2025 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

KanCare

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KanCare

United Healthcare® Community Plan

Welcome

Dear care provider partner,

I'd like to welcome you to UnitedHealthcare Community Plan of Kansas. As a care provider, you are fundamental to our mission of helping people live healthier lives. We value your partnership as we strive to improve the health and well-being of the Kansans we serve.

Health care is personal and individual. Thus providing support at the local level by meeting our members and care providers where they are is an essential piece of our strategy. UnitedHealthcare is committed to enhancing the relationship among patient and care provider. This provider manual is a tool to provide a comprehensive overview of our company and how best to work with us. We encourage you to become familiar with all aspects of this guide.

We look forward to working with you and continuing to strengthen our partnership as we provide care to the consumers of Kansas. We welcome your feedback and ideas for ways we can help you deliver health and wellness. Thank you for sharing our passion of helping people live healthier lives.

Sincerely,

Kevin Sparks
Health Plan CEO, UnitedHealthcare Community Plan of Kansas

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

Click to access different care provider 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 care provider manual – UHCprovider.com/guides**
  - Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on **Find Your State.**

View the **Medicaid glossary** for definitions of terms commonly used throughout the care provider manuals.

If you have questions about the information or material in this manual, or about our policies, please call **Provider Services** at **1-877-542-9235**.

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

Using this care provider manual

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

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

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

This care provider manual will be amended as policies change.

Participation Agreement

Terms and definitions as used in this care provider manual:

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

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** Live chat available at **UHCprovider.com/chat**	**1-877-542-9235**
Training	**UHCprovider.com/training**	
UnitedHealthcare Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID or go to **UHCprovider.com/portal** New users: **UHCprovider.com/access**	
One Healthcare ID support	Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**	**1-855-819-5909**
CommunityCare Provider Portal training	**UnitedHealthcare CommunityCare Provider Portal user guide**	**1-877-542-9236**
Resource library	**UHCprovider.com/resourcelibrary**	

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

- Children, from birth through 18 years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act
- Pregnant member eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act
- Children eligible for the Children's Health Insurance Program (CHIP)
- Categorically needy – blind and disabled children and adults who are not eligible for Medicare
- Medicaid-eligible families

The Kansas Department of Health and Environment – Department of Children and Families (KDHE-DCF) 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 **1-877-542-9235**.

How to join our network

Learn how to join the UnitedHealthcare Community Plan care provider network at **UHCprovider.com/join**. There you will find guidance on our credentialing process, how to sign up for self-service and other helpful information. Note: You must have a Kansas Medical Assistance Program (KMAP) ID to contract/credential with Kansas Medicaid.

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/attestation.**

Approach to health care

Care Model

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

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

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

The Care Model program goals are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates
- Improve access to PCP and other needed services, measured by number of PCP visit rates within identified time frames
- Identify and discuss behavioral health (BH) needs, measured by number of BH health care provider visits within identified time frames
- Improve access to pharmacy
- Identify and remove social and environmental barriers to care
- Improve health outcomes, measured by improved Healthcare Effectiveness Data and Information Set (HEDIS®) and Centers for Medicare & Medicaid Services (CMS) Star Ratings metrics
- Empower the member to manage their complex/chronic illness or problem and care transitions
- Improve coordination of care through dedicated staff resources and to meet unique needs
- Engage community care and care provider networks to help ensure access to affordable care and the appropriate use of services
- To refer your patient who is a UnitedHealthcare Community Plan member to Care Model, call **Member Services** at **1-877-542-9238**, TTY **711**. You may also call **Provider Services** at **1-877-542-9235**.

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 goal of the program is to break down linguistic and cultural barriers to build trust and improve health outcomes. You must support our Cultural Competency Program. For more information,

go to **UHCprovider.com** > Resources > Resource Library > Health Equity Resources > **Cultural Competency**.

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

UnitedHealthcare Community Plan provides the following:

- **Language interpretation line**
  - We provide oral interpreter services Monday–Friday from 8 a.m.–8 p.m. ET
  - To arrange for interpreter services, please call **1-877-842-3210** TTY **711**
- **I Speak language assistance card**
  This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare members.
- **Materials for limited English-speaking members**
  We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

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

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual® for medical care determinations.

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 the **digital solutions comparison guide**. Care providers in the UnitedHealthcare network will conduct business with us electronically.

This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents. This includes appeals prior authorization requests and decisions. Using electronic transactions is fast and 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

Application Programming Interface (API) is a free digital solution that allows health care professionals to automate administrative transactions. API is designed to help your organization improve efficiency, reduce costs and increase cash flow. Automatic data feeds are created to share information between your organization and UnitedHealthcare on a timetable you set, and transfer the data to your practice management system, proprietary software, portal, spreadsheets or any application you prefer.

This can help you create a smoother workflow with fewer interruptions. We have API functionality for many of your day-to-day transactions. For more information, visit **UHCprovider.com/api**.

Electronic data interchange

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

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

- Send and receive information faster
- Identify submission errors immediately and avoid processing delays
- Exchange information with multiple payers
- Reduce paper, postal costs and mail time
- Cut administrative expenses
- EDI transactions available to care providers are:
  - Claims (837)
  - Eligibility and benefits (270/271)
  - Claims status (276/277)

  - Referrals and authorizations (278)
  - Hospital admission notifications (278N)
  - Electronic remittance advice (ERA/835)

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

Getting started

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

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

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 into 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**.

Electronic Payment Statements /Optum Pay

Electronic Payments and Statements (EPS)/Optum Pay™ is the tool for your practice to receive electronic funds transfer (EFT) and electronic remittance advice (ERA) for most UnitedHealthcare health plans.

EPS/Optum Pay has an enrollment process for billing companies that limits their access to your care providers' banking information and keeps you in control.

How EPS works

- Receive claims payments by direct deposit or Virtual Card Payment (VCP) which may be faster than paper checks
- Access explanation of benefits (EOBs) or provider remittance advice (PRA) online or via 835 ERA files
- Receive email notification when payments are deposited to your designated account
- View your deposit amounts along with all remittance advice associated with each deposit
- View or print remittance advice and post payments manually to your practice management system or auto-post using the 835 ERA file

For more information and to enroll in EPS/Optum Pay, visit **UHCprovider.com/claims** > EPS/Optum Pay. You will need the following information for enrollment:

- Bank account information for direct deposit
- A voided check or a bank letter to verify bank account information
- A copy of your organization's W-9 form

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

Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal**. You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information – all at no cost without calling. See **UnitedHealthcare Provider Portal** for access and to create ID or sign in using a One Healthcare ID.

- If you already have a One Healthcare ID, simply go to the **UnitedHealthcare Provider Portal** to access
- 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 **UnitedHealthcare 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/priorauth**.
- **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 the provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.
- **Document Library**
  Access reports and claim letters for viewing, printing, or download. The Document Library Roster provides member contact information in a PDF, which can only be pulled at the individual practitioner level. For more information, go to **UHCprovider.com/documentlibrary**.

  See **UnitedHealthcare Provider Portal** to learn more about the available self-paced user guides for various tools/tasks.
- **Paperless Delivery Options**
  The Paperless Delivery Options tool can send daily or weekly email notifications to alert you to new letters added to your Document Library. With our delivery options, you decide when and where the emails are sent for each type of letter. This is available to UnitedHealthcare Provider Portal One Healthcare ID password owners only.

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 **UnitedHealthcare Provider Portal**. On-site and online training are available.

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

Privileges

To help members 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.

They 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.

Topic	Contact	Information
Behavioral, mental health and substance abuse	Optum® **providerexpress.com** **1-800-888-2998**	Eligibility, claims, benefits and authorization. Refer members for behavioral health services. A PCP referral is not required.
Benefits	**UHCprovider.com/benefits** **1-877-542-9235**	Confirm a member's benefits and/or prior authorization.
Cardiology prior authorization	**UHCprovider.com/cardiology** > Sign In **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Care Model (care management/disease management)	**ksltssadminssuport@uhc.com** **1-877-542-8997**	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
Claims	**UHCprovider.com/claims** **1-877-542-9235** Mailing address: **UnitedHealthcare Community Plan** P.O. Box 5270 Kingston, NY 12402-5270 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 709 Grant Avenue, North Lobby Lake Katrine, NY 12249	Verify a claim status or get information about proper completion or submission of claims.
Claim overpayments	Sign in to **UHCprovider.com/claims** to access the UnitedHealthcare Provider Portal. **1-877-542-9235** Mailing address: **UnitedHealthcare Community Plan** P.O. Box 101760 Atlanta, GA 30392-1760	Ask about claim overpayments. See the **Overpayment** section for requirements before sending your request.
Dental services	SKYGEN USA (formerly Scion Dental) 1-855-878-5327 skygenusa.com/login	Ask questions, get support and program information.

Topic	Contact	Information
Electronic Data Interchange (EDI) issues	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315**	Contact EDI Support for issues or questions
Eligibility	**UHCprovider.com/eligibility** **1-877-542-9235**	Confirm member eligibility.
Enterprise Voice Portal	Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud, waste and abuse (payment integrity)	Payment integrity information: **UHCprovider.com/kscommunityplan** > Integrity of Claims, Reports and Representations to the Government Reporting: **uhc.com/fraud** **1-844-359-7736**	Learn about our payment integrity policies. Report suspected fraud, waste and abuse by a care provider or member by phone or online.
KanCare Medicaid for Kansas	1-800-792-4884	Contact KanCare directly.
Kansas Department for Aging and Disability Services (KDADS)	kdads.ks.gov 1-785-296-4986 or 1-800-432-3535	KDADS is the state agency responsible for the administration and management of the home and community-based (HCBS) waiver of Medicaid provisions for specific groups.
Kansas Department of Health and Environment (KDHE)	kdhe.kancare@ks.gov 1-800-792-4884	KDHE Division of Health Care Finance (DHCF) is the single-state Medicaid agency for Kansas responsible for the administration and management of the KanCare medical assistance program.

Topic	Contact	Information
Medical claim, reconsideration and appeal	**UHCprovider.com/claims** **1-877-542-9235** Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations and appeals, see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at one of the following addresses: Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5270 Kingston, NY 12402-5270 Appeals mailing address: **UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	**myuhc.com®** **1-877-542-9238** TTY **711** for help accessing member account 8 a.m.–6 p.m. CT, Monday–Friday	Assist members with issues or concerns.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	**1-877-542-9238** TDD **711**	Available 8 a.m.–5 p.m. CT, Monday–Friday, except state-designated holidays.
Network management support	Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**	Self-service functionality to update or check credentialing information.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).
NurseLine	**1-866-351-6827**	Available 24 hours a day, 7 days a week.
Obstetrics and baby care	Healthy First Steps® Pregnancy Notification Form at **UHCprovider.com**, then Sign In for the UnitedHealthcare Provider Portal. **1-800-599-5985** **uhchealthyfirststeps.com**	For pregnant members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form. Refer members to **uhchealthyfirststeps.com** to sign up for Healthy First Steps Rewards.

Topic	Contact	Information
One Healthcare ID support center	Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat.** **1-855-819-5909**	Contact if you have issues with your ID. Available 7 a.m.–9 p.m. CT, Monday–Friday; 6 a.m.–6 p.m. CT, Saturday; and 9 a.m.–6 p.m. CT, Sunday.
Pharmacy services	**professionals.optumrx.com** **1-877-305-8952**	Optum Rx® oversees and manages our network pharmacies.
Prior authorization/ notification for pharmacy	**UHCprovider.com/pharmacy** **1-800-310-6826**	Request authorization for medications as required. Use the UnitedHealthcare Provider Portal to access the **PreCheck MyScript®** tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives.
Prior authorization requests and advanced/ admission notification	To notify us or request a medical prior authorization: • EDI: Transactions 278 and 278N **UHCprovider.com/priorauth** Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications" or call **1-877-542-9235.** Children's Mercy Pediatric Care Network **1-833-802-6427**	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/kscommunityplan** > **Prior Authorization and Notification**

Topic	Contact	Information
Provider Services	**UHCprovider.com/kscommunityplan** **1-877-542-9235** **ks_provider_requests@uhc.com** This email inbox is intended to be used solely for communications that do not contain encrypted Protected Health Information (PHI). Email messages and any documents containing PHI are protected by various state and federal laws including 45 C.F.R. Part 164. No emails or documentation should be sent to this inbox that contain PHI unless the communication is encrypted. Examples of PHI include a member's name, date of birth, any detail regarding their medical condition including diagnoses and any other combination of identifiable information.	Available 8 a.m.–5 p.m. CT, Monday–Friday.
Radiology prior authorization	**UHCprovider.com/radiology** > Sign In **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Referrals	**UHCprovider.com/referrals** Provider Services **1-877-542-9235**	Submit new referral requests and check the status of referral submissions.
Reimbursement policy	**UHCprovider.com/kscommunityplan** > **Policies and Protocols**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Transportation	ModivCare member.modivcare.com 1-877-796-5847, 8 a.m.–8 p.m., Monday–Friday	Non-emergent medical transportation reservations must be scheduled at least 3 business days before the member's appointment. Discharges and urgent trips can be scheduled 24 hours a day.
Technical support	For chat options and contact information, visit **UHCprovider.com/contactus** **1-866-209-9320** for Optum support	Call if you have issues logging in to the UnitedHealthcare Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit line	1-800-784-8669	Ask about services for quitting tobacco/smoking.

Topic	Contact	Information
Utilization management	**1-877-542-9235**	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/protocols.** Request a copy of our UM guidelines or information about the program.
Vaccines for Children (VFC) program	kdhe.vaccine@ks.gov 1-877-296-0464	You must participate in the VFC program administered by the KDHE. You must also use the free vaccine when administering vaccine to qualified eligible children. You must enroll as VFC care providers with KDHE to bill for the administration of the vaccine.
Vision services	MARCH® Vision Care providers.enesynergy.com 1-844-506-2724	Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from MARCH Vision. Available 8 a.m.–5 p.m. PT, Monday–Friday.
Website for Kansas Community Plan	**UHCprovider.com/kscommunityplan**	Access your state-specific Community Plan information on this website.

If you have questions about UnitedHealthcare Community Plan of Kansas, view a contact list of care provider support teams available to assist you at **UHCprovider.com/kscommunityplan** > Contact Us > **Provider Contact Us List**.

Chapter 2: Care provider standards and policies

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com**	**1-877-542-9235**
Enterprise Voice Portal	Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**	
Eligibility	**UHCprovider.com/eligibility**	
Referrals	**UHCprovider.com/referrals**	**1-877-542-9235**
Provider Directory	**UHCprovider.com/findprovider**	

General care provider responsibilities

Non-discrimination

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

Communication between care providers and members

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

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

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

Provide official notice

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

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

Visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

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 services for a reasonable time at our in-network rate. **Provider Services** at **1-877-542-9235** is available to help you and our members with the transition.

Arrange substitute coverage

For the most current list of network professionals, review our Provider Directory at **UHCprovider.com/findprovider**.

Changing an existing TIN or adding a care provider

Visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

Updating your practice or facility information

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

- Visiting **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data electronically
- For general provider assistance, connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**

After-hours care

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

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

Participate in quality initiatives

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

We base clinical quality initiatives on optimal delivery of health care for diseases and conditions. This is determined by United States government agencies and professional specialty societies. See **Chapter 10** for more details on the initiatives.

Provide access to your records

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

Performance data

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

Comply with protocols

You must comply with the UnitedHealthcare Community Plan and payer's protocols, including those contained in this care provider manual. You may view protocols at **UHCprovider.com/protocols.**

Office hours

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

Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

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

Follow medical record standards

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

Inform members of advance directives

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

You may contract with other entities to furnish this information but you are still legally responsible for ensuring that the requirements of this section are met. Such information must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the state law.

Specific requirements:

1. Each hospital must provide written information to every adult receiving medical care by or through the hospital. This information must contain:
   - The person's right to make decisions concerning their own medical care
   - The person's right to accept or refuse medical or surgical treatment
   - The person's right to make advanced directives.
   - The Kansas Department for Aging and Disability Services (KDADS) Description of the Law of Kansas Concerning Advance Directives
2. Additionally, each hospital must provide written information to every adult person about the hospital's policy on implementing these rights.
3. A hospital must document in every person's medical record whether the person has executed an advanced directive.
4. A hospital may not place any health care conditions or otherwise discriminate against a person based upon whether that person has executed an advance directive.
5. Each hospital must comply with state law regarding advance directives.
6. Each hospital must provide staff and community education about advance directives. This may be done with brochures, newsletters, articles in the local newspapers, local news reports or commercials.

Your Agreement

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

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

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal

process in the member's benefit contract or handbook. You may locate the member handbook at **UHCCommunityPlan.com/ks**.

Also reference **chapters 11 and 12** of this manual for information on care provider claim reconsiderations, appeals and grievances.

