1** of this manual or by visiting **UHCprovider.com/portal**. You can also access UHCprovider.com/training > **Digital Solutions** for many of the tools and tasks available in the portal.
  - Have a question? Skip the phone and chat with a live service advocate when you sign in to the UnitedHealthcare Provider Portal.

  Available 7 a.m.– 7p.m. CT, Monday through Friday, chat support can help with claims, prior authorizations, credentialing and member benefits.

Care provider education and training

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

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

Email communication / required contact information

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

Submit your email address in 1 of the following ways:

- Sign up for a **One Healthcare ID**, which also gives you access to the UnitedHealthcare Provider Portal

Already have a One Healthcare ID? To review or update your email, simply sign into the portal, go to “Profile & Settings,” then “Account Information” to manage your email

Care provider office visits

Provider advocates regularly visit PMPs and specialist offices. All in-network care providers have an assigned provider advocate account manager arranged by territories that mirror the Indiana Medicaid’s 5 Indiana Regions. Our advocates are available to deliver face-to-face or virtual support depending on the provider preference. We do this to create program awareness, promote compliance and problem resolution.

If you are not sure who your provider advocate is, you can view a map to determine which provider advocate to contact based on your location at **UHCprovider.com/INcommunityplan** > Contact Us

Care provider manual

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

State websites and forms

Find the following forms on the state’s website at **in.gov/fssa**:

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

Glossary

Abuse (by care provider)

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

Abuse (of member)

- Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault

Acute inpatient care

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

Advance directive

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

Adverse benefit determination

- For a resident of a rural area, the denial of a member's request to exercise their right, to obtain services outside the network
- The denial, in whole or in part, of payment for a service
- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
- The failure of someone or a company to act within the time frames provided in the contract and within the standard resolution of grievances and appeals
- The failure to provide services in a timely manner, as defined by the state
- The reduction, suspension, or termination of a previously authorized service

Aged and Disabled Waiver

- Allows Indiana to provide an alternative to nursing facility admission for adults and persons of all ages with a disability. The waiver is designed to provide services to supplement informal supports for people who would require care in a nursing facility if waiver or other supports were not available. Waiver services can be used to help people remain in their own homes, as well as assist people living in nursing facilities to return to community settings such as their own homes, apartments, Assisted Living or Community Home Share. Americans with Disabilities Act (ADA) - Public Law 101-336. The ADA prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, state and local government services, public accommodations, commercial facilities, and transportation. It also mandates the establishment of TDD/telephone relay services.

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 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

Americans with Disabilities Act

- Americans with Disabilities Act (ADA) Public Law 101-336.The ADA prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, state and local government services, public accommodations, commercial facilities, and transportation. It also mandates the establishment of TDD/telephone relay services.

American Indian or Alaska Native enrollee

- American Indian or Alaska Native (AI/AN) is an individual eligible for services from an Indian health care provider

Ancillary care provider services

- Extra health services, like laboratory work and physical therapy, which a member gets in the hospital

Appeal

- A member request that their health insurer or plan to review an adverse benefit determination

Area Agencies on Aging

- Not-for-profit agencies around the state that provide case management, information, and referrals to various services for persons who are aging or developmentally disabled

Authorization

- Approval obtained by care providers from UnitedHealthcare Community Plan for a service before the service is rendered
- Used interchangeably with “preauthorization” or “prior authorization”

Billed charges

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

Capitation

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

Care provider group

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

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 PMP

Centers for Medicare & Medicaid Service

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

Children’s Health Insurance Program

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

Clean claim

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

Contracted health professionals

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

Coordination of benefits

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

Covered services

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

Credentialing

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

Current procedural terminology (CPT ®) codes

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

Delivery system

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

Disallow amount

- Medical charges for which the network care provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member, examples are:
  - The difference between billed charges and in-network rates
  - Charges for bundled or unbundled services as detected by Correct Coding Initiative edits

Discharge planning

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

Disenrollment

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

Dispute

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

Dual Eligible Member

- A member who is eligible for both Medicare and Medicaid. There are two types of Dual Eligible Members:
  - A Qualified Medicare Beneficiary (QMB) Dual Eligible Member (a QMB Plus or a QMB Only), and
  - A Non QMB Dual Eligible Member (a Special Low-Income Beneficiary [SLMB] Plus or an Other Full Benefit Dual Eligible). Eligible member - Person certified by the State as eligible for medical assistance.