Appointment standards (KanCare access and availability standards)

Comply with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- After-hours care phone number – 24 hours, 7 days a week
- Emergency care – Immediately or referred to an emergency facility
- Urgent care appointment – within 48 hours
- Routine care appointment – within 3 weeks
- Physical exam – within 180 calendar days
- EPSDT appointments – within 6 weeks
- New member appointment – within 30 calendar days
- In-office waiting for appointments – not to exceed 45 minutes of the scheduled appointment time

Specialty care

Specialists should arrange appointments for:

- Urgent care appointment – within 48 hours of request
- Non-urgent "sick" visit – within 48-72 hours of request, as clinically indicated
- Routine care appointment – within 30 days of request/referral

Behavioral health (mental health and substance use)

Mental health

- Discharge from inpatient care – within 24–72 hours from date of discharge
- Emergent care appointments – within 3 hours of request
- Urgent, non-emergency care appointments – within 72 hours of request
- Routine outpatient services – within 14 business days of request

Substance use disorder (SUD)

- Emergent care appointments – immediately
- Urgent care appointments – within 24 hours of request
- Routine care appointments – within 14 days of request
- IV drug users who have used within the last 6 months – within 14 days of request
- IV drug users who are pregnant and all other pregnant substance users – within 24 hours of assessment
  - If it is not possible to admit the member, you must provide interim services within 48 hours and include prenatal care

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- First trimester – within 3 weeks of request
- Second trimester – within 2 weeks of request
- Third trimester – within 1 week of request
- High-risk – within 3 calendar days of identification of high risk

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

Provider Directory

You are required to tell us, within 5 business days, if 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:

- Delegated care providers – submit changes to your designated submission pathway
- Nondelegated care providers – visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data

Find the medical, dental and mental health care provider directory at **UHCprovider.com/findprovider**.

Care provider attestation

Confirm your data every quarter through the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-877-542-9235**. If you have received the upgraded My Practice Profile and have editing rights, access the **UnitedHealthcare Provider Portal** for My Practice Profile to make many of the updates required in this section.

When you submit demographic updates, list only those addresses where a member may make an appointment and see the health care provider. On-call and substitute health care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address.

Prior authorization request

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

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

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

- Verify eligibility using the UnitedHealthcare Provider Portal at **UHCprovider.com/eligibility** or by calling **Provider Services** at **1-877-542-9235**. 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 UnitedHealthcare Provider Portal:
  1. To access the Prior Authorization app, go to **UHCprovider.com**, then click Sign In.
  2. Select the Prior Authorization and Notification app.
  3. View notification requirements.

Identify and bill other insurance carriers when appropriate.

If you have questions, for chat options and contact information, visit **UHCprovider.com/contactus**, 7 a.m.–9 p.m. CT, Monday–Friday.

Notification requirements

For all notifications, call **1-877-542-9235.**

- **Urgent/emergent** – 72 hours
- **Non-emergent** – 14 days

Return calls from health service coordinators or medical directors and provide complete health information within 1 business day.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

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

Requirements for primary care providers and specialists serving in primary care provider role

Specialties include internal medicine, pediatrics or obstetrics/gynecology

Primary care providers (PCPs) are an important partner in the delivery of care and Kansas Medical Assistance Program (KMAP) members may seek services from any participating care provider. KMAP requires members

be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

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

Medical doctors (M.D.s), doctors of osteopathy (D.O.s), N.P.s and P.A.s from any of the following practice areas can be PCPs:

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

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

Members may change their assigned PCP by contacting Member Services at **1-877-542-9238**. Customer service is available 7 a.m.–7 p.m., Monday–Friday.

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

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

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support and benefit from the primary care case management system. The coverage will include availability of 24 hours a day, 7 days a week. During non-office hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services.

Recorded messages are not acceptable.

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

- Make sure clinical and non-clinical services are in the overall care plan for special needs members
- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing
- Submit all accurately coded claims or encounters timely
- Provide all well baby/well-child services
- Coordinate each UnitedHealthcare Community Plan member's overall course of care
- Accept UnitedHealthcare Community Plan members at each office location at least 16 hours a week for a 1-M.D. practice and at least 30 hours per week for a 2-or more-M.D. practice
- Be available to members by telephone any time
- Tell members about appropriate use of emergency services
- Discuss available treatment options and alternative courses of care with members

Responsibilities of primary care providers and specialists serving in primary care provider role

Specialties include internal medicine, pediatrics or obstetrics/gynecology

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide
- Conduct a baseline examination (to include KAN Be Healthy and/or biometric screening) 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 Department as appropriate
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.
- Provide covered benefits consistent with professionally recognized standards of health care and UnitedHealthcare Community Plan standards
- Document procedures for monitoring members' missed appointments, as well as outreach attempts to reschedule missed appointments
- Encourage members to receive all necessary and recommended preventive health procedures
- Screen members for behavioral health problems, using the Behavioral Health Toolkit at providerexpress.com > Clinical Resources > **Behavioral Health Toolkit for Medical Providers**
- Inform UnitedHealthcare Community Plan case management of any member showing signs of end stage renal disease. Call **1-877-542-9238.**
- Provide culturally competent care and services. You must have a program designed to educate and train staff on addressing cultural and linguistic barriers to the delivery of health care services to members of all cultures.
- Maintain staff privileges at a minimum of 1 UnitedHealthcare Community Plan participating hospital
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws and regulations
- 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 KanCare Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment standards are covered in **Chapter 2** of this manual.

Primary care provider checklist

1. Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-877-542-9235.**
2. Check the member's ID card at the time of service. Verify member with photo identification. Plan participating specialists when needed.
3. Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth.**
4. Refer patients to UnitedHealthcare Community Plan care providers.
5. Identify and bill other insurance carriers when appropriate.
6. Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form.

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

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

- **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 social worker, PA, NP and/or other care provider
  - Mental health services
  - Immunizations (shots)
  - Home nurse visits

- **PCC**
  A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a primary care clinic that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

Specialist responsibilities

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

- Contact the PCP to coordinate the care/services
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer
- Verify the eligibility of the member before providing covered specialty care services
- Provide only those covered specialty care services, unless otherwise authorized
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at 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 KanCare Access and Availability standards for scheduling routine visits. Appointment standards are covered in **Chapter 2** of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, 7 days a week, or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

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

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

Ancillary care provider responsibilities

Ancillary providers include:

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

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

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

Ancillary care provider checklist

1. Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-877-542-9235.**
2. Check the member's ID card at the time of service. Verify member with photo identification.
3. Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth**.
4. Identify and bill other insurance carriers when appropriate.

Home and community-based services care provider responsibilities

As a home and community-based services (HCBS) care provider, you must:

- Provide services according to the Person-Centered Service Plan including the amount, frequency, duration and scope of each service according to the member's service schedule

- Use the Electronic Visit Verification (EVV) system to submit claims, if applicable. All other HCBS providers will file claims according to the options listed in the claims filing portion of this manual. Requirements regarding use of EVV can be found in **Chapter 4.**
- Follow the documentation requirements for each HCBS program service as defined in the applicable KMAP provider manual
- Adhere to providing timely initiation of services according to the KDHE published Network Adequacy Standards, HCBS Service Initiation Standards, Section V, Tables 2 and 3

Chapter 3: Care provider office procedures and member benefits

Key contacts

Topic	Link	Phone number
Member benefits	**UHCCommunityPlan.com**	**1-877-542-9238**
Member handbook	**UHCCommunityPlan.com/ks** > Plan Details > Member Resources > View Available Resources	
Provider Services	**UHCprovider.com**	**1-877-542-9235**
Prior authorization	**UHCprovider.com/priorauth**	
D-SNP	**UHCprovider.com/KS** > Medicare > **Dual Complete Special Needs Plan**	

Benefits

Go to **UHCCommunityPlan.com/ks** or **UHCprovider.com/eligibility** for more information.

Member advocate

Members may also contact a member advocate, who can help them work better with us and you. This means:

- Communicating the values and practices of all cultures we serve
- Filing a grievance, changing care coordinators or getting the care they need
- Referring members to the right UnitedHealthcare Community Plan staff or programs
- Solving problems with member care

Members may reach a member advocate by calling **1-877-542-9238**, TTY **711**.

KanCare ombudsman

The KanCare consumer ombudsman helps members on KanCare with their rights and responsibilities. They step in when members:

- Need help with a concern or filing a grievance
- Need help with a problem they can't solve by speaking with your KanCare plan
- Do not think that they are getting the care that they need
- Feel their rights are being violated

Members may call 1-855-643-8180 to reach the KanCare Ombudsman.

Assignment to primary care provider panel roster

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

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

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

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

View the **Document Library Interactive User Guide** to see the basic steps you'll take to access letters and secure reports.

Choosing a primary care provider

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

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

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

Medically necessary definition

Medically necessary health care services or supplies are those necessary to:

- Prevent, diagnose, correct, prevent the worsening of, 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 or causes suffering or pain or results in illness or infirmity
- Prevent the deterioration of a condition
- Promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capabilities that are appropriate for individuals of the same age
- Prevent or treat a condition that may cause or aggravate a handicap or cause physical deformity or malfunction and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member

Member assignment

Assignment to UnitedHealthcare Community Plan

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

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

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

Member dismissal

To dismiss a member, you must complete the following steps:

1. Notify the member in writing, giving them 30 day's notice, and include specific reason(s) for dismissal.
2. Notify us in writing and include a copy of the letter sent to the member.

Mail UnitedHealthcare Community Plan notifications to:

UnitedHealthcare Community Plan
Attn: Member Services
6860 West 115th Street
Overland Park, KS 66211
Mail Route: KS015 - M400

We will contact the member and assist them in finding a new PCP.

Member eligibility

UnitedHealthcare Community Plan serves members enrolled with KanCare, Kansas' Medicaid program. The Kansas Department of Health and Environment (KDHE) determines program eligibility. An individual who becomes eligible for the KanCare program either chooses or is assigned to one of the KanCare-contracted health plans.

Member ID card

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

If a fraud, waste and abuse event arises from a care provider or a member's ID card, go to **uhc.com/fraud** or call the Fraud, Waste and Abuse Hotline at **1-844-359-7736**.

The member's ID card also shows the PCP assignment on the front of the card. If a member does not bring their card, call **Provider Services** at **1-877-542-9235**. Also document the call in the member's chart.

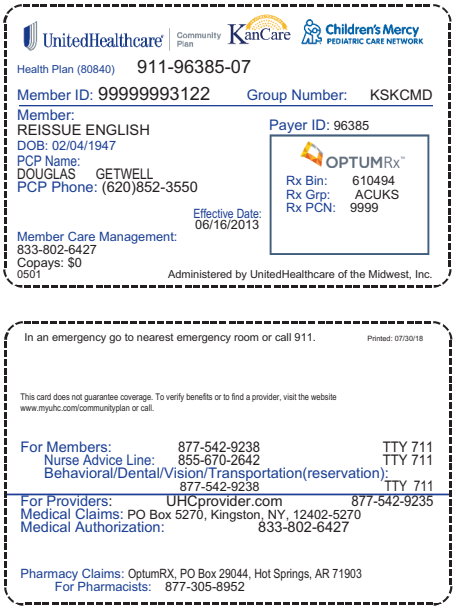
Member identification numbers

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

Sample health member ID card

Children's Mercy Pediatric Care Network

Children's Mercy Pediatric Care Network (CMPCN) Pediatric Care Network Provider Resources are available for care providers. These resources include reference guides, forms and frequently asked questions.


UnitedHealthcare Community Plan KanCare Children's Mercy Pediatric Care Network

Health Plan (80840) 911-96385-07

Member ID: 99999993122 Group Number: KSKCMD

Member:
REISSUE ENGLISH
DOB: 02/04/1947
PCP Name:
DOUGLAS GETWELL
PCP Phone: (620)852-3550

Payer ID: 96385

OPTUMRx
Rx Bin: 610494
Rx Grp: ACUKS
Rx PCN: 9999

Effective Date:
06/16/2013

Member Care Management:
833-802-6427
Copays: $0
0501

Administered by UnitedHealthcare of the Midwest, Inc.

In an emergency go to nearest emergency room or call 911.

Printed: 07/30/18

This card does not guarantee coverage. To verify benefits or to find a provider, visit the website www.myuhc.com/communityplan or call.

For Members: 877-542-9238 TTY 711
Nurse Advice Line: 855-670-2642 TTY 711
Behavioral/Dental/Vision/Transportation(reservation): 877-542-9238 TTY 711
For Providers: UHCprovider.com 877-542-9235
Medical Claims: PO Box 5270, Kingston, NY, 12402-5270
Medical Authorization: 833-802-6427

Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 877-305-8952

Verifying member enrollment

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

- Access the portal through **UHCprovider.com/eligibility**
- **Provider Services** at **1-877-542-9235** is available from 7 a.m.–5 p.m. CT, Monday–Friday
- Kansas Medical Assistance Program (KMAP)

Benefit information

Visit **UHCCommunityPlan.com/ks** > Medicaid Plans > UnitedHealthcare Community Plan KanCare View Plan Details > Member handbook to view member benefit coverage information.

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 Kansas-specific D-SNP information, go to **UHCprovider.com/ks** > Resources > Health Plans > Choose Your Location > Kansas > Medicare > **Kansas Dual Complete Special Needs Plans**.

Chapter 4: Medical management

Key contacts

Topic	Link	Phone number
Referrals	**UHCprovider.com/referrals**	**1-877-542-9235**
Prior authorization	**UHCprovider.com/priorauth**	**1-877-542-9235**
Pharmacy	**professionals.optumrx.com**	**1-877-305-8952**
Dental	skygenusa.com/login	1-855-878-5327
Healthy First Steps	**uhchealthyfirststeps.com**	**1-800-599-5985**

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

Ambulance services

Air ambulance

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

- Great distances or other obstacles keep members from reaching the destination
- Immediate admission is essential
- The pickup point is inaccessible by land

Non-emergent air ambulance requires prior authorization. For authorization, go to **UHCprovider.com/priorauth** or call **Provider Services** at **1-877-542-9235**

Emergency ambulance transportation

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

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

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

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

Ambulance services for a member receiving inpatient hospital services are not included in the payment to the hospital. They must be billed by the ambulance provider. This includes transporting the member to another facility for services (e.g., diagnostic testing) and returning them to the first hospital for more inpatient care.

Make urgent, non-emergency trips, such as when a member is sent home from the hospital, through our Member Call Center after 7 p.m. CT. Schedule rides up to 30 days in advance.

Members must call between 8 a.m.–8 p.m. CT, Monday–Friday, to schedule transportation. If they have questions about their order, they may call ModivCare.

Bus transportation will also be available if the member:

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

Non-emergent medical transportation

UnitedHealthcare Community Plan members may get non-emergent medical transportation (NEMT) services through ModivCare for covered services. Covered transportation includes sedan, taxi, wheelchair-equipped vehicle, public transit, mileage repayment and shared rides. Members may get transportation when they are bed-confined before, during and after transport. Members under 18 require an adult to ride with them. Members 18 and over, emancipated minors and pregnant minor members can ride on their own.

We also offer up to 24 total round-trip rides per year to cover for example: getting to the pharmacy, grocery store, food bank, WIC, prenatal classes, support group meetings, job related activities such as interviews, job training, shopping for work clothes, career counseling and other local community activities. Members in Wyandotte, Sedgwick, Shawnee and Johnson counties can get $25 in annual bus passes. Nonemergent stretcher/ambulance transportation must be requested at least 3 days before their appointment. Requests can be made online anytime at member.modivcare.com or by phone at 1-877-796-5847

Cardiology

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

You must obtain prior authorization for the following cardiology procedures:

- Diagnostic catheterizations
- Electrophysiology implant procedures
- Echocardiograms
- Stress echocardiograms

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

- Emergency rooms
- Hospital observation units
- Urgent care centers
- Inpatient settings

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

Request prior authorization online or by phone:

- **Online** – **UHCprovider.com/cardiology** > Sign In
- **Phone** – **1-866-889-8054** from 7 a.m.–7 p.m. local time, Monday–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** > Sign In > Specific Cardiology Programs.

Care coordination/ management

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

The program goals are to:

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

Our program makes available population-based, condition-specific health education materials, websites, interactive mobile apps and newsletters that include recommended routine appointment

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

Identification

Use the health risk assessment as an initial assessment tool used to identify a member's health risks. Based on the member's response to a series of questions, you can identify if the member may benefit from care coordination and refer them appropriately.

All members enrolled in the following long-term support services (LTSS) waiver programs are immediately assigned a care coordinator for comprehensive assessment and coordination of physical/behavioral health needs and LTSS.

- Frail Elderly (FE)
- Physical Disability (PD)
- Brain Injury 16–64 (BI)
- Intellectual and Developmental Disability (I/DD)
- Technology Assisted (TA)
- Serious Emotional Disturbance (SED)
- Autism

Dental services

Any adult member age 21 and older can visit a participating dental care provider. Benefits include cleanings, check-up, X-rays, fillings, crowns, dentures and partials with prior authorization.

For more details, see the UnitedHealthcare KanCare Dental Provider Manual at UHCprovider.com/guides > Community Plan Care Provider Manuals for Medicaid Plans by State > Kansas > **KanCare/Skygen Dental Provider Manual**.

To find a dental care provider, go to UHCprovider.com/findprovider > **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/policies > For Community Plans > **Medical & Drug Policies and Coverage Determination Guidelines for Community Plan**.

Durable medical equipment /medical supply specific billing information

For specific information about benefits, limitations and covered codes under the KanCare program, please see the Kansas Medical Assistance Program (KMAP) durable medical equipment (DME) care provider manual at kmap-state-ks.us.

Prior authorization information in the KMAP DME manual is specific to fee-for-service members. For prior authorization information for UnitedHealthcare Community Plan members, visit **UHCprovider.com/kscommunityplan**.

Effective May 1, 2021, we will use UnitedHealthcare medical policy and InterQual Care Guidelines to review your DME prior authorization request for medical necessity, unless otherwise indicated.

For more billing and submission information, see **Chapter 11** of this manual.

Wheelchair seating assessments

We cover physical medicine and rehabilitation procedure codes 97542, 97755 and 97760 for the management of wheelchair seating assessments.

Wheelchair seating assessment reimbursement cannot exceed $500 per member per year and is limited to the following care providers:

- Carney Center Seating Clinic – Wichita, KS
- Children's Mercy Hospital Seating Clinic – Kansas City, MO
- KU Medical Center Seating Clinic – Kansas City, KS

For more information on wheelchairs and wheelchair seating assessments, see the KMAP DME provider manual at kmap-state-ks.us.

Emergency/urgent care services

Emergency services do not require prior authorization.

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

Covered services include:

- Hospital emergency department room, ancillary and care provider service by in and out-of-network care providers
- Medical examination
- Stabilization services
- Access to designated level I and level II trauma centers or hospitals meeting the same levels of care for emergency services

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

Emergency room care

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

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

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

Urgent care (non-emergent)

Urgent care services are covered.

For a list of urgent care centers, contact **Provider Services** at **1-877-542-9235.**

Observation room

Observation in the outpatient setting is a service which requires monitoring the patient's condition beyond the usual amount of time in an outpatient setting.

Examples of the appropriate use of the observation room include: monitoring head trauma, drug overdose, cardiac arrhythmias and false labor.

A care provider or mid-level practitioner must see the patient within 2 hours prior to admission to the observation room except for obstetrical labor or scheduled administration of IV medication or blood products.

The observation room stay must be medically necessary.

- The observation stay is limited to 48 hours. Observation hours in excess of 48 hours are not reimbursable.
  - You must have personal contact with the patient at least once during the observation stay
  - A registered nurse or an employee under his or her direct supervision must monitor patients in the observation unit
- Ancillary charges (such as lab work or X-rays) must be billed separately. Medical supplies and injections (99070 and J7030-J7130) are considered content of service of the observation room service.
- Observation services are considered content of service to any surgical procedure for which global surgery rules apply when performed by the same care provider during the global surgery period
- Observation services are considered content of service to respiratory services (94010-94700) when performed on the same date of service by the same care provider, unless the observation is a significant and separate identifiable service

Do not bill the observation room for the following:

- Recovery room services following inpatient or outpatient surgery
- Recovery/observation following scheduled diagnostic tests such as arteriograms and cardiac catheterization
- ER physician fee

Note: Additional information may be added to your claim if applicable.

If the claim and/or attachments do not support the medical necessity of the provided service, we will deny the claim.

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 UnitedHealthcare Provider Portal at **UHCprovider.com/priorauth**, EDI 278N transaction at **UHCprovider.com/edi**, or call **Provider Services** at **1-877-542-9235.**

UnitedHealthcare Community Plan makes utilization management determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally-developed clinical criteria. UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize Utilization Management staff to support service underutilization. Care determination criteria is available upon request by contacting **Provider Services** at **1-877-542-9235**.

For policies and protocols, go to UHCprovider.com/policies > **For Community Plans**.

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

Facility notification requirements

Admission notification

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
- SNF admissions
- Admission following outpatient surgery
- Admissions following observation

Required discharge notification

We must receive the discharge notification from rehabilitation center and SNF stays within 24 hours after actual weekday discharge (or by 5 p.m. local time on the next business day if the 24-hour limit would require notification on a weekend or holiday). For weekend and holiday discharges, we must receive the notification by 5 p.m. local time on the next business day.

Required observation stay notification

Observation stay notifications are required to be submitted within 24 hours of patient no longer being held for observation (or by 5 p.m. local time on the next business day if the 24-hour limit would require notification on a weekend or holiday). For weekend and holiday admissions, we must receive the notification by 5 p.m. local time on the next business day.

We will accept these notifications through automated channels, like 278N or ADT, but will also support the notification intake through EMR, Prior Authorization and Notification Tool in the **UnitedHealthcare Provider Portal**, or by phone.

To start using these automated channels, you can:

1. Contact your current claims processing vendor or clearinghouse.
2. Submit through the Optum Electronic Discharge Interchange (EDI) portal.

Family planning

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

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

Voluntary sterilization

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the KMAP Hospital Provider Manual at kmap-state-ks.us for more information on covered sterilization and family planning services.

Hearing services

For coverage information on hearing aids, please see the UnitedHealthcare Community Plan KanCare **Member handbook**.

For coverage information on bone-anchored hearing aids (BAHA), please see the KMAP Hospital Manual.

Cochlear implants are covered using KS coding guidelines.

Home- and community-based services

The state of Kansas now fully integrates home- and community-based services (HCBS) into KanCare. The state, or its designees, determines eligibility for all HCBS programs.

Programs include:

- Autism (AU)
- Frail and elderly (FE)
- Physical disability (PD)
- Technology assisted (TA)
- Brain injury 0-64 (BI)
- Serious emotional disturbance (SED)
- Intellectual/developmental disability (I/DD)

We follow the service description, billing guidelines, service and care provider requirements and other protocols as outlined in the applicable KMAP provider manual. Visit kmap-state-ks.us > Publications > Provider Manuals.

Work Opportunities Reward Kansans program

UnitedHealthcare Community Plan coordinates services covered under the Work Opportunities Reward Kansans (WORK) program. For specific program criteria, refer to the Kansas Department of Health and Environment WORK Policy Manual at kdheks.gov.

Electronic visit verification

HCBS care providers must use AuthentiCare for electronic visit verification (EVV) for certain services. Do not use AuthentiCare for HCBS services in assisted living, residential health care, home plus or boarding home care settings (including attendant care, wellness monitoring and adult day care). Adult day care providers should use AuthentiCare only when they provide services in a free-standing licensed adult day care setting.

HCBS care providers using EVV through AuthentiCare are responsible for monitoring and immediately addressing service gaps, including back-up staffing.

New care providers can register for an AuthentiCare user account at authenticare.com/Kansas.

For more information about the AuthentiCare system, refer to the KS AuthentiCare User Manual at kdads.ks.gov > Providers > Home and Community Based Services Information > AuthentiCare® Kansas Information > Presentation and General Information > KS AuthentiCare User Manual.

Institutional transitions

An institutional transition is the process of moving residents of qualified institutional settings into the community. This process identifies individuals who have expressed a desire to return to the community and provides them with community supports to help them maintain residence in the least restrictive setting of their choice. Institutional transitions are available for the FE, PD, BI or I/DD program members. They can receive transition services and funds (up to $2,500) when meeting certain criteria.

Financial management services

KMAP provides financial management services (FMS) for FE, PD, TA, BI and I/DD program members.

UnitedHealthcare Community Plan will reimburse the FMS provider's administrative functions as an HCBS program service.

We follow the service description, billing guidelines, service and care provider requirements, and other protocols as outlined in the KMAP FMS Manual at kmap-state-ks.us > Publications > Provider Manuals > HCBS FMS Manual.

Care coordination for nursing facility residents

Care coordinators are responsible for:

- Completing a comprehensive assessment that includes the member's functional ability, physical and behavioral health conditions, available informal supports, environmental considerations, social assessment, as well as member and family preferences
- Initial assessment and care within 14 days of member assignment
- Assisting with transition management following inpatient admissions
- Facilitating integration with Optum Behavioral Health as needed to support the member and family

Care coordination for Home and Community-based services program members

Care coordinators are responsible for:

- Creating a Person-Centered Service Plan that includes a comprehensive assessment of the member's functional ability, physical and behavioral health conditions, available informal supports, environmental considerations, social assessment, as well as member and family preferences
- Initial assessment and care/service plan development within 7 days of member assignment
- Annual reassessments
- Reassessments every 6 months of TA waiver members
- Supporting and educating about chronic condition management
- Facilitating community resource supports

- Submitting the authorization for HCBS services
- Contacting HCBS members by phone at least quarterly; face-to-face reviews every 6 months

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice. These services do not require prior authorization.

For additional information on hospice services, forms and coverage, refer to the KMAP Hospice Provider Manual.

Home hospice

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

Respite hospice

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

Inpatient hospice

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.

Immunizations

Adult immunization (19 years of age and older)

You will bill the appropriate vaccine immunization and administration code. Services are processed in accordance with state benefits and paid per state fee schedule. We will not reimburse CPT codes for vaccines covered under the Vaccines for Children (VFC) program for children 18 years of age and younger.

Laboratory

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

For more information on our in-network labs, go to UHCprovider.com/findprovider > **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.

Advanced outpatient imaging procedures

Advanced outpatient imaging procedures do not require prior authorization unless it is a Positron-Emission Tomography (PET) scan. Review the **Radiology Prior Authorization** section of this chapter for more information.

Local health departments

Local health departments are required to coordinate care with UnitedHealthcare Community Plan and complete standard reporting to the state health department any time a member is diagnosed with a sexually transmitted disease or tuberculosis.

Lock-In program

The Lock-In program improves medical management for members who may not be using medical services appropriately. This happens through educational interventions, service coordination and reinforcement of the care provider-member relationship. Members participating in the Lock-In program are limited to 1 pharmacy, 1 hospital and 1 PCP for all outpatient non-emergent medical care.

UnitedHealthcare Community Plan selects a member for Lock-In program review when any of the following occur:

1. A utilization review report indicates the member has not used healthcare services appropriately, including but not limited to:
   - Over-utilization
   - Persistent non-compliance
   - Abusive/threatening behavior
2. Medical care providers, social service agencies or other concerned parties provided direct referrals to the state or to UnitedHealthcare Community Plan
3. Member is committing fraud or abuse of medical benefits

UnitedHealthcare Community Plan reviews the member's medical and/or billing history to determine if the member used health care services and/or medications that were not medically necessary, abusive or excessive.

As a result of the Lock-In program review, we may take any of the following steps:

1. Determine that no action is needed and close the member's file.
2. Send the member, or their authorized representative, a letter of concern with information on specific findings and notice of potential placement in the Lock-In program.
3. Educate the member on appropriate use of health care services.
4. Refer the member to substance abuse or behavioral health treatment, or to other support services as needed.
5. Enroll the member in the Lock-In program.

The initial lock-in period is 24 months. Before enrollment, we will assist the member in selecting lock-in care providers for PCP, pharmacy and hospital. We will send the member a written notice containing the following information:

- The action we intend to take related to the lock-in and the reason for this action
- Instructions for choosing a PCP, pharmacy and hospital
- Effective date the lock-in
- The duration of the enrollment and re-evaluation period
- The member's right to file an appeal
- Any other requirements under federal, state laws and regulations

The member will have the same care providers throughout the lock-in enrollment period unless:

- The member moves outside of the care provider's service area
- The care provider moves outside of the member's local area and is no longer reasonably accessible
- The care provider refuses to continue service to the member
- We assigned the member to the care provider because the member did not select a care provider. In this case, the member may request a change once within 30 calendar days of the initial assignment.
- The member's current care provider no longer participates in the health plan. The member has been assigned to the same care provider for at least 1 year and requests a care provider change.

A member remains in the Lock-In program for the initial 24-month period regardless of whether they change health plans or become a fee-for-service member. We will review the member before the end of the 24-month lock-in period. If service utilization and medical compliance has improved, we will remove the member from the program and notify them in writing. If the member still meets Lock-In program criteria, they will remain in the program for an additional 24 months and we will notify them in writing.

Care provider participation

The Kansas Medical Assistance Program (KMAP) website provides Medicaid eligibility and Lock-In program information to all care providers participating in UnitedHealthcare Community Plan. You should verify

eligibility and Lock-In program status before providing services to a member. If you provide outpatient non-emergent services to a Lock-In program member without a PCP referral, we will deny the claim.

When a Lock-In program member selects a PCP, we will confirm the PCP is willing to accept a Lock-In program member. We will verify the care provider's practice location and billing NPI number.

Care providers participating in the Lock-In program must meet the following requirements:

1. You must be located in the member's local geographic area and/or be reasonably accessible to the member.
2. As the Lock-In program PCP, you must supervise and coordinate all of the Lock-In member's health care services, including continuity of care and referrals to specialists when necessary.
   - Perform a thorough history and physical examination of the member before making referrals to other care providers
   - Document the medical necessity for all referrals in the member's medical record
   - Use the PCP Lock-In Referral Form for all non-emergent medical services performed by another care provider. The form and referral guidelines are located at **UHCprovider.com/kscommunityplan** > Provider Forms and Resources > Community Plan Kansas KanCare Primary Care Physician PCP Locked In Referral Form
   - After the referral is made, the Lock-In PCP must provide ongoing management of the member's health care
   - The referred-to care provider must receive the UnitedHealthcare Lock-In Referral Form before providing services and agrees to provide only the requested services by the Lock-In PCP
   - The referred-to care provider must provide the Lock-In PCP with a consultation report, including test and lab results, X-rays, follow-up or prescribing recommendations
   - A referral is NOT required for the following services:
     - Transportation
     - HCBS and Work program
     - Mental health care providers
     - DME
     - Optometrists and opticians
     - Radiology and laboratory services
     - Inpatient services
     - Ambulatory surgical centers
     - SNFs
     - Psychiatric, rehabilitation and state institutions
     - Home health agencies and hospice
     - Physical, occupational and speech therapy
     - Audiologists and hearing aid dealers
     - Targeted case managers
     - Nutritionists
     - Dentists
     - Renal dialysis centers
     - Pathologists
   - Retain prescribing privileges when appropriate, based on the prescribed medications and your scope of practice
3. The pharmacy fills all Lock-In members' prescriptions. The pharmacy must verify that the prescribing physician is a valid prescriber for the member. If the prescribing physician is not the Lock-In PCP, the pharmacy must obtain a copy of the PCP Lock-In Referral Form given to the prescribing physician by the Lock-In PCP.
4. The hospital provides all Lock-In members non-emergent outpatient hospital services.

For more information, visit **UHCprovider.com/kscommunityplan** or call **Provider Services** at **1-877-542-9235**.

Maternity/pregnancy/ well-child care

Pregnancy notification risk screening

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

Call Healthy First Steps at **1-800-599-5985**.

Healthy First Steps program

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

Members self-enroll on a smartphone or computer at **uhchealthyfirststeps.com** or calling **1-800-599-5985**.

The HFS-Maternal care model strives to:

- Increase early identification of expectant members and facilitate case management enrollment
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it
- Multidisciplinary support for pregnant 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 healthcare decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits
- Foster a care provider-member collaboration before and after delivery as well as for non-emergent settings
- Encourage members to stop smoking with our Quit for Life tobacco program
- Help identify and build the 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 Community Plan for care coordination.

Pregnancy/maternity

Bill the initial pregnancy visit as a separate office visit. You may bill global days if the member 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.

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. The member has an established relationship with a non-participating obstetrician.

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

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

Maternity admissions

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

Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, the online Prior Authorization and Notification tool at **UHCprovider.com/priorauth**, or by calling **1-877-542-9235**.

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

- Date of admission
- Member's name and Medicaid ID number

- Obstetrician's name, phone number, care provider ID
- Facility name (care provider ID)
- Vaginal or cesarean delivery

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

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

Non-routine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires prior authorization. Infants remaining in the hospital after 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 NP, physician's assistant or licensed professional nurse. If handled through supervision, the services must be within the staff's scope of practice or licensure as defined by state law.

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

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

Post-maternity care

UnitedHealthcare Community Plan covers post-discharge care to the member and their newborn. Post-discharge care consists of a minimum of 2 visits, at least 1 in the home, according to accepted maternal and neonatal physical assessments. These visits must be conducted by a registered professional nurse with experience in maternal and child health nursing or a care provider. The first post-discharge visit should occur within 24 to 48 hours after the member's discharge date. Prior authorization is required for home health care visits for postpartum follow-up. The attending care provider decides the location and post-discharge visit schedule.

Newborn enrollment

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

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

Bright Futures assessment

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

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

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

Home care and all prior authorization services

The discharge planner ordering home care should call **Provider Services** at **1-877-542-9235** 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 the Hysterectomy Necessity form. The member should sign and date the form stating she was told before the surgery that the procedure will result in permanent sterility.

Find the form on the KMAP website at kmap-state-ks.us > Publications > Forms > **Hysterectomy Necessity Form**.