Durable medical equipment

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

Electronic data interchange

- **EDI** - the electronic exchange of information between 2 or more organizations

Electronic funds transfer

- **EFT** - the electronic exchange of funds between 2 or more organizations

Electronic medical record

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

Eligibility determination

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

Eligible care providers

- Person, organization, or institution approved by the State as eligible for participation in Medicaid

Emergency care

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

Encounter

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

Enrollee

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

Enrollment

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

Evidence-based care

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

Expedited appeal

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

Family and Social Services Administration

- Indiana Family and Social Services Administration (FSSA) is a health care and social service funding agency with eight care divisions established by Indiana to consolidate and better integrate the delivery of human services by state government. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs; includes the Office of Medicaid Policy and Planning, the Division of Aging, the Division of Family Resources, the Division of Mental Health and Addiction, and the Division of Disability & Rehabilitative Services.

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

Fraud

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

Grievance

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

Home and Community-Based Services

- Home and Community-Based Services (HCBS) that are provided, pursuant to the Indiana Section 1915(c) waiver, as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility.
- An HCBS listing and definitions of services can be found in the HCBS Waiver Provider Manual posted on the FSSA Medicaid HCBS webpage **https://www.in.gov/fssa/da/medicaid-hcbs/**

Health Insurance Portability and Accountability Act

- **HIPAA** - a federal law that provides data privacy protection and security provisions for safeguarding health information

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

Home health care (home health services)

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

Home Health Services

- Nursing services, home health aide services, therapy services, and medical supplies, equipment, and appliances as described in 42 CFR 440.70 when provided to a member at his place of residence and on his or her physician's orders, or beginning March 1, 2020, ordered by the member's nurse practitioner, physician assistant, or clinical nurse specialist, as a part of the plan of care and is reviewed by the practitioner annually as part of a written plan of care [42 CFR 440.70]

Indian or American Indian

- Any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. Indian Health Service (IHS) is the federal agency charged with administering the health programs for federally recognized American Indians

Indiana PathWays for Aging

- Indiana's health care program for Medicaid enrollees who are 60 years of age and older and are eligible for Medicaid based on age, blindness, or disability
- Enrollees include members who have a full Medicare benefit, those in a nursing facility, and those who are receiving long-term services and supports LTSS in a home or community-based setting health risk assessment(s) to ensure that the care of members is adequately coordinated and appropriately managed

Individualized Care Plan

- A plan of care, with contractually defined minimum components, developed for each member based on the results of the member's initial screening and

In-network care provider

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

Long-Term Services and Supports

- Long-Term Services and Supports (LTSS) services and support individuals of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting [42 CFR 438.2]

Managed care

- An arrangement whereby a single care provider or organization oversees the overall care of a patient to ensure cost-efficient quality health care to its members. Managed care helps individuals who are elderly or living with disabilities by providing them with ongoing monitoring and care coordination to assess their needs, identify and treat health conditions, and ultimately close gaps in care.

Managed Care Entity

- Managed Care Entity (MCE) is an organization contracted with the state of Indiana for this contract that meets all applicable requirements of Medicaid managed care organizations under Sections 1903(m) and 932 of the Social Security Act, as well as the implementing regulations set forth in 42 CFR 438, and IC 12-15 as may be amended

Medicare Advantage Special Needs Plan

- A Medicare Advantage Special Needs Plan (MASNP) that exclusively enrolls, or enrolls a disproportionate percentage of, special needs Enrollees and provides Part D benefits under 42 CFR Part 423 to all Enrollees; and has been designated by CMS as meeting the requirements of a MA SNP as determined on a case-by-case basis using criteria that include the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against sicker members of the target population [42 CFR §§422.2 and 422.4(a)(1)(iv)]

Medicaid

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

Medical emergency

- An illness, injury, symptom, or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention, you could reasonably expect 1 of the following to result:
  - Their health would be put in danger
  - They would have serious problems with their bodily functions
  - They would have serious damage to any part or organ of their body