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

Exception: KMAP does not require informed consent if:

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

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

Abortion

UnitedHealthcare Community Plan covers abortions only under the following conditions:

1. If the pregnancy is the result of rape or incest (use the G7 modifier).
2. If the member suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by, or arising from, the pregnancy.

Complete the Abortion Necessity Consent form and submit it with the claim. The form is located at kmap-state-ks.us > Publications > Forms > **Abortion Necessity**.

Abortions do not require prior authorization.

Sterilization and hysterectomy procedures

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

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

Sterilization informed consent

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

Sterilization consent form

Use the consent form for sterilization:

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

The consent form is located at kmap-state-ks.us > Publications > Forms > **Consent for Sterilization-HMS-687**.

Have 3 copies of the consent form:

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

Complete and submit the forms with your initial claim for any sterilization procedures, including hysterectomies, for KanCare members, even if KanCare is not the primary payer.

If you have questions, call **Provider Services** at **1-877-542-9235** or your provider advocate.

Neonatal Intensive Care Unit case management

The Neonatal Intensive Care Unit (NICU) management program manages inpatient and post-discharge NICU cases to improve outcomes and lower costs. Our dedicated team of NICU case managers, social workers and medical directors offer both clinical care and psychological services.

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

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

Pharmacy services

Optum Rx adheres to the state-approved formulary and preferred drug list (PDL) for members enrolled in UnitedHealthcare Community Plan. You may access the list of covered drugs at **UHCprovider.com/kscommunityplan** > Pharmacy Resources and Physician Administered Drugs.

Pharmacy preferred drug list

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

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

If a member requires a non-preferred medication, call the Pharmacy Prior Authorization department at **1-800-310-6826**.

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 /kscommunityplan**.

Prior authorization

Some drugs on the state-approved formulary and PDL may require prior authorization. Pharmacists should work with the prescribing care provider to change to a preferred alternative medication. If a preferred alternative is not appropriate, the care provider should contact UnitedHealthcare's Pharmacy department at **1-800-310-6826** with questions about the prior authorization process. The PDL and those that require prior authorization are at **UHCprovider.com/kscommunityplan** > Pharmacy Resources and Physician Administered Drugs.

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

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

Refill Too Soon

Refill Too Soon thresholds (effective 2/1/18):

1. **Non-controlled substances** – The Refill Too Soon threshold is 85%. This means members may refill their medication when they have used 85% of it.
2. **Controlled substances** – The Refill Too Soon threshold is 90%. This means members may refill their medication when they have used 90% of it.

Exemptions to this change include all long-term care members and any member who is residing or transitioning to or from a residential care facility. The long-term care population identified by state eligibility will be a hard code bypass of the new coding and the pharmacist attestation will allow overrides at point of sale as needed.

Quantity limitations

UnitedHealthcare Community Plan places quantity limitations on medications, which may differ from limitations placed by the Kansas Vendor Drug Program's Fee-for-Service Program. For more information about drug-specific quantity limits, visit **UHCprovider.com/kscommunityplan** > Pharmacy Resources and Physician Administered Drugs or call our Pharmacy Department at **1-800-310-6826.**

Specialty pharmacy medications

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

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

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

Optum Rx administers Disease Therapy Management (DTM) programs as part of specialty pharmacy care management services. The Kansas Medicaid plan requires DTM programs to cover the following diseases/conditions:

- Rheumatoid arthritis
- Growth disorders
- Hemophilia
- Respiratory syncytial virus (RSV) due to prematurity
- Hepatitis C

- Multiple sclerosis
- Anemia related to chemotherapy

Preventive health care standards

UnitedHealthcare Community Plan's goal is to partner with care providers to help ensure our members receive preventive care. We endorse and monitor preventive health standards recommended by recognized medical and professional organizations.

Preventive health care standards and guidelines are available at **UHCprovider.com/kscommunityplan**.

Standards such as well child, adolescent and adult visits, childhood and adolescent immunizations, lead screening, and cervical and breast cancer screening are included on the website. We provide education to both members and care providers related to preventive health services. We will assist members with access to these services, if needed. Members may self-refer to all public health agencies for available treatment options.

Healthcare Effectiveness Data and Information Set and Consumer Assessment of Healthcare Providers and Systems

The PATH program focuses on improving Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results by collaborating with care providers and providing the necessary resources to help you successfully address care opportunities for our members.

The goals of PATH are to:

- Get more members to engage with their physicians, so they get the preventive care services they need
- Share valuable data, tools and resources with physician practices
- Deliver administrative tools and clinical support to maximize performance

For more information about the PATH program, go to **UHCprovider.com/path**.

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.

- Positron-Emission Tomography (PET)

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:

- **UHCprovider.com/radiology** > Sign In
- Phone: **1-866-889-8054** from 7 a.m.–7 p.m. local time, Monday–Friday. Make sure the medical record is available. An authorization number is required for each CPT code.

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

Rehabilitative therapy

KanCare covers rehabilitative physical therapy, occupational therapy and speech/language therapy prescribed by a physician. The following care providers may bill for these services:

- Rehabilitation agencies
- Home health agencies (HHAs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Hospices
- Outpatient departments of hospitals and suppliers (such as physicians, NNPs, physical, occupational and speech/language therapists in private practice)

A registered physical therapist (PT) or a certified physical therapy assistant (PTA), working under the supervision of a registered PT, must provide all physical therapy services. The PT must document supervision. This may include the registered PT initialing each treatment note written by the certified PTA, or the registered PT writing "treatment was supervised" followed by their signature.

Habilitative

Habilitative therapy helps achieve and maintain maximum possible functioning for children. Members younger than age 21 may receive habilitative therapy, when medically necessary, for any birth defects and/or developmental delays (habilitative diagnoses) only when approved and provided by an early childhood intervention (ECI), Head Start or local educational agency (LEA). Treatments performed in LEA settings may be habilitative or rehabilitative for disabilities due to birth defects or physical trauma/illness.

Developmental

Children younger than age 21 may receive developmental therapy services to treat Autism Spectrum Disorders (ASDs), birth defects and other developmental delays. Treatment can be in any appropriate community setting and from any qualified care provider with prior authorization and medical necessity documentation.

A licensed medical care provider must diagnose ASD with an appropriate assessment. Services must be pre-approved and may include speech therapy, developmental occupational therapy, or developmental physical therapy. The care provider must complete an initial comprehensive assessment. Periodic re-evaluations and assessments are required at least every 6 months. The member must show continuous improvement in order to qualify for continued treatment.

Any qualified care provider, in any appropriate place of service, can provide services to all children with birth defects and developmental delays including ASD. Services include developmental physical therapy, developmental occupational therapy and developmental speech/language pathology services as documented in a comprehensive treatment plan.

Note: An acceptable ICD-10 diagnosis is required on the treatment plan. We will not accept the following codes as a primary diagnosis:

- R68.89
- R62.50
- R62.59

Rehabilitative

All therapies must be physically rehabilitative. Members age 21 and older may receive rehabilitative therapies following physical debilitation due to an acute physical trauma or illness. A psychiatric diagnosis does not qualify for rehabilitative therapy treatments.

Documentation

You must include a copy of the order for physical therapy, occupational therapy and speech/language pathology services in the member's medical record and support the service billed. Documentation must be legible and complete and must include the following:

- Pertinent past and present medical history with approximate date of diagnosis
- Identification of expected goals or outcomes
- Description of therapy and length of treatment
- Member's response to therapy
- Progress toward goal(s)
- Date and signature of therapist by each entry

Regulations require there be a method for determining whether the individual authenticated the document after transcription. The person (identified by name and discipline) responsible for providing the service must authenticate and date each entry. Authentication may include the person's signature, written initials or computer entry.

Note: When you provide short-term therapy services due to an acute exacerbation of pain and decline in mobility or function related to an existing condition, documentation must support the services. Therapy for an extended duration to treat symptoms related to an existing or chronic condition is not acceptable due to lack of rehabilitation potential. These services are subject to recoupment in a post-pay review.

Limitations

Therapy services are limited to up to 6 consecutive months per injury or illness for members 21 and older. Services begin at the discretion of the care provider. Members with Brain Injury 16-64 (BI) may receive 6 months of therapy services as a state plan benefit. When state plan therapy benefits are exhausted, BI members may receive additional rehabilitative therapy services as outlined in the waiver-approved plan of care.

Screening, brief intervention, and referral to treatment services

Screening, brief intervention, and referral to treatment (SBIRT) is an evidence-based approach identifying patients who use alcohol and other drugs at risky levels, with the goal of reducing and preventing related health consequences, disease, accidents and injuries.

The following services will be covered for this program:

- H0049
- H0050
- 99408
- 99409
- SBIRT providers include health care and other licensed and/or certified professionals and include:
- Physicians
- PAs
- NPs
- Psychiatrists
- Nurses
- Dentists
- Certified health educators
- Psychologists
- Social workers
- Professional counselors
- Psychologists
- Marriage and family therapists
- Addiction counselors

How to become a screening, brief intervention, and referral to treatment services practitioner

- Complete the SBIRT training with a KDADS-approved SBIRT trainer and/or through an authorized online training course
- Complete the SBIRT coursework with a score of 70% or greater
- Enroll on the Kansas Department of Aging and Disability Services (KDADS) website
- Submit the CEU and/or certificate of completion, documentation of a score of 70% or greater and professional license and/or certificate to KDADS and each Managed Care Organization (MCO) with whom you want to be affiliated

Approved service locations for SBIRT practitioners include:

- Primary medical care practices
- Acute medical care facilities
- RHC
- Critical access hospitals
- FQHC
- Community mental health centers
- State mental hospitals
- Substance use disorder treatment programs
- Indian health services
- SNF
- Hospice
- Family planning clinics

Approved full screens include:

- Alcohol Use Disorders Identification Test (AUDIT)
- Drug Abuse Screening Test (DAST)
- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
- CRAFFT-Adolescent Screening Test

You must maintain documentation of full screen results, brief intervention and appropriate referrals in the member's medical record and electronic health records.

If you are unable to diagnose, use diagnosis code R68.89.

Medication-assisted treatment

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

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

As a medical care provider, you may provide MAT services even if you don't offer counseling or behavioral health therapy in-house. However, you must refer your patients to a qualified care provider for those services. If you need help finding a behavioral health 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 Kansas:

1. Go to **UHCprovider.com/findprovider.**
2. Click on "Medical Care Directory."
3. Click on "Medicaid Plans."
4. Click on applicable state.
5. Select applicable plan.
6. Refine the search by selecting "Medication Assisted Treatment."

If you have questions about MAT, please call **Provider Services** at **1-877-542-9235** and enter your TIN. Say "Representative," and "Representative" a second time. Then "Something Else" to speak to a representative.

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

For behavioral health and substance use disorder authorizations, please contact **Optum**.

If you have questions, go to Kansas' prior authorization page at **UHCprovider.com/kscommunityplan** > Medicaid > Prior Authorization and Notification Resources.

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

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
Non-urgent pre-service	Within 5 working days of receipt of medical record information required but no longer 14 calendar days of receipt	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/expedited pre-service	Within 3 days of request receipt	Within 3 days of the request	Within 3 days of the request
Concurrent review	Within 24 hours or next business day following	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within 2 business days

Concurrent review guidelines

UnitedHealthcare Community Plan requires you to chart progress notes for each day of an inpatient stay. 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 including: primary and secondary diagnosis, clinical information, care plan, admission order, member status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information by access to Electronic Medical Records (EMR).

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

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

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

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

We don't consider experimental treatments medically necessary.

Determination process

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

Evidence-based clinical guidelines

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

Medical and drug policies and coverage determination guidelines

Find medical and drug policies and guidelines at **UHCprovider.com/policies** > **For Community Plans**.

Referral guidelines

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

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

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

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

Reimbursement

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

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

UnitedHealthcare Community Plan will not reimburse:

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

Second opinion benefit

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by KanCare. These access standards are defined in **Chapter 2.** The care provider giving the second opinion must not be affiliated with the attending care provider.

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. 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 his or her report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.

- If an in-network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating care provider. The participating care provider should contact UnitedHealthcare Community Plan at **1-877-542-9235.**
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations.
- If follow-up care is recommended, the member meets with the PCP before receiving treatment

Services covered/not covered by UnitedHealthcare Community Plan

The following resources provide more information about covered and non-covered services:

- **Non-Covered Codes and Covered Codes Policy**
- KMAP General Benefits Manual

Services requiring prior authorization

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

Seek prior authorization within the following time frames

- **Emergent/urgent admission** – 72 hours
- **Non-emergent** – 14 days

Utilization management guidelines

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

Utilization management appeals

UM appeals are considered medically necessary appeals. They contest UnitedHealthcare Community Plan's UM decisions. They include such things as UnitedHealthcare Community Plan's admission, extension of stay, level of care, or other health care services determination. They do not include benefit appeals, which are appeals for non-covered services. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal. See Appeals in **Chapter 12** for more details.

Vision services

MARCH Vision Care is UnitedHealthcare Community Plan's Medicaid vision vendor. Members may self-refer to any MARCH Vision Care Medicaid network care provider for services. If a member asks for assistance in selecting a care provider, please refer them to our Member Services department at **1-877-542-9238.**

When making an appointment, members must notify their MARCH Vision care provider that they are a UnitedHealthcare Community Plan member and that they have MARCH Vision Care coverage. The member must also provide their UnitedHealthcare Community Plan Medicaid ID number. For details about their coverage, members may call **1-877-542-9238** or visit **UHCCommunityPlan.com/ks**.

For specific care provider information, please refer to the MARCH Vision Care Provider Manual at UHCprovider.com/guides > **Community Plan Care Provider Manuals for Medicaid Plans by State** > Kansas.

Key contacts

Topic	Links	Phone number
EPSDT	portal.kmap-state-ks.us > Publications > Forms > KBH-EPSDT Screening	1-800-933-6593
Vaccines for Children	kdhe.vaccine@ks.gov	1-877-296-0464

In Kansas, the **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** program is called KAN Be Healthy (KBH).This program provides comprehensive and preventive health care services for: children, teenagers and young adults, from birth up to the age of 21 years of age.

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

Under EPSDT, we may cover non-covered services if they are medically necessary. You must get prior authorization. Examples of services that may be covered under EPSDT, if determined to be medically necessary services needed or to correct and ameliorate health conditions, include but are not limited to:

- Orthodontic services to prevent disease and promote oral health and to restore oral structures to health and function
- Orthodontic services for cosmetic purposes are not covered
- Vision and hearing services
- Rehabilitative equipment, for instance, daily living aids
- Specially adapted car seat
- Nutritional supplements

EPSDT medical necessity does not include:

- Experimental or research treatments
- Services or items not generally accepted as effective and/or not within the normal course and duration of treatment
- Services for caregiver or providers convenience are not allowed

The KAN Be Healthy (KBH) program follows the American Academy of Pediatrics (AAP) periodicity schedule located at aap.org.

The KBH EPSDT form is located at portal.kmap-state-ks.us > Publications > Forms > KBH-EPSDT Screening.

Development disability services and coordination with regional centers

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

Referral

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

Continuity of care

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

Full screening

Perform a full screen. Include:

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

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

Interperiodic screens

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

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

Lead screening/treatment

Call **Provider Services** at **1-877-542-9235** if you find a child has a lead blood level over 10ug/dL. Children with elevated blood lead levels will be offered enrollment in a care coordination program.

Safe/care examinations

Medicaid covers Sexual Assault Findings Examination (SAFE) and Child Abuse Resource Education (CARE) Examinations. It also covers related laboratory studies that determine sexual or physical abuse. The exam is performed by SAFE-trained care providers certified by the Department of Health and Senior Services. Children enrolled in a managed health care plan receive SAFE-CARE services through Kansas Medicaid (KanCare) on a fee-for-service basis. Information on SAFE-CARE examinations is located at 1-913-732-3670. Call KanCare for more information.

Targeted case management

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

Identification

The 5 target populations include:

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

Referral

Refer eligible members to a regional center or local governmental health program, as appropriate, for TCM services. To refer, contact your local CMHC. If you're not sure who your local CMHC is, call BH Member Services at **1-877-542-9238.**

Continuity of care

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

Vaccines for Children

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

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

Contact VFC if you have questions.
Phone: 1-877-296-0464

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

- Eligible for Medicaid
- American Indian or Alaska Native, as defined by the Indian Health Services Act

Chapter 6: Value-added benefits

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com**	**1-877-542-9235**
Healthy First Steps	**uhchealthyfirststeps.com**	**1-800-599-5985**
Value-added benefits	**uhc.com/communityplan/kansas/plans/medicaid/community-plan/mltss**	**1-877-542-9235**

We offer many programs and tools to help our UnitedHealthcare Community Plan members stay healthy.

If you have questions or need to refer a member, call **Provider Services** at **1-877-542-9235** unless otherwise noted.

2025 value-added benefits

Pregnant and new moms

Babyscripts – Pregnant members can join the Babyscripts program and earn up to $75 in rewards on Walmart e-Gift Card. Members can download the app from Apple or Google Play stores and sign-up with their Member ID number.

Nutrition support for high-risk pregnancy – Pregnant members identified as high risk and engaged in care coordination, get food support the last trimester and first month post-partum. Member works with care coordinator who determines need. Member receives $145 credit per month to use from a designated website (only healthy food items are available for purchase).

First trimester prenatal exam reward – Members can earn a $75 reward* for completing a first prenatal exam in the first trimester or 42 days from enrollment. Provider has to complete an Obstetric Risk Assessment Form (OBRAF) on the portal – **uhcprovider.com/en/resource-library/maternity-support.html**

If manual OBRAF submission is preferred, download it from **uhcprovider.com/forms** > Multi-States-UHCCP-OBRAF.pdf Care providers may also be eligible to earn incentives for the accurate and timely submission of an OBRAF in **the portal**.

Pack'n play – Pregnant members who attend a participating community baby shower and fill out an attendance form, can get a pack'n play.

WellHop: Virtual group prenatal and postnatal sessions. Includes conversations with a trained facilitator and members at the same stage in pregnancy. Member can enroll at: momandbaby.wellhop.com/signup

NEW FOR 2025! In-home visit reward: Members identified with a high-risk pregnancy, who complete the initial visit from our case management team, receive a $50 reward*. Other pregnant members who complete an in-home visit from a local participating maternal community program, will receive the $50 reward* after their visitor submits the completion information to UnitedHealthcare. One reward per pregnancy.

More coverage

Adult dental – Members 21 and over are eligible for additional dental benefits not already covered under KanCare, up to $500 per year.

Additional vision – Adult members over 21 can get an additional $60 to upgrade their frames, once a year. Providers wanting to participate should contact **Provider Services** at **1-877-542-9235**.

Additional transportation

24 extra round-trip rides – Get up to 24 total round-trip additional rides, within a 10 mile radius per year to places like the pharmacy, grocery store, food bank, WIC, prenatal classes, community activities, support group meetings, job interviews, trainings, career counseling or any other to access services. Member can call ModivCare at 1-877-796-5847 or Member Services at least 3 days before the need.

*Reloadable OTC Network® card can be used at specific retailers. Can be used for CMS approved health related items. To activate card, check balance, or find a store, call member services: 1-888-542-9238 or go to mybenefitscenter.com.

Nutrition

Nutrition classes – Complete the Create Better Health SNAP Education classes and get a food journal and cooking item valued at $50. Once class is completed, member can call Member Services. Information on classes at k-state.edu/ks-snaped.

Post-discharge Mom's Meals – Get 14 meals (2 meals a day for 7 days) when being discharged from a medical facility, have mobility needs, no family support, and are at risk for readmission due to nutritional issues. Available within 30 days of discharge. Member can call Member Services or work with discharge planner.

Dining with diabetes – Members with type 2 diabetes (or their caregivers) are eligible to attend a K-State Research and Extension Dining with Diabetes class, at no cost. To access, member can call Member Services. Limited to one set of classes annually per member/caregiver.

Social consideration and wellness

Educational advancement – Supports members (age 16 and older) with education like GED, coding classes, resumé writing workshops and English as a Second Language (ESL). Covers up to $200. To access, member can call Member Services.

Healthy activity for youth and for adults – All members (adults and youth) can access a $50 activity at participating organizations, like some YMCA, Boy Scouts, Boys & Girls Clubs, and Parks and Rec locations. Or instead, get a fitness kit or sports ball, for healthy activities at home. To access, member can call Member Services.

Healthy rewards – Earn OTC card rewards* for completing things like annual health assessment and well-child annual visits. Reward amounts are $10 and $25 (up to $75 annually). Once a member completes an activity, a card will be mailed, or reward will be added to existing card.

Help with getting cell phone – Free smartphone with unlimited messaging for members 18 years and older. Limit of 1 device per household that qualifies to federal eligibility criteria. Member can call Member Services for assistance.

School supplies – Members who are in foster care can get a school supply box per year. Members can ask their foster care agency.

Air purifier – Members 18 years old and under with an asthma diagnosis can request an air purifier valued at $75, per year. To access, member can call Member Services.

Bike helmets – Members 18 years old and under can request a bike helmet each year. To access, member can call Member Services.

Weighted blankets – Members in foster care or on the Autism or SED Waivers can request a weighted blanket, to help with anxiety. To access, member can call Member Services.

OTC Network® reward for frontier and rural counties – Members living in Rural and Frontier counties (as determined by the state of Kansas) can receive a $50 reward* per year. To access, member can call Member Services. Member needs to live in a rural or frontier county, and:

- If currently on a Waiver: will receive in February
- If new to the waiver: will receive a month after becoming a member
- If NOT on a waiver: call member services to confirm address and request

Technology programs

On My Way (OMW) program – Young adult members can access **uhcomw.com**. This website teaches skills like managing money, getting housing, finding job training and applying for college.

Pyx Health – Members 18 and older can access 24/7 support and companionship using the Pyx Health mobile app. Go to HiPyx.com or download the Pyx Health app from the Apple or Google Play stores.

AbleTo App – A self-care app for dealing with stress, anxiety and depression. Member can download the AbleTo app in the Apple or Google Play Stores and use Medicaid ID number to access.

Supportiv - Online 24/7 on-demand peer support, facilitated, small group chat conversations and resources for coping, problem-solving, and healing. Available to high school students in Allen, Ellis, Neosho and Saline counties, plus the city of Wichita. Students can go to supportiv.com/Kansas to access.

*Reloadable OTC Network® card can be used at specific retailers. Can be used for CMS approved health related items. To activate your card, check your balance, find a store, call member services:1-888-542-9238 or go to mybenefitscenter.com.

Community programs

NEW FOR 2025! ATTACh: Annual membership to a support program for the parent or caregiver of children at risk for behavioral health conditions. Includes one-on-one support, registration to ATTACh conferences, and access to a support group. ATTACh will reach out to offer program to eligible parents.

Mental Health First Aid training – Learn how to identify, understand and respond to signs of mental illness and substance use. Trainings are in English and Spanish. UnitedHealthcare will attempt to hold events in major areas of the state. Upcoming dates can be found at bit.ly/45qyemn.

Waivers

OTC Network® for waiver members – Members on waivers receive a $50 reward*, in February or in the second month of becoming our member. To activate card, check balance, or find a store, call Member Services or go mybenefitscenter.com.

Internet access – Members on waivers may be invited to get internet services, to complete a specific health activity. Member works with care coordinator.

Pest control – Waiver members who own their home can get pest control services. Up to $250 maximum annually. Member works with care coordinator.

Wellness calendar – Members enrolled in care management, whole person care, pregnant, or behavioral health programs will be mailed a calendar at the beginning of each year to track their doctor appointments, medications and social events. Member can contact their care coordinator if they haven't received it.

NEW FOR 2025! Medication lockbox - Members enrolled in care coordination, whole-person care, pregnant or certain behavioral health programs can request a medication lockbox to help reduce intentional or accidental overdose or misuse. One lockbox per household. Member can work with Care Coordinator.

NEW FOR 2025! Walmart+ Membership - Adult members with chronic conditions or mobility issues, or who are enrolled in care management or whole person care, or are pregnant, or in behavioral health programs, can get a Walmart+ membership through OnePass™. Membership includes: Same day grocery delivery (12-mile radius of a Walmart), shipping with no minimum, video streaming Paramount+ subscription, fuel savings at selected gas stations. Members can go to youronepass.com to access or call member services for help.

Chapter 7: Mental health and substance use

Key contacts

Topic	Link	Phone number
Provider Express	**providerexpress.com**	**1-800-888-2998**
Provider Services	**UHCprovider.com**	**1-877-542-9235**

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

Optum's National Behavioral Health 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.

You must have an NPI and a Kansas Medical Assistance Program (KMAP) identification number to see Medicaid members and receive payment from UnitedHealthcare Community Plan.

To request an ID number, go to the KMAP website at **kmap-state-ks.us** > Start New Online Application.

Access to behavioral health services

Members have access to behavioral health services for all levels of care through Optum's statewide KanCare network of care providers. In general, out-of-state services are limited to specific emergency services. Due to the proximity of several out-of-state cities, we cover routine services from licensed mental care providers within a 50-mile range of the Kansas border. Care providers must meet credentialing and contracting guidelines.

KanCare autism waiver program

Optum manages the autism waiver program benefits for KanCare members with coverage through UnitedHealthcare Community Plan.

KanCare autism program care providers must meet the following criteria:

- Be an approved KMAP care provider
- Complete state-required autism waiver training
- Meet professional liability insurance requirements
- After submitting your KMAP enrollment application, you have the option to contact Optum to start the contracting process. Call **1-877-614-0484** and ask to start the contracting process with Optum. Ask to speak to the Kansas ABA Network Manager.

For more information about the application process and the clinical protocols your participation in this network would require you to follow, visit **providerexpress.com**.

How to join our network

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

Covered services

UnitedHealthcare Community Plan offers covered behavioral health services for mental, emotional and SUDs. We offer care management to help members, clinicians and PCPs using and offering behavioral health services. We provide information and tools for mental

health and substance abuse diagnoses, symptoms, treatments, prevention and other resources in one place.

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

For member resources, go to **providerexpress.com** click on the Live and Work Well (LAWW) link at the bottom of the page. LAWW includes tools to help members address mental health and substance use issues. Access the site using the guest access code "Clinician."

Benefits include:

- Crisis stabilization services (includes treatment crisis intervention)
- Inpatient psychiatric hospital (acute and sub-acute)
- Psychiatric residential treatment facility
- Outpatient assessment and treatment:
  - Intensive outpatient (only covered for SUD services)
  - Medication management
  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)
  - Child-parent psychotherapy
  - Electro-convulsive therapy
  - Telehealth
- Rehabilitation services
- Dual-disorder residential
- Intermediate residential (SUD)
- Short-term residential (SUD)
- Community support

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 **UnitedHealthcare Provider Portal** > 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, inpatient or residential care.

Help ensure prior authorizations are in place before rendering non-emergent services. Request prior authorization using the Prior Authorization and Notification tool on the portal or by calling **1-877-542-9235.**

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 condition

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

Portal access

You can use the **UnitedHealthcare Provider Portal** for all of your online services, including claims, eligibility, prior authorization, referrals and much more. The portal allows you to take action and quickly access claims-related information using our digital features and tools. It's a one-stop shop for working with us more efficiently.

View the Prior Authorization list, find forms and access

the care provider manual. Or call **Provider Services** at **1-877-542-9235** to verify eligibility and benefit information (available 8 a.m.–5 p.m. CT, Monday–Friday).

providerexpress.com

Update care provider practice information, review guidelines and policies, and view the national Optum Behavioral Health Network Manual.

This website includes both public and secure pages. Public pages include general updates and useful information. Secure pages are available only to network care providers and require registration. For assistance, contact the Provider Express Support Center at **1-800-888-2998** from 8 a.m.–8 p.m. ET, Monday–Friday.

Claims

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

Monitoring audits

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

Addressing the opioid epidemic

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

Brief summary of framework

- Prevention
  - Prevent opioid use disorders (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 solutions for pregnant mom and child
  - Prevent neonatal abstinence syndrome and supporting moms in recovery
- Enhanced data infrastructure and analytics
  - Identify needs early and measure progress

Increasing education and awareness of opioids

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

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

Prescribing opioids

Go to our **UHCprovider.com/kscommunityplan** > Pharmacy Resources and Physician Administered Drugs to learn more about which opioids require prior authorization and if there are prescription limits.

Pharmacy lock-in

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

Clinical outcomes model

Optum is committed to working with our network care providers to achieve optimal therapeutic outcomes for the members we both serve. This means focusing on helping care providers to make consumer-directed, outcome-based, cost-effective and clinically appropriate treatment decisions.

As a result, we have developed an outpatient program that analyzes member responses to the Wellness Assessment (WA) along with claims information. The program uses a set of algorithms to measure a member's behavioral health status and identify potential risks. In addition, it identifies cases that may benefit from a Care Advocacy review. Such reviews may include considering best practice guidelines, coverage determination guidelines, level of care guidelines or behavioral clinical policies as described on **providerexpress.com**.

The use of clinical and claims-based algorithms helps us prevent possible treatment concerns sooner. Care Advocacy will notify you by phone and/or letter to inform you of cases that require a review.

The WA is completed at multiple points in treatment. This offers more immediate feedback on health status and functioning, which may inform further treatment planning. This includes level of care changes or coordination with medical professionals.

Chapter 8: Member rights and responsibilities

Key contacts

Topic	Link	Phone number
Member Services	**UHCCommunityPlan.com/ks**	
Member handbook	**UHCCommunityPlan.com/ks** > Medicaid Plans > UnitedHealthcare Community Plan KanCare > Member handbook	**1-877-542-9238**

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

Privacy regulations

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

Access to protected health information

Members may access their medical records or billing information protected health information (PHI) - 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 protected health information

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/ks/medicaid/community-plan**.

Native American access to care

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

Member rights

Members have the right to:

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

Member responsibilities

Members should:

- Understand their benefits so they can get the most value from them
- Contact a care provider when they have a medical need
- Show you their Medicaid member ID card
- Prevent others from using their ID card
- Notify us if their ID card is lost or stolen
- Learn about UnitedHealthcare Community Plan procedures
- Understand their health problems and give you true and complete information
- Ask questions about treatment
- Work with you to set treatment goals
- Follow the agreed-upon treatment plan
- Get to know you before they are sick
- Keep appointments or tell you when they cannot keep them

- Treat your staff and our staff with respect and courtesy
- Get any approvals needed before receiving treatment
- Use the emergency room only during a serious threat to life or health
- Notify us of any change in address, family status or other coverage information
- Make sure you are in-network
- Follow your advice and understand what may happen if they do not follow it
- Give you and us information that could help improve their health
- Notify us if they have a workers' compensation claim, a personal injury or malpractice lawsuit, or have been in a car accident. Also, they must immediately notify the KDHE-DHCF Medical Unit TPL manager about this claim.

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

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

Chapter 9: Medical records

Medical record charting standards

You are required to keep complete and orderly medical records in paper or electronic format, which fosters efficient and quality member care. A member, or their representative, is entitled to 1 free copy of their medical record. Additional copies may be available at member cost. Medical records are generally kept for a minimum of 5 years unless federal requirement mandates a longer time frame (i.e., immunization and tuberculosis records required for lifetime). 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 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**
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*

***Critical element**

Topic	Contact
History	An initial history (for members seen 3 or more times) and physical is performed. It should include: • **Medical and surgical history*** • A family history that includes relevant medical history of parents and/or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use and/or substance abuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults • Screenings of/for: – **Recommended preventive health screenings/tests** – **Depression** – **High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit** – **Medicare members for functional status assessment and pain** – **Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate**
Problem evaluation and management	Documentation for each visit includes: • Appropriate vital signs (measurement of height, weight and BMI annually) – **Chief complaint*** – **Physical assessment*** – **Diagnosis*** – **Treatment plan*** • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines • Documentation of all elements of age appropriate federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets • Treatment plans are consistent with evidence-based care and with findings/diagnosis: – **Time frame for follow-up visit as appropriate** – **Appropriate use of referrals/consults, studies, tests** • X-rays, labs consultation reports are included in the medical record with evidence of care provider review • There is evidence of care provider follow-up of abnormal results • Unresolved issues from a previous visit are followed up on the subsequent visit • There is evidence of coordination with behavioral care provider • Education, including lifestyle counseling, is documented • Member input and/or understanding of treatment plan and options is documented • Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented

***Critical element**

Medical record review

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

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

Member hospitalization records should include, as appropriate:

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

Chapter 10: Quality management program and compliance information

Key contacts

Topic	Link	Phone number
Credentialing	Medical: Network management support team Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal** Chiropractic: **myoptumhealthphysicalhealth.com**	
Fraud, waste and abuse (payment integrity)	**uhc.com/fraud**	**1-844-359-7736**

What is the Quality Improvement program?

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

The program consists of:

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

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

Cooperation with quality-improvement activities

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

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

We require your cooperation and compliance to:

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

Care provider satisfaction

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

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

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

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

Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. We respect our network care providers. We appreciate the collaboration to promote better health, improve health outcomes and lower overall costs to offer our members. You are encouraged to visit **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 Kansas statutes and the National Committee of Quality Assurance (NCQA). The following items are required to begin the credentialing process:

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

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

Credentialing and recredentialing process

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

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates 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 NPs)
- 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
- NPs and PAs who practice under a credentialed UnitedHealthcare Community Plan care provider

Health facilities

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

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

UnitedHealthcare Community Plan does not make credentialing and recredentialing decisions based

on race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes.

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

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

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

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

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

Peer review

Credentialing process

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

Recredentialing process

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

Performance review

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

Applicant rights and notification

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

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

Confidentiality

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

Resolving disputes

Contract concerns

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

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

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

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

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

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

Health Insurance Portability and Accountability Act compliance – your responsibilities

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

Transactions and code sets

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

Unique identifier

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

National Provider Identifier

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

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

- Help ensure the confidentiality, integrity and availability of all electronic protected health information (PHI) the covered entity creates
- Protect against any reasonably anticipated threats, uses or disclosures of information not permitted or required under the Privacy Regulations
- 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 HIPPA regulations on 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, go to **uhc.com/fraud**, or refer to the fraud, waste, and abuse section of this care provider 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 Kansas 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 Kansas Department of Health and Human Services.