Medically necessary

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

Member

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

National Provider Identifier

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

Out-of-area care

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

Preventive health care

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

Primary medical provider

- **PMP** - a physician, including geriatricians, internal medicine physicians, general practitioners, family medicine physicians, endocrinologists (if primarily engaged in internal medicine) and physician extenders, as allowed under state law and the terms of the plan who provides, coordinates, or helps members access a range of health care services

Prior authorization (notification)

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

Quality management

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

Rural health clinic

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

Service area

- The geographic area served by UnitedHealthcare Community Plan, designated, and approved by the state of Indiana

Service Coordinator

- Individuals meeting Indiana residential, educational and/or experience requirements responsible for the development and continuous modification of the Service Plan for members who are determined NFLOC and receiving LTSS, to establish goals and priorities, comprehensively assess needs, evaluate available resources, and develop a plan of care; and to identify LTSS care providers as well as other community partners to provide a combination of services and supports that best meet the needs and goals of the member and caregiver

Specialist

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

State fair hearing

- An administrative hearing requested if the member does not agree with a notice of appeal resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department

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

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

Appendix A

Indiana state benefits

Benefit	Coverage definitions and limitations
Chiropractic services	Available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic • Limited to 5 and 50 therapeutic physical medicine treatments per member per year
Dental services	Coverage for medically necessary, covered dental services with no annual dollar limit applied. Reimbursement is available for diagnostic services, including initial and periodic evaluations, prophylaxis, radiographs and emergency treatment. • Full-mouth series or panorex are limited to 1 set per recipient every 3 years and 1 set per recipient every 12 months for bitewing radiographs • Comprehensive detailed oral evaluation is limited to 1 per lifetime, per recipient, per care provider, with an annual limit of 2 per recipient • A periodic or limited oral evaluation is limited to 1 every 6 months, per recipient • Topical fluoride is not covered for recipients 21 years of age or older. Prophylaxis is limited to 1 unit every 6 months for noninstitutionalized children ages 12 months up to their twenty-first birthday and 1 unit every 12 months for noninstitutionalized recipients older than 21 years. • Periodontal surgery is a covered service only for cases of drug-induced periodontal hyperplasia Payment for office visits is not covered; reimbursement is only available for covered services performed. In accordance with federal law, all medically necessary dental services are provided for children younger than 21 years, even if the service is not otherwise covered.
Diabetes self-management training services	Services enable the member to, or enhance the member's ability to, properly manage the member's diabetic condition, optimizing the member's own therapeutic regimen. • Limited to 16 units per member per year. Additional units may be prior authorized
Emergency services	Provided to individuals who require immediate medical attention and covered subject to the prudent layperson standard of an emergency medical condition. • All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered

Benefit	Coverage definitions and limitations
Eye care, eyeglasses and vision services	Must be provided by licensed ophthalmologists or optometrists within their scope of practice. Coverage for the initial vision care examination will be limited to: • 1 examination every 2 years for a recipient 21 years of age or older, unless more frequent care is medically necessary Coverage for eyeglasses, including frames and lenses, will be limited to a maximum of: • 1 pair every 5 years for members 21 years and older Other vision-related services – such as pharmaceutical services, surgeries and diabetes self-management training – are covered services when determined to be medically necessary.
Family planning services and supplies	Family planning services include • Limited history and physical examination • Pregnancy testing and counseling provision of contraceptive pills, devices, and supplies • Education and counseling on contraceptive methods • Laboratory tests, if medically indicated as part of the decision-making process for choice of contraception • Initial diagnosis and treatment (no ongoing treatment) of sexually transmitted diseases (STDs) • Screening, and counseling of members at risk for HIV and referral and treatment • Tubal ligation • Vasectomies Pap smears are included as a family planning service if performed according to the United States Preventative Services Task Force Guidelines
Federally qualified health centers (FQHCs)	Coverage is available for services provided by: • Physician • Physician assistant • Nurse practitioner • Clinical psychologist • Licensed clinical addiction counselor • Licensed marriage and family therapists • Licensed mental health counselors • Clinical social worker
Food supplements, nutritional supplements and infant formulas	Available only when no other means of nutrition is feasible or reasonable. • Coverage not available in cases of routine or ordinary nutritional needs • Coverage also not available in cases in which the item is to be used for other than nutritional purposes

Benefit	Coverage definitions and limitations
Hospital services inpatient	Covered when inpatient services (acute, psychiatric and rehabilitation) are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition
Hospital services outpatient	• Provided by an acute care hospital, psychiatric hospital, an ambulatory surgical center or other treatment setting (i.e., birth center) to individuals who are registered as patients with the facility but not admitted as inpatients • Services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition
Home health services	Covered when home health agencies perform medically necessary skilled nursing services provided by: • Registered nurse or licensed practical nurse • Home health aide services • Physical, occupational and respiratory therapy services • Speech pathology services • Renal dialysis for home-bound individuals Services must be certified and ordered in writing by a physician and performed on a part-time or intermittent basis in accordance with a written plan of treatment
Hospice care	Covered in the home and institutional setting under Medicaid if the recipient is expected to die from illness within 6 months. Coverage is available for 2 consecutive periods of 90 calendar days followed by an unlimited number of periods of 60 calendar days. Covered services include: • Palliative care for the physical, psychological, social, spiritual and other special needs of a hospice program patient during the final stages of the patient's terminal illness • Care for the psychological, social, spiritual and other needs of the hospice program patient's family before and after the patient's death
Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)	Covered for up to 60 days. Includes: • Room and board • Mental health services • Dental services • Therapy and habilitation services • Durable medical equipment • Medical supplies • Pharmaceutical products • Transportation • Optometric services

Benefit	Coverage definitions and limitations
Laboratory and radiology services	Must be ordered by a physician or other practitioner authorized to do so under state law. The order must include a condition-related diagnosis that necessitates the laboratory services.
Legend drugs	Covered by Medicaid if the drug is approved by the United States Food and Drug Administration; not designated by CMS as less than effective or identical, related or like a less-than-effective drug; and not specifically excluded from coverage by Indiana Medicaid.
Long-term acute care hospitalization	Covered if ordered in writing by a physician. Prior authorization is required. An all-inclusive per diem rate is paid based on level of care.
Medical supplies and equipment (prosthetic devices, implants, hearing aids, dentures, etc.)	Coverage is available for medical supplies, equipment and appliances suitable for use in the home when they serve a medical purpose, ordered in writing by a physician, optometrist or dentist and are part of the treatment plan. Must be medically necessary.
Mental health/behavioral health services – inpatient	Covered when provided in a freestanding psychiatric hospital or in the psychiatric unit of an acute care hospital. The need for admission must be certified and ordered in writing by a physician and be medically necessary. • Medicaid rehabilitation option services are carved out of the PathWays for Aging program and is provided on a FFS basis. Psychiatric residential treatment facilities (PRTFs) are excluded from managed care. The member will need to be suspended from managed care and moved into FFS. • UnitedHealthcare Community Plan provides care coordination services and associated services related to PRTF services before and after admission • Mental health and addiction services are included
Mental health/behavioral health services – outpatient	Includes outpatient mental health services provided by physicians or licensed behavioral health professionals. We also provide coverage for: • Partial hospitalization services • Clinic option services • Peer recovery • Intensive outpatient therapy • Crisis intervention • Psychiatric wings of acute care hospitals • Outpatient mental health facilities • Psychologists endorsed as health services care providers in psychology Prior authorization is required for higher levels of outpatient care MRO services are carved out and not covered by the health plan. Coverage requirements include treatment plans and progress notes explaining medical necessity and effectiveness of treatment.
Nonlegend drugs	Covered on Medicaid's Formulary (over-the-counter)
Nurse-midwife services	Covered services are restricted to those the certified nurse-midwife is legally authorized to perform
Nurse practitioners	Available for medically necessary services or preventive health care services provided by a licensed, certified nurse practitioners within the scope of the applicable license and certification