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least 10 years from the close of the Kansas 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 Kansas program standards.

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

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

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

Delegating and subcontracting

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

Delegated medical management

Delegation oversight

We may assign medical management to a medical group/Independent Practice Association (IPA) with established medical management standards. We refer to the medical group/IPA as a “delegate.” Care providers associated with these delegates may use the delegate’s office and protocols for authorizations. The delegate’s medical management protocols and procedures must comply with UnitedHealthcare Community Plan as well as all applicable state and federal regulatory requirements.

Before assigning medical management functions, we assess the delegate. Within 90 calendar days of the contract effective date, we assess it again to measure compliance with UnitedHealthcare Community Plan standards. We assess the delegate annually thereafter. We may also conduct an off-cycle assessment if needed.

Based on the assessment findings, we may have the delegate develop and implement a corrective action plan to bring the medical group/IPA back into compliance. Delegates who do not achieve compliance within the established time frames may undergo further corrective action. If the action is not successful, the medical management function will be withdrawn.

Appeals

When we review a member or care provider’s adverse determination appeal from a delegate, we use InterQual (We previously used MCG.) as the externally licensed medical management guidelines. This happens even if the delegate used different externally licensed medical management guidelines to make the determination.

Semi-annual reporting

The delegate provides UnitedHealthcare Community Plan with semi-annual reports as outlined in the delegation agreement. Reports must meet applicable requirements and accreditation standards.

Purpose of Medical Management program

The Medical Management program helps determine if medical services are:

- Medically necessary
- Covered under the UnitedHealthcare Community Plan benefit
- Performed at both the appropriate place and level of care

Determining medical necessity

Delegates review nationally recognized criteria to determine medical necessity and appropriate level of care for services. This includes Medicaid coverage guidelines. For services not addressed in Medicaid coverage guidelines, delegates use UnitedHealthcare Community Plan's medical policies. If other nationally recognized criteria disagree with Medicaid coverage guidelines, delegates follow Medicaid coverage guidelines.

Members may call the delegate's general number (or the number listed in the denial letters) to request individual eligibility and benefit criteria. They may also call our Member Services department.

NCQA Accreditation standards require all health care organizations, health plans and delegates distribute a statement to members, care providers and employees who make UM decisions. The statement must note the following:

- UM decision-making is based only on appropriateness of care, service and coverage
- You or others are not rewarded for issuing denials or encouraging decisions that result in under-utilization

Care provider requirements

Render covered services at the most appropriate level of care based on nationally recognized criteria. With few exceptions, we do not reimburse for non-covered services and those not medically necessary. We do not reimburse for the wrong procedures (e.g., notification requirements, preauthorization, verification guarantee process). Authorization receipts do not affect how payment policies determine reimbursement.

We nor the member are responsible for reimbursing medical services, admissions, inappropriate facility days and/or medically necessary services if you did not obtain required prior authorization. Regardless of the Medical Management program determination, the decision to render medical services lies with the member and you, as the attending care provider. If you and the member decide to go forward with the medical services after UnitedHealthcare Community Plan or the delegate deny preauthorization, no care provider, facility or ancillary services will be reimbursed. The delegate's medical director can discuss the decisions and criteria with the member. The delegate also makes the medical policy decisions available upon request.

Medical management denials/adverse determinations

UnitedHealthcare Community Plan or a delegate may issue a denial when a non-covered benefit is requested but deemed not medically necessary. This may also happen when we receive insufficient information.

Denials, delays or modifications

UnitedHealthcare Community Plan or the delegate must make and communicate timely approvals, modifications or denials. We or the delegate must also state the decision to delay a service based on medical necessity or benefit coverage appropriate to the member's medical condition, in accordance with the applicable state and federal law.

We base all authorization decisions on sound clinical evidence, including medical record review, consultation with the treating care providers, and review of nationally recognized criteria. You must clearly document the medical appropriateness with your authorization request. State and federal law applies to criteria disclosure.

The medical director, Utilization Management Committee (UMC) or you must review referral requests not meeting the authorization criteria. Otherwise, you must present the information to UMC or the subcommittee for discussion and a determination. Only a care provider (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist, as appropriate) may delay, modify or deny services for medical necessity reasons. Board-certified, licensed care providers from appropriate specialties must help make medical necessity decisions, as appropriate. Determination rules include:

- You may not review your own referrals
- Care providers qualified to make an appropriate determination will review referral requests considered for denial
- Any referral request where the medical necessity or the proposed treatment is not clear will be discussed with the care provider. Complex cases may be brought to the UMC/medical director for further discussion.
- Individual(s) who can hold financial ownership interest in the organization may not influence the clinical or payment decisions

Possible request for authorization determinations include:

- Approved as requested – No changes
- Approved as modified – Referral approved, but changed the requested care provider or treatment plan (e.g., requested chiropractic, approved physical therapy)
- Extension – Delay of decision (e.g., need additional information, require consultation). CMS allows an extension when a Medicaid member requests one.
- Delay in Delivery – Postpone access to an approved service until a certain date. This is not the same as a modification. A written notification in the denial letter format is required.
- Denied – Non-authorization request for health care services

Reasons for denials of requests for services include:

- Not a covered benefit – The requested service(s) is excluded under the member's benefit plan
- Not medically necessary or benefit coverage limitation – Specify criteria or guidelines used to make the determination
- Member not eligible at the time of service
- Benefit exhausted – Include what benefit was exhausted and when
- Not a participating care provider – A participating care provider/service is available within the medical group/IPA in-network
- Experimental or investigational procedure/treatment
- Self-referred/no prior authorization (for non-emergent post-service)
- PCP can provide requested services

Medical group/Independent Practice Association's responsibilities related to member grievance and appeals

Occasionally, a member may contact the delegate instead of the plan. In such cases, delegates must:

- Within 1 hour of receipt, forward all member grievances and appeals to UnitedHealthcare Community Plan for processing
- Respond to UnitedHealthcare Community Plan requests for appeal or grievance information within the designated time frame. (Standard appeals with 24 hours, expedited appeals within 2 hours. Time frames apply to every calendar day.)
- Comply with all final UnitedHealthcare Community Plan determinations
- Cooperate with UnitedHealthcare Community Plan and the external independent medical review organization or state fair hearing. This includes promptly forwarding all medical records and information related to the disputed health care service.
- Provide UnitedHealthcare Community Plan with the authorization (pre-service) within the requested time frames on adverse determinations reversals
- Respond to requests for proof of overturned appeals

Referrals

Referral authorization procedure

The delegate may initiate a member referral. (Refer to the delegated group's pre-authorization list, as applicable). The following capitated medical services are examples of when a referral authorization may be needed:

- Outpatient services
- Laboratory and diagnostic testing (non-routine, performed outside the delegated medical group/IPA's facility)
- Specialty consultation/treatment

The delegate, PCP and/or other referring care provider must verify the care provider participates in UnitedHealthcare Community Plan.

You must also comply with the following procedures:

- Review the service request for medical necessity
- If the treatment is not medically necessary, discuss an alternative treatment plan with the member
- If the treatment requires referral or prior authorization, submit the request to the delegate UMC for determination

If the request is not approved, the delegate must issue the member a denial letter.

Referral authorization form

The delegate may design its own authorization form, without approval from UnitedHealthcare Community Plan. The form should include all the following:

- Member identification (e.g., Member ID number and birth date)
- Services requested (including appropriate ICD-10-CM and/or CPT codes)

- Authorized services (including appropriate ICD-10-CM and/or CPT codes)
- Proper billing procedures (including the medical group/IPA address)
- Verification of member eligibility

The delegate provides this form to the following:

- Referral care provider
- Member
- Member's medical record
- Managed care administrative office

The delegate does so within 36 hours of receipt of information necessary to make a decision. This includes 1 working day and does not exceed 14 calendar days.

If UnitedHealthcare Community Plan is financially responsible for the services, the delegate submits the authorization information to the plan.

Continuity of care

Continuity of care lets members temporarily continue receiving services from a non-participating care provider. It's intended to last a short period.

The delegate facilitates continuity of care for medically necessary covered services. If a member entering the health plan is receiving medically necessary services (in addition to or other than prenatal services) the day before enrollment, the health plan covers the continued costs of such services without prior approval. This is regardless of whether in-network or out-of-network care providers grant these services.

- The health plan provides continuation of such services for the lesser of 60 calendar days or until the member has transferred without disruption of care to an in-network care provider.
- For members eligible for care management, the new health plan provides service continuation authorized by the prior health plan for up to 60 calendar days after the member's enrollment in the new health plan. Services will not be reduced until the new health plan assesses the situation.

Members in their third trimester of pregnancy may receive services from their prenatal care provider (whether in-network or out-of-network) without any form of prior authorization through the postpartum period (defined as 60 calendar days from date of birth).

A member should not continue care with a non-participating care provider without formal approval by UnitedHealthcare Community Plan or the delegate.

Except for emergent or urgent out-of-area (OOA) care, payment for services performed by a non-participating medical group/IPA become the member's responsibility.

UnitedHealthcare Community Plan (or the delegate) reviews all requests for continuity of care. We consider the member's condition and the potential effect on the member's treatment. We also consider how changing the care provider can affect the health outcome.

A member may request to continue covered services with a care provider who has terminated from UnitedHealthcare Community Plan for reasons other than cause or disciplinary action. As the care provider, you must agree in writing:

- To agree to the same contractual terms and conditions imposed on participating care providers, including credentialing, facility privileging, utilization review, peer review and quality assurance requirements
- To be compensated at rates and payment methods similar to those used by UnitedHealthcare Community Plan and participating care providers granting similar services who are not capitated and are practicing in the same geographic area

Notification requirements for facility admissions when UnitedHealthcare pays claims

Contracted facilities are accountable to provide timely notification to both the delegate and UnitedHealthcare Community Plan within 24 hours of admission for all inpatient and observation status cases. This information is needed to verify eligibility, authorize care and initiate concurrent review and discharge planning.

In maternity cases, notify vaginal delivery or C-section delivery on or before the end of the mandated period 48 hours or 96 hours, respectively. We require notification if the baby stays longer than the member. In all cases, separate notification is required immediately when a baby is admitted to the neonatal intensive care unit.

For emergency admissions, notification occurs once the member has been stabilized in the emergency department.

Authorization log and denial log submission

Authorization logs for all inpatient acute, observation status and skilled nursing facility cases must be accurately submitted at least twice a week to the Authorization Log Unit at **clinicaloperations@uhc.com**. When no inpatient acute, observation statuses or skilled nursing facility cases are active, the delegate must submit its weekly authorization log indicating either "no activity" or "no admissions" for each designated admission service type specified in this section and for the applicable reporting time.

Authorization logs covering facility and skilled nursing facility daily information includes the following:

- Member ID
- Member name
- Member date of birth
- Attending care provider (Name and address, with TIN if available)
- Facility care provider (Name and address, with TIN if available)
- Admitting diagnosis (ICD-10-CM or its successor code)
- Planned and actual admission dates
- Planned and actual discharge dates
- Level of care (i.e., bed type, observation status, outpatient procedures at acute facilities)
- Length of stay (LOS) (i.e., number of days approved, as well as the number of days denied)
- Procedure/surgery (CPT Code)
- Discharge disposition
- Service type
- Authorization number (if available)

The delegate must clearly define medical necessity and authorizing outpatient services paid as either shared risk or plan risk per the medical group/IPA contract. It must submit authorization or denials for services the group authorized or denied care on behalf of UnitedHealthcare Community Plan.

For more information, please contact your Provider Advocate.

Fraud, waste, and abuse

Go to **uhc.com/fraud** or call **1-844-359-7736** to report questionable incidents involving plan members or care providers.

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

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

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

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

As part of ongoing efforts to help ensure compliance with federal and state requirements, we perform monthly screenings of the Office of Inspector General (OIG), the Excluded Parties List System (EPLS), and other databases for individuals or entities who have been "excluded" or "debarred" from federal programs. If we identify excluded or debarred individuals or entities as a result of these screenings, we will terminate their participation in the KanCare plan immediately. We will recover payments we make to the excluded or debarred care providers retroactive to the date of exclusion.

For more information or access to the publicly accessible, excluded party online databases, please see the following links:

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

What you need to do for exclusion checks

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

Office site quality

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

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

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

Criteria for site visits

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

QOC issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	1 complaint
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space	Office facilities are dirty; smelly or otherwise in need of cleaning Office exams rooms do not provide adequate privacy	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**	**1-866-633-4449**

Our claims process

For claims, billing and payment questions, go to UHCprovider.com/kscommunityplan > **Claims and Payments**.

We follow the same claims process as UnitedHealthcare. See **Chapter 10** of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) and D-SNP on **UHCprovider.com/guides**.

Claims process from submission to payment

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

If you think we processed your claim incorrectly, please see the **Claims reconsiderations, appeals and grievances** chapter in this care provider manual for next steps.

National Provider Identifier

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

If you have not applied for an NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan, call **Provider Services** at **1-877-542-9235**. Your clean claims must include your NPI and federal TIN.

General billing guidelines

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

Additional requirements:

1. Care providers must bill in line with their Kansas Medical Assistance Plan (KMAP) enrollment. Specific to the billing care provider information (name, TIN, NPI, address) listed on the claim must match to their KMAP enrollment. If billing information is not in line with KMAP enrollment, we may deny the claim.

2. Care providers enrolled with KMAP as a group provider must bill with the group information in the billing provider field and the rendering care provider NPI is required in the rendering/performed provider field. If group providers do not bill as noted, we will deny the claim.

Special billing guidelines

Hospital

For Medicaid-specific inpatient, outpatient and inpatient/outpatient billing information, refer to the KMAP Hospital Provider Manual.

Nursing facilities (NF)

- NFs should use the UB-04 claim form or accepted electronic equivalent when requesting payment for NF services. You may submit claims through your electronic data interchange (EDI) vendor and communicated through the OptumInsight clearinghouse (formerly Ingenix) using payer ID 96385.
- You may submit paper claims to:

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

- You may also bill through the KanCare Front End Billing solution

For additional information on the MS-2126 form, claims, benefits and limitations, refer to the KMAP Nursing/ Intermediate Care Facility Provider Manual.

Home and Community-based services

- HCBS care providers should use the CMS 1500 claim form or an accepted electronic equivalent when requesting payment for HCBS services. You may submit claims through your EDI vendor and communicated through the OptumInsight clearinghouse using payer ID 96385.
- You may submit paper claims to:

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

- You may submit claims directly through the secure UnitedHealthcare Provider Portal at **UHCprovider.com** and also through the KanCare Front End Billing solution

Hospice

Hospice care providers must use the CMS 1500 red claim form or the appropriate electronic format for professional claim submission when requesting payment for medical services and supplies provided under KanCare.

Hospice care providers must bill the room and board charges for hospice beneficiaries residing in nursing facilities (NFs), intermediate care facilities for individuals with an intellectual disability (ICF/IDD) or hospital swing beds. NFs include skilled nursing facilities, nursing facilities and nursing facilities for mental health. ICF/IDD includes state- and privately-owned institutions.

Please follow these instructions for faster, more accurate claims processing:

Paper claims: Complete the claim as usual and document the NF, ICF/IID, or hospital swing bed name in Field 17, the NPI in Field 17b, or the provider identification (ID) in Field 17a.

Electronic claims (such as 837P): Complete the claim as usual. NF, ICF/IID, or hospital swing bed providers must be included as the referring provider in loop 2310A or 2420A on hospice claims.

Provider Electronic Solutions (PES): Complete the claim as usual and document the NF, ICF/IID, or hospital swing bed in the referring provider field under Header 2.

Claims: Complete the claim as usual and document the NF, ICF/IID, or hospital swing bed name and NPI in the referring physician field. Go to **UHCprovider.com** and click on Sign In in the top right corner.

We prefer you submit the NPI for the referring care provider's identifier, but we will accept the care provider ID unless we notify you otherwise. The referring care provider must be enrolled with KMAP.

KanCare is the payer of last resort and is to be billed only after payment has been sought from primary insurance carriers (including Medicare).

Dental

For specific billing instructions for dental claims, please refer to the KanCare/Skygen Dental Provider Manual at **UHCprovider.com/guides** > Community Plan Care Provider Manuals for Medicaid Plans By State > Kansas.

Vision

For specific billing instructions for vision claims, please refer to the March Vision Provider Manual at **UHCprovider.com/guides** > Community Plan Care Provider Manuals for Medicaid Plans By State > Kansas.

State-approved billing guidelines when KanCare members have other coverage

If the member has third-party liability or insurance coverage other than KanCare

The following codes are not covered regardless of health insurance carrier. If the service code being billed is on this list, a remittance advice from the primary carrier is not required. You may bill these services directly to UnitedHealthcare Community Plan using paper or electronic claims.

97532	99368	99408	G0151	G0152	G0153
G0515	H0001	H0002	H0004	H0005	H0017
H0018	H0036	H0038	H0045	H0049	H0050
H2010	H2011	H2012	H2014	H2015	H2016
H2017	H2019	H2021	H2023	H2032	S0315
S0316	S0317	S5101	S5102	S5110	S5125
S5126	S5130	S5135	S5150	S5160	S5161
S5165	S5170	S5185	S5190	S9128	S9129
S9131	S9446	S9482	S9485	T1000	T1001
T1002	T1004	T1005	T1016	T1017	T1019
T1023	T1027	T1505	T2002	T2003	T2011
T2016	T2020	T2021	T2023	T2024	T2025
T2028	T2029	T2038	T2039	T2040	T2046
T4521	T4526	T4530			

If the billed code is not on this list, and the member has third-party liability (TPL) or insurance coverage other than KanCare, the other insurance is the primary carrier.

You should bill the primary carrier first and, upon payment or denial, submit the remaining claim to UnitedHealthcare Community Plan.

- You may submit the claim to us through an EDI transaction or as a paper claim with a paper copy of the primary carrier's EOB.
- You may submit the claim electronically through the KMAP portal. You must follow the KMAP billing guidelines when entering TPL information as defined in the KMAP Professional Billing Guide.

Client obligation

The state communicates to UnitedHealthcare Community Plan each member's client obligation, as applicable, by sending us the member enrollment file. Care providers who have been assigned the client obligation should not reduce the billed amount on the claim by the client obligation amount because it will be deducted as we process the claim.

The client obligation will typically be assigned to a single care provider (if a single care provider's services will offset the client obligation amount). In addition, we will make every effort to assign the client obligation to a single service, when possible, if the total services provided each month are sufficient to offset the monthly client obligation amount. In the absence of state direction, we will assign client obligation to the care provider who has the largest service cost for the month.

We send monthly notification letters to each member and a report to each care provider detailing the members who are assigned client obligation for the month. We will communicate mid-month changes to client obligation amounts to members and care providers within 5 days of receiving information from the state.

Reimbursement requirements

All participating care providers must enroll with the state of Kansas and have a KMAP ID in order to receive payment.

All non-participating care providers must submit a prior authorization for any KanCare member service. We will not approve authorizations unless there are no contracted participating care providers available in the area to perform the requested services.

Use the UnitedHealthcare Provider Portal to request prior authorizations at **UHCprovider.com/priorauth** or call **1-877-542-9235**.

Care providers who do not participate in the UnitedHealthcare Community Plan network are required to complete **one** of the following before they are eligible to receive payment for services provided to UnitedHealthcare KanCare members:

1. Enroll with the Kansas Medical Assistance Program (KMAP) and submit the UnitedHealthcare Non-Participation Reimbursement Agreement
   - Enroll with KMAP at kmap-state-ks.us > Start a new online application
   - Complete the UnitedHealthcare Non-Participation Reimbursement Agreement at **UHCprovider.com,** and send to **uhc_disclosures@uhc.com**
2. Submit the Disclosure of Ownership and Control Interest Statement and the UnitedHealthcare Non-Participation Reimbursement Agreement
   - The disclosure of ownership form is at kmap-state-ks.us > Provider > Forms > Disclosure of Ownership and Control Interest Statement. Send the completed form to **uhc_disclosures@uhc.com** before submitting any claims.
   - Complete the UnitedHealthcare Non-Participation Reimbursement Agreement at **UHCprovider.com,** and send to **uhc_disclosures@uhc.com**

Fee schedule

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

Modifier codes

Use the appropriate modifier codes on your claim form. Find our modifier reference policies in our **Community Plan Reimbursement Policies** by searching for "modifier." The modifier must be used based on the date of service.

Member ID card for billing

The member ID card has both the UnitedHealthcare Community Plan member ID. 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, hospice services, RHCs/FQHCs, urgent care centers and hospital services.

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

Submit dialysis services on a HCFA claim form.

Clean claims and submission requirements

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

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

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

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

Care provider coding

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

For more information about ICD-10 coding and social determinants of health protocol and how they apply to the members you treat, see the Specific Protocols chapter in the Administrative Guide for Commercial, Medicare Advantage and D-SNP at **UHCprovider.com/guides**. You can also visit **UHCprovider.com/policies**. 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 96385
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for HCFA 1500 and UB-04 forms.

For more information, visit **UHCprovider.com/edi**.
Note: Electronic claim submission through KMAP is also still available.

Span dates

You must include exact dates of service when the claim spans a period of time. Indicate the specific dates of service in Box 24 of the CMS 1500, Box 45 of the UB-04, or the Remarks field. This will eliminate the need for an itemized bill and allow electronic submission.

Electronic Data Interchange companion documents

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

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

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

The companion documents are located on **UHCprovider.com/edi** > **EDI transaction and code sets.**

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 **1-877-542-9235** for help with online billing, claims, Electronic Remittance Advices (ERAs), Electronic Funds Transfers (EFTs).

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

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

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on UHCprovider.com > Resources > Resource Library > **Electronic Data Interchange (EDI)**.

Visit kmap-state-ks.us to learn how to complete the CMS 1500 form.

Completing the UB-04 form

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

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

An example of the UB-04 claim form and instructions for how to complete this form are available on the KMAP website at kmap-state-ks.us > Providers > Forms > Claims (Sample Forms and Instructions) > **UB-04**.

Electronic payment solutions: Optum Pay

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

Why choose ACH/direct deposit?

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

What does this mean to you?

- If your practice/healthcare organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a Virtual Card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**
- If your practice/healthcare organization is already enrolled and receiving your claim payments through AHC/direct deposit from Optum Pay or receiving Virtual Cards there is no action you need to take
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Library
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

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

Paper claim submissions

Mail paper claims directly to UnitedHealthcare Community Plan for our KanCare members. Do not send claims to KMAP. If KMAP receives paper claims for our KanCare members, they will return the claims to you.

Mail paper claims for KanCare members to the applicable address:

Service	Address
Behavioral health and substance use disorders	**UnitedHealthcare Community Plan** P.O. Box 5270 Kingston, NY 12402-5270
Dental services	SkyGen P.O. Box 1158 Milwaukee, WI 53201
Pharmacy orders	**Optum Rx** P.O. Box 29044 Hot Springs, AR 71903
Non-emergent medical transportation	ModivCare Claims Dept. 2552 West Erie Drive Suite 101 Tempe, AZ 85282
Vision services	**UnitedHealthcare / MARCH Vision Care** Attn: Medicaid Vision Claims P.O. Box 30989 Los Angeles, CA 90045
All other health care services, such as hospital and home and community-based care	**UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84130-0364

Claims processing time

Our standard timely filing requirement is 180 days from the date of service (for new day claims only). Please refer to your UnitedHealthcare Community Plan Participation Agreement for your specific requirement.

Please allow 30 days before inquiring about claims status. The standard turnaround time for clean claims is 30 business days from date of receipt.

Denial

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

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

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

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

Other top reasons for denial include:

Extenuating circumstances – If prior authorization was not obtained due to extenuating circumstances, you have a right to submit documentation supporting the extenuating circumstance, using our appeal process. You may also submit documentation with the appeal that can be reviewed for medical necessity if we determine sufficient evidence of extenuating circumstances.

Extenuating circumstances are defined as any of the following:

- Catastrophic events that interfered with a provider's normal business operations, mechanical or administrative delays or errors by the MCO or KDHE-DHCF
- You could not determine member's identity
- Member provided inaccurate information
- Member provided a primary insurance only
- Member identified as self-pay
- Member did not provide information of enrollment with an MCO
- You called or checked MCO's website to obtain prior authorization and was told or website indicated no authorization was required

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

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

Eligibility expired – Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired and the patient and

practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.

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

Time limit expired – This is when you don't send the claim within the standard timely filing requirement of 180 calendar days.

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. You have 365 days from the date of service to file a corrected claim.

When to use:

Submit a corrected claim to fix or void one that has already processed.

How to correct electronic claims

UB claims:

- You may submit a corrected claim electronically through your electronic claim clearinghouse
- Update the third digit in the bill type to:
  - **"7" for a replacement request**
  - **"8" for a void request**
- The change in bill type will flag the claim as a corrected claim

CMS 1500 claims:

- You may submit an adjustment or void claim request electronically through your electronic claim clearinghouse
- Using resubmission codes in Box 22 on the CMS 1500 claim titled **Resubmission Code**
  - Resubmission code "7" for replacement request
  - Resubmission code "8" for void request
- Include original claim number in the Original Reference Number box

How to correct paper claims

UB claims:

- Mail corrected claims to:

  UnitedHealthcare Community Plan
  P.O. Box 5270
  Kingston, NY 12402-5270
- Write "CORRECTED" on the claim
- Update the third digit of the bill type to a "7"
- The change in bill type will flag the claim as a corrected claim

CMS 1500 claims:

- Mail corrected claims to:

  UnitedHealthcare Community Plan
  P.O. Box 5270
  Kingston, NY 12402-5270
- Write "CORRECTED" on the claim
- Add the original claim number in Box 22 of the CMS 1500 form

Additional information:

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

Resubmitting a claim

What is it?

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

When to use it:

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

Common reasons for rejected claims:

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

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

How to use:

To resubmit the claim, follow the same submission instructions as a new claim. View the **appeals and grievances grid** for submission information.

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

Claim reconsideration

What is it?

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

When to use:

Submit a claim reconsideration when you think a claim has not been properly processed.

For administrative denials:

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

For medical necessity denials:

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

How to use:

If you disagree with a claim determination, submit a claim reconsideration request electronically, by phone or mail within 120 calendar days from the remittance date (plus 3 calendar days mailing): View the **appeals and grievances grid** for submission information.

Do not send a claim or claim copy with your reconsideration request. The reconsiderations team cannot accept it and will return it to you.

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved
- Call **Provider Services** at **1-877-542-9235** 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:

View the **appeals and grievances grid** for submission information.

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

- Correct member name
- Correct date of service
- Claim submission date

Additional information:

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

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

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

If you prefer we recoup the funds from your next payment, call **Provider Services** at **1-877-542-9235.**

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:

- Patient name
- Patient Medicaid ID#
- Date of service
- Amount originally paid by UnitedHealthcare Community Plan
- Amount overpaid
- Reason account is considered overpaid
- Claim number (if available)
- UID from recovery letter (if available)
- Copy of UnitedHealthcare Community Plan remit (if available)
- Name and phone number of person authorized to sign checks or approve financial decisions

Where to send:

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

UnitedHealthcare Community Plan
P.O. Box 101760
Atlanta, GA 30392-1760

Instructions are at **UHCprovider.com/kscommunityplan**.

If you do not agree with the overpayment findings, you may file an appeal 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.

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	01/01/24	14A000000001	01/31/24	$115.03	$115.03	Double payment of claim
2222222	02/02/24	14A000000002	03/15/24	$77.29	$27.19	Contract states $50.00, claim paid $77.29
3333333	03/03/24	14A000000003	04/01/24	$131.41	$98.56	You paid 4 units, we billed only 1
44444444	04/04/24	14A000000004	05/02/24	$412.26	$412.26	Member has other insurance
55555555	05/05/24	14A000000005	06/15/24	$332.63	$332.63	Member terminated

Subrogation and coordination of benefit

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

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

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

Note: UnitedHealthcare Community Plan follows KMAP Third Party Liability (TPL) policy. All KMAP TPL billing requirements still apply. Refer to the KMAP General TPL Payment Provider Manual at kmap-state-ks.us > Publications > Provider Manuals > General TPL Payment Manual.

Hospital and clinic method of billing professional services

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

Global days

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

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

Correct coding initiative

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

Comprehensive and component codes

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

- **Separate procedures**
  Only report these codes when performed independently:
- **Most extensive procedures**
  You can perform some procedures with different complexities. Only report the most extensive service.
- **With/without services**
  Don't report combinations where one code includes and the other excludes certain services
- **Medical practice standards**
  Services part of a larger procedure are bundled
- **Laboratory panels**
  Don't report individual components of panels or multichannel tests separately
- **Sequential procedures**
  When procedures are performed in sequence, or when an initial approach is followed by a more invasive procedure during the same session, you should only report the procedure that receives the expected result

Mutually exclusive codes

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

For more information on CCI, visit cms.gov.

Clinical Laboratory Improvements Amendments

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

Medicare crossover claims

You must enter Medicare information at both the claim level, in addition to the line level. When entering Medicare information at the claim level, please ensure the amount entered is the sum of the amounts entered at the line level.

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.

Ambulance claims (emergency)

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

National drug code

Claims must include:

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

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

Medical necessity

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

Place of service codes

Go to cms.gov for Place of Service codes.

Asking about a claim

You can ask about claims through **UnitedHealthcare Provider Portal**.

To access the portal, go to **UHCprovider.com**. Follow the instructions to get a user ID. You will receive your user ID and password within 48 hours.

Provider Services

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

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

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

UnitedHealthcare Provider Portal

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

Resolving claim issues

View the **appeals and grievances grid** for submission information.

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

For paper claims

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

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

Timely filing

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

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

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

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

To be timely, you must receive the claim within the timely filing period from the date on the other carrier's correspondence. If we receive the claim after the

timely filing period, it will not meet the criteria.

If a claim is rejected, and corrections are not received within 180 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.

If submitting a claim for retroactive eligibility on a member, timely filing limits start on the day the member is determined to be eligible by the Kansas Department of Health and Environment (KDHE) and not the back-dated eligibility start date.

Balance billing

Do not balance bill members if:

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

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

If you don't know who your provider advocate is, connect with a live advocate via chat on **UHCprovider.com/chat**, available 7 a.m.-7 p.m. CT.

Third-party resources

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

Multiple rendering care providers

If a member is seen in your office or clinic more than 1 time in a day, by different rendering care providers, you must submit a separate claim for each visit. Only 1 rendering care provider can be listed on a professional claim form.

Chapter 12: Appeals and grievances

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider contract. For claims, billing and payment questions, go to **UHCproviders.com/claims**. We no longer use fax numbers. Please use our online options or phone number.

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

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form	Contact phone number	Care provider website for online submissions	Filing time frame	UnitedHealthcare Community Plan response time frame
Care provider claim correction (resubmission)	Creating a new claim. If a claim was denied and you resubmit (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission.	Care provider	**UnitedHealthcare Community Plan** P.O. Box 5270 Kingston, NY 12402-5270	**UHCprovider.com/claims**	Provider Services **1-877-542-9235** TTY **711**	Use Claims Management or Claims on the **UnitedHealthcare Provider Portal** or **UHCprovider.com/claims**	Must receive within 45 business days	30 business days
Care provider claim reconsideration (step 1 of dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care provider	Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at the following address: **UnitedHealthcare Community Plan** P.O. Box 5270 Kingston, NY 12402-5270		Provider Services **1-877-542-9235** TTY **711**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**	Must receive within 123 calendar days from the remittance date	45 business days
Care provider claim formal appeal (step 2 of dispute)	A second review in which you did not agree with the outcome of the consideration.	Care provider	Most care providers in your state must submit appeals requests electronically. For further information on appealss, see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at the following address: **UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364 **Drop off in person** during regular business hours (8 a.m.–5 p.m. CT) at: 6860 West 115th St. Overland Park, KS 66211 Mail Route: KS015-M400 ***Must be labeled UnitedHealthcare Community Plan of Kansas - Appeal***		Provider Services **1-877-542-9235** TTY **711** ****You must submit appeals in writing. Provider Services cannot accept appeals by phone.****	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**	63 calendar days from the date of the notice of action	30 calendar days

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form	Contact phone number	Care provider website for online submissions	Filing time frame	UnitedHealthcare Community Plan response time frame
Care provider grievance	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member.	Care provider	**UnitedHealthcare Community Plan** Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131-0364 **Drop off in person** during regular business hours (8 a.m.–5 p.m. CT) at: 6860 West 115th St Overland Park, KS 66211 Mail Route: KS015-M400 ***Must be labeled UnitedHealthcare Community Plan of Kansas - Grievance***		Provider Services **1-877-542-9235** TTY **711**	Use Claims Management or Claims on the UnitedHealthcare Provider Portal or **UHCprovider.com/claims**	180 calendar days	30 calendar days
Member appeal	A request to change an adverse benefit determination that we made.	*Member *Care provider or authorized representative (such as a friend or family member) on behalf of a member with member's written consent.	**UnitedHealthcare Community Plan** Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131-0364 **Drop off in person** during regular business hours (8 a.m.–5 p.m. CT) at: 6860 West 115th St Overland Park, KS 66211 Mail Route: KS015-M400 ***Must be labeled UnitedHealthcare Community Plan of Kansas - Appeal***	**providerforms.uhc.com/Provider Appealsand Grievance.html** *AOR Consent Form on this site for member appeals.	Member Services **1-877-542-9235** TTY **711**	Members can log on to **myuhc.com** to request an appeal. **personalhealthmessagecenter.com/public/forms/ks-appeal** Electronically via UnitedHealthcare fax: 1-801-994-1082	63 calendar days	Urgent appeals: 72 hours Standard appeals: 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 a friend or family member) on behalf of a member with member's written consent.	**UnitedHealthcare Community Plan** Attn: Appeals and Grievance Unit P.O. Box 31364 Salt Lake City, UT 84131-0364 **Drop off in person** during regular business hours (8 a.m.–5 p.m. CT) at: 6860 West 115th St Overland Park, KS 66211 Mail Route: KS015-M400 ***Must be labeled UnitedHealthcare Community Plan of Kansas - Grievance***		**1-877-542-9235** TTY **711**	Members can log on to **myuhc.com** to request a **grievance**. **personalhealthmessagecenter.com/public/forms/ks-appeal** Electronically via UnitedHealthcare fax: 1-801-994-1082	N/A	30 calendar days