Benefit	Coverage definitions and limitations
Nursing facility services (long-term)	Covered for up to 60 days while the level of care determination is pending. Coverage includes: • Room and board • Nursing care • Medical and nonmedical supplies and equipment • Durable medical equipment • Medically necessary • Reasonable therapy services • Transportation to vocational/habilitation service programs
Nursing facility services (short-term)	The managed care entity may obtain services for its members in a nursing facility setting on a short-term basis, i.e., for fewer than 30 calendar days. This may occur if this setting is more cost-effective than other options, and the member can obtain the care and services needed in the nursing facility. The managed care entity can negotiate rates for reimbursing the nursing facilities for these short-term stays.
Occupational therapy	Must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Must be performed by a registered occupational therapist or by a certified occupational therapy assistant under the direct on-site supervision of a registered occupational therapist. Therapy services provided away from the facility must meet the criteria outlined in 405 IAC 5-22. Prior authorization is not required for initial evaluations or services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate or for services provided within 30 calendar days (up to 30 units) following discharge from a hospital when ordered by a physician prior to discharge. Prior authorization is required for therapy in excess of 30 units in 30 calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed 12 units in 30 calendar days without prior authorization. Evaluations and reevaluations are limited to 3 hours of service per evaluation. General strengthening exercise programs for recuperative purposes are not covered by Medicaid. Passive range of motion services as the only or primary modality of therapy and occupational therapy psychiatric services are not covered by Medicaid. Therapy for rehabilitative services will be covered for a recipient no longer than 2 years from the initiation of the therapy unless there is a significant change in medical condition requiring longer therapy.
Organ transplants and services	Covered if medically necessary. Coverage is in accordance with prevailing standards of medical care. Similarly situated individuals are treated alike. Prior authorization is required. Both transplant donor's hospital and surgical expenses for the removal of donor tissue and organ during the inpatient admission is covered when the member is an IHCP member, the member meets criteria for the transplant and the transplant is medically necessary.
Orthodontics	Not covered except in cases of craniofacial deformity or cleft palate. Coverage allows for phased orthodontic treatment that incorporates both an interceptive phase and a comprehensive phase, with specific objectives at various stages of dentofacial development.

Benefit	Coverage definitions and limitations
Out-of-state medical services	Medicaid reimbursement is available for the following services provided outside Indiana: • Acute general hospital care • Physician services • Dental services • Pharmacy services • Transportation services • Therapy services • Podiatry services • Chiropractic services • Durable medical equipment and supplies • Hospice services, subject to the conditions in **405 IAC 5-34-3** • Diagnostic services, including genetic testing All out-of-state services are subject to the same limitations as in state services. Prior authorization is required except for Emergency services (however, continuing inpatient treatment and hospitalization does require prior authorization). Services may be obtained in the following designated out-of-state cities subject to the prior authorization requirements for in-state services: • Louisville, Owensboro (Kentucky) • Cincinnati, Harrison, Hamilton, Oxford (Oxford) • Sturgis (Michigan) • Danville, Watseka (Illinois) Recipients may obtain services in Chicago, Illinois if the recipient's physician determines the service is medically necessary, transportation to an appropriate Indiana facility would cause undue hardship to the patient or the patient's family, the service is not available in the immediate area, the recipient's physician complies with all the criteria set forth in accordance with the state plan and **42 CFR 456.3**. Prior authorization will not be approved for the following out of state services: nursing facilities, ICFs/IID, or home health agency services or any other type of long-term care facility, including facilities directly associated with or part of an acute general hospital.

Benefit	Coverage definitions and limitations
Physicians' surgical and medical services	Reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice: • PMP office visits limited to a maximum of 30 per calendar year, per member, per care provider without prior authorization • New patient office visits are limited to 1 per recipient, per care provider within the last 3 years
Physical therapy	Must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for: • Initial evaluations • Services provided within 30 calendar days (up to 30 units) following discharge from a hospital when ordered by a physician prior to discharge • Services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate Prior authorization is required for therapy in excess of 30 units in 30 calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed 12 units in 30 calendar days without prior authorization. Evaluations and reevaluations are limited to 3 hours of service per evaluation.

Benefit	Coverage definitions and limitations
Podiatrists	Reimbursement provided for podiatric services performed within the scope of the practice of the podiatric profession. • Services covered include diagnosis of foot disorders and mechanical, medical or surgical treatment of these disorders • Surgical procedures involving the foot, laboratory or X-ray services, and hospital stays are covered when medically necessary • No more than 6 routine foot care visits per year are covered for patients with a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous and has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet • Proof must be submitted of patient visit to an M.D. or D.O. for treatment or evaluation of the systemic disease during the 6-month period prior to the rendering of routine foot care services Prior authorization is required for inpatient hospital stays, corrective footwear for patients younger than 21 years and fitting or supplying of orthopedic shoes for patients with severe diabetic foot disease.
Rehabilitative unit services – inpatient	Covered when the following criteria demonstrates the inability to function independently with demonstrated impairment: • Cognitive function • Communication • Continence • Mobility • Pain management • Perceptual motor function • Self-care activities
Residential substance use disorder (SUD) services	Prior authorization is required for all residential SUD stays. Admission criteria for residential stays for OUD or other SUD treatment is based on the following American Society of Addiction Medicine (ASAM) Patient Placement Criteria: • ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services • ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services
Respiratory therapy	Must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for: • Inpatient or outpatient hospital and emergency care • Oxygen equipment and supplies necessary for the delivery of oxygen • Therapy within 30 calendar days (up to 30 units) following discharge from hospital when ordered by physician prior to discharge • Services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate Prior authorization is required for therapy in excess of 30 units in 30 calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed 12 units in 30 calendar days without prior authorization. Evaluations and reevaluations are limited to 3 hours of service per evaluation.

Benefit	Coverage definitions and limitations
Rural health clinics	Covered when provided by a: • Physician • Physician assistant • Nurse practitioner • Clinical psychologist • Licensed clinical addiction counselor • Licensed marriage and family therapists • Licensed mental health counselors • Clinical social worker Reimbursement is also available for services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. Services to a homebound individual are only available in the case of those clinics located in an area that has a shortage of home health agencies as determined by Medicaid.
Sexually transmitted infections	Coverage if medically necessary including initial diagnosis and ongoing treatment of STDs and sexually transmitted infections after diagnosis
Smoking cessation and tobacco dependence treatment services	May include prescription of any combination of smoking cessation and tobacco dependence treatment products and counseling. Care providers can prescribe 1 or more modalities of treatment. Care providers must include counseling in any combination of treatment. Care providers must order tobacco dependence treatment services for the IHCP to reimburse for the services. Ordering and rendering practitioners must maintain sufficient documentation of respective functions to substantiate the medical necessity of the service rendered and to substantiate the provision of the service itself. The IHCP does not require prior authorization for reimbursement for smoking cessation and tobacco dependence treatment products or counseling. The IHCP reimburses pharmacy care providers for smoking cessation and tobacco dependence treatment products, including over-the counter products when a licensed practitioner prescribes them for a member. This includes utilization of the statewide standing order for tobacco cessation products. Only patients who agree to participate in tobacco dependence counseling may receive prescriptions for tobacco dependence treatment products. The prescribing practitioner may want to have the patient sign a commitment to establish a "quit date" and to participate in counseling as the first step in tobacco dependence treatment. A prescription for such products serves as documentation that the prescribing practitioner has obtained assurance from the patient that counseling will occur concurrently with the receipt of tobacco dependence drug treatment. Care providers must perform tobacco dependence counseling for a minimum of 30 minutes (2 units) and a maximum of 150 minutes (10 units) within the course of treatment. IHCP coverage of tobacco dependence counseling services is limited to a maximum of 10 units of counseling per member per calendar year.

Benefit	Coverage definitions and limitations
Speech, hearing and language disorders	Must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, for services provided within 30 calendar days (up to 30 units) following discharge from a hospital when ordered by physician prior to discharge or following discharge from hospital when ordered by physician prior to discharge and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy in excess of 30 units in 30 calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed 12 units in 30 calendar days without prior authorization. Evaluations and reevaluations are limited to 3 hours of service per evaluation.
Transportation - emergency	No coverage limit or prior authorization requirement for: • Emergency ambulance or trips to/from hospital for inpatient admission/discharge • Transportation for patients on renal dialysis or those residing in nursing homes • Accompanying parent or recipient attendant (or both) or for a return trip from the emergency room in an ambulance, if use of ambulance is medically necessary for the transport
Transportation – nonemergency medical	Covered for unlimited trips of less than 50 miles per year without prior authorization when another alternative is not available