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

Written denial notice

Notice of action – care providers

UnitedHealthcare Community Plan will issue a written notice of action to a care provider. The notice may be a letter or remittance advice and will contain the following information:

- The date of the notice of action
- The action UnitedHealthcare Community Plan has made or intends to make
- The date the action was made or will be made
- The reason for the action, including medical necessity, benefits limitation or exclusion, statute, regulation or policy
- Your right to request a reconsideration or an appeal
- An explanation of the optional reconsideration process and UnitedHealthcare Community Plan's requirement for you to complete our appeal process before requesting a state fair hearing
- Your right to submit a reconsideration within 120 calendar days of the date of the notice of action and your right to submit an appeal request within 63 calendar days of the date of the notice of action. The notice includes the address and contact information for the reconsideration and appeal submission.
- Your right to terminate the reconsideration process and submit an appeal request to us within 63 calendar days of the date of the notice of action. The appeal request is not dependent upon completion of the process or receipt of a notice of reconsideration resolution.
- Your right to submit an appeal request within 63 calendar days of the date of the notice of reconsideration resolution. If you do not submit an appeal request within 63 calendar days and you have submitted a reconsideration request, you must wait until you receive the notice of reconsideration resolution.
- Your right to represent yourself or be represented by legal counsel or another spokesperson when requesting a reconsideration or an appeal
- The specific change in federal or state law that requires the action
- Your right to a state fair hearing after completing the appeal process or, in cases of an action based on a change in law, the circumstances under which a state fair hearing will be granted

Notice of adverse benefit determination – members

UnitedHealthcare Community Plan's member notice of adverse benefit determination includes information required by Kansas statute that relates to our adverse benefit determination and any of the following information:

- Dates, types and amount of requested services (if the adverse benefit determination pertains to a service authorization request)
- Date of the Notice of Adverse Benefit Determination
- Date the Notice of Adverse Benefit Determination was sent
- The adverse benefit determination UnitedHealthcare Community Plan has made or intends to make
- The reason for the adverse benefit determination, including medical necessity, benefits limitation or exclusion, statute, regulation or policy
- The date the adverse benefit determination was made or will be made
- The member's right to request an appeal and state fair hearing
- How to request an expedited appeal
- The member's right to request an appeal within 63 calendar days of the date of the notice of adverse benefit determination. The notice includes the address and contact information for the appeal submission.
- Information about how a member may continue to receive benefits pending appeal resolution or state fair hearing
- The member's right to represent themselves or be represented by an authorized representative when requesting an appeal or a state fair hearing
- Contact information to request assistance, submit an appeal or request a state fair hearing
- The specific change in federal or state law that requires the adverse benefit determination
- The member's right to a state fair hearing and how to request one

Formal appeal

What is it?

An appeal is a request to review an adverse action.

When to use:

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

How to use/file:

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

View the **appeals and grievances grid** for submission information.

Questions about your appeal or need a status update? Call **Provider Services** at **1-877-542-9235**. If you filed your appeal online, you should receive a confirmation email or feedback through the secure UnitedHealthcare Provider Portal.

External independent third party review

Effective with denials issued on or after Jan. 1, 2020, care providers may request an external independent third party review (EITPR) of UnitedHealthcare Community Plan's appeal decision. You may not request an EITPR for a reconsideration decision. You may request an EITPR if UnitedHealthcare Community Plan denies:

- Authorization of a new health care service to a member
- A claim reimbursement for health care service to a member

The external reviewer will only review the records and documentation you submit during the appeal process, along with medical necessity criteria applied in the appeal decision. If additional documentation needs review, you must use the state fair hearing process. EITPR is an optional process available to care providers only.

External independent third party review submission

Download the External independent third party review (EITPR) request form at **UHCprovider.com** > Health Plans By State > Kansas > Medicaid (Community Plan) > Provider Forms and References. Complete the form and submit:

- **Mail:**
  Attn: UnitedHealthcare Community Plan of Kansas - EITPR
  P.O. Box 31218
  Salt Lake City, UT 84131
- **Drop off in person during regular business hours** (8 a.m.–5 p.m. CT) at:
  UnitedHealthcare Community Plan of Kansas
  6860 West 115th Street
  Overland Park, KS 66211
  Mail Route: KS015 - M400
  Must be labeled UnitedHealthcare Community Plan of Kansas - EITPR
- **Email:** ks_eitpr@uhc.com

External independent third party request requirements

1. You must complete the appeal process prior to requesting an external review.
   - For denials of authorization of a new health care service, you may submit authorization from the affected member. You are no longer required to submit authorization to appeal a denial of a new health care service.
2. We must receive EITPR requests within 63 days from the date of the notice of appeal resolution.
3. EITPR requests must involve a denial of an authorization for a new health care service or a denial of a claim for reimbursement. Authorization decisions that terminate, suspend, or reduce previously authorized services, and qualify for continued services, are not eligible for EITPR.
   - We will deny your request for external review if the member no longer wants the denied health care service
4. EITPR requests must include all of the following:
   - Identification of each specific issue and dispute directly related to the adverse final decision issued by UnitedHealthcare Community Plan

- Why you believe our decision is wrong
- Your contact information, including name, mailing address, phone number and email address

We will deny the request if you do not meet the requirements listed above.

UnitedHealthcare Community Plan will acknowledge receipt of your request, in writing, within 5 business days of receipt. The external independent third party reviewer must complete their review within 30 calendar days of receiving documentation. The reviewer may extend the time to issue a decision by 14 calendar days if UnitedHealthcare Community Plan and you agree to it. We will notify you within 10 business days of receipt of the external reviewer's decision.

External independent third party review bundling

The external reviewer may determine multiple EITPR requests in 1 action upon your request or UnitedHealthcare Community Plan's request if it involves:

- The same beneficiary
- A common question of fact
- A common interpretation of applicable regulations or reimbursement requirements

You may add initial claim denials to an EITPR request prior to the external reviewer's decision if the claims involve a common:

- Question of fact
- Interpretation of applicable regulations or reimbursement requirements

You must complete UnitedHealthcare Community Plan's appeal process for each additional claim before adding those claims to the review. You must also submit an external review request to UnitedHealthcare Community Plan for each additional denied claim. The external reviewer must provide separate decision letters, as needed, to protect health information.

External independent third party review determination

The external reviewer's decision letter will direct the losing party to pay for the third party review unless the losing party requests a state fair hearing. You still have state fair hearing rights if there is an adverse decision from the EITPR. You must submit the state fair hearing request within 33 calendar days from the date of UnitedHealthcare Community Plan's notice of the external review decision. If the state fair hearing decision reverses the external reviewer's decision, the hearing's losing party must pay the third-party reviewer within 45 calendar days of the initial order.

Care provider grievance

What is it?

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

When to file:

You have 180 calendar days to file a grievance with us about:

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

How to file:

File verbally or in writing. View the **appeals and grievances grid** for submission information.

We track and resolve your grievance within 30 calendar days of receipt and will respond in writing.

You may only file a grievance on a member's behalf with the written consent of the member. See Member appeals and grievances definitions and procedures.

Member appeals and grievances definitions and procedures

Member appeals

When we deny a service authorization request, or lower, suspend or end a previously authorized service, we mail a Notice of Adverse Benefit Determination to the member.

We mail the adverse benefit determination as quickly

as the member's health condition requires, but no later than 14 calendar days following receipt of the authorization request.

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

1. Member requests an extension.
2. We request additional information and explain how the delay is in the member's best interest.

In cases where the standard time frame could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain or regain maximum function, we will make an expedited adverse benefit determination no later than 72 hours after receipt of the request for service.

Filing an appeal

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
- Doesn't act within the time frame the state requires

When to use:

You may act on the member's behalf with their written consent. The Appointment of Representative (AOR) form is at **https://providerforms.uhc.com/ProviderAppealsandGrievance.html**. You may provide medical records and supporting documentation as appropriate.

Where to send:

You or the member may file an appeal with us by phone, in writing, online or in person within 60 calendar days (plus 3 calendar days will be allowed for mailing time) from the date of the adverse benefit determination.

- **Phone: Member Services** at **1-877-542-9238** TTY **711**
  - For standard appeals, if you appeal by phone or in person, you must follow up in writing, ask the member to sign the written appeal, and mail it to UnitedHealthcare Community Plan. Expedited appeals do not need to be in writing. View the **appeals and grievances grid** for submission information.

How to use:

Whenever we deny a service, we 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 72 hours from when we receive it.

Member benefits continue until UnitedHealthcare Community Plan makes the appeal decision:

- If the adverse benefit determination lowers, suspends or ends previously authorized waiver services, those services will continue for 60 calendar days (plus 3 calendar days from the date of the notice) to allow time to file an appeal. This applies to waiver benefits/beneficiaries only.
- If the member, or their authorized representative, files an appeal for non-waiver benefits within 10 calendar days from the date the adverse benefit determination is sent, and the member requests continuation of services, the current non-waiver services will continue during the appeal. A care provider may serve as a member's authorized representative in an appeal, but the care provider cannot request continuation of benefits.

If submitting the appeal by mail, you must complete the Appointment of Representative (AOR) form. A copy of the form found at: **providerforms.uhc.com/ProviderAppealsandGrievance.html.**

Member grievance

What is it?

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

When to use:

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

Where to send:

You or the member may file a grievance with us by phone, in writing, in person or online. View the **appeals and grievances grid** for submission information.

We will send an answer no longer than 60 calendar days from when you filed the complaint/grievance or as quickly as the member's health condition requires. We offer a 14-calendar-day extension if the member or UnitedHealthcare Community Plan requests additional time.

Member/care provider state fair hearings

What is it?

If you disagree with UnitedHealthcare Community Plan's appeal decision, you may ask the Kansas Office of Administrative Hearings (OAH) to review the decision. Members and care providers may only request state fair hearing after completion of the appeal process.

When to use:

You have 120 calendar days (plus 3 days for mailing) from the date on UnitedHealthcare Community Plan's appeal resolution notice.

How to use:

You may ask for a state fair hearing in the following ways:

- Complete the Request for Administrative Hearing form online at oah.ks.gov/Home/Forms and mail it to:

  Office of Administrative Hearings
  1020 S. Kansas Avenue
  Topeka, KS 66612

- **Phone:**
  - **Provider Services at 1-877-542-9235**
  - **Member Services at 1-877-542-9238**
- **Drop off in person during regular business hours** (8 a.m.–5 p.m. CT) at:

  UnitedHealthcare Community Plan of Kansas
  6860 West 115th Street
  Overland Park, KS 66211
  Mail Route: KS015 - M400
  Must be labeled UnitedHealthcare Community Plan of Kansas - State Fair Hearing

The member may ask UnitedHealthcare Community Plan Member Services for help requesting a state fair hearing.

The member may have someone attend with them. This may be a family member, friend, care provider or lawyer. Written consent is required.

The OAH will provide a decision in writing within 30 days from the date of the hearing.

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 or
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.

Chapter 13: Care provider communications and outreach

Key contacts

Topic	Link	Phone number
Provider education	**UHCprovider.com/resourcelibrary**	**1-877-542-9235**
News and bulletins	**UHCprovider.com/news**	
Care provider manuals	**UHCprovider.com/guides**	

Communication with care providers

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

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

- **Chat support available**
  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.–7 p.m. CT, Monday–Friday, chat support can help with claims, prior authorizations, credentialing and member benefits.
- **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/kscommunityplan**
  The UnitedHealthcare Community Plan of Kansas page has state-specific resources, guidance and rules
- **Policies and protocols**
  UHCprovider.com/policies > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols
- **Social media**
  Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics.
  - Facebook
  - Instagram
  - LinkedIn
  - YouTube
  - X (formerly Twitter)
- **Kansas health plans**
  UHCprovider.com/ks is the fastest way to review all of the health plans UnitedHealthcare offers in Kansas. To review information for another state, use the drop-down menu at **UHCprovider.com/plans**. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **UnitedHealthcare Community & State newsletter**
  Stay current on the latest insights, trends and resources related to Medicaid. **Sign up** to receive this twice-a-month newsletter.
- **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 care provider manual or by visiting **UHCprovider.com/portal.**
  - You can also access **self-paced user guides** for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News**
  Bookmark **UHCprovider.com/networknews**. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans.

- You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your practice and care for patients.
- Get news related to your role, specialty, health plan and state. When you **subscribe** to Network News, you can update your preferences to select what news you receive.
- You'll get the latest news, policy and reimbursement updates we've posted on our news webpage. These email briefs include monthly notification of policy and protocol updates, including medical and reimbursement policy changes. They also include announcements of new programs and changes in administrative procedures. You can tailor your subscription to help ensure you only receive updates relevant to your state, specialty and point of care.

Care provider education and training

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

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

Email communication – required contact information

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

Submit your email address in one of the following ways:

1. Sign up for a **One Healthcare ID**, which also gives you access to the **UnitedHealthcare Provider Portal**.
2. **Subscribe** to Network News email briefs to receive regular email updates. Need to update your information? It takes just a few minutes to manage your **email address** and **content preferences**.
3. Already have a One Healthcare ID? To review or update your email, simply sign in to the **UnitedHealthcare Provider Portal**. Go to "Profile & Settings," then "Account Information" to manage your email.

Care provider office visits

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

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/kscommunityplan** > Contact Us.

Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a number for Provider Services and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting **Provider Services** at **1-877-542-9235.**

Care provider forms and references

To download necessary forms, go to **UHCprovider.com/kscommunityplan**

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

Chapter 14: Provider Agreement Example

INTRODUCTION

Our agreement consists of this contract, the appendices, and the additional materials we reference in the attached Appendix 1.

Guiding principles

We strive to operate in accordance with the following principles:

- *We want to work together with America's best physicians [practitioners] to improve the health care experience of our customers.*
- *We respect and support the physician [practitioner]/patient relationship while adhering fairly to the contract for benefits we provide our customers.*
- *Whether a particular treatment is covered under a benefit contract should not determine if the treatment is provided. Physicians [Practitioners] and health care professionals should provide the care they believe is necessary regardless of coverage.*
- *You should discuss treatment options with patients regardless of coverage. We encourage that communication.*
- *Physicians [Practitioners] should describe any factors that could affect their ability to render appropriate care. Matters such as professional training, financial incentives, availability constraints, religious or philosophical beliefs, and similar matters are all things that a physician [practitioner] should consider discussing with a patient. We encourage these communications. We urge full disclosure.*
- *Fairness and efficiency will govern the ways in which we administer our products. We will make our determinations promptly. Our commitments to our customers will be clear. We will honor our agreements. When it comes to coverage determinations, the language of the benefit contract will take precedence.*

Next steps

Please read this agreement. If you have questions, write to or call:

UnitedHealthcare - Contract Support
Attention: Imaging Center
2300 W Plano Pkwy #C1E105
Plano, TX 75075-8427

(xxx) xxx-xxxx]

You can visit our website at www.UHCprovider.com for additional details on items described in the agreement. If the agreement is acceptable to you, please sign both of the enclosed copies of the contract and send both copies to the address above.

PHYSICIAN [PRACTITIONER] **CONTRACT**

UnitedHealthcare Insurance Company is entering into this agreement with you. It is doing so on behalf of itself, UnitedHealthcare of the Midwest, Inc., and its other affiliates for certain products and services we offer our customers, all of which we describe in the attached Appendix 2.

This agreement applies to you and the services you provide in all of your practice arrangements and for all of your tax identification numbers, except that if your services are covered under an agreement between us and a medical group that you are part of services that you provide through that medical group will be subject to that other agreement and not this agreement.

What you will do

You need to be credentialed in accordance with our Credentialing Plan, as referenced in Appendix 1, for the duration of this agreement.

You must notify us in a timely manner about certain services you provide in accordance with our Administrative Guide so that we can provide our customers with the services we have committed to provide. If you do not so notify us about these services, you will not be reimbursed for the services, and you may not charge our customer.

Within one year of the effective date of this agreement, you must conduct business with us entirely on an electronic basis to the extent that we are able to conduct business electronically (described in the Administrative Guide), including but not limited to determining whether your patient is currently a customer, verifying the customer's benefit, and submitting your claim. We will communicate enhancements at www.UHCprovider.com as they become available and will make information available to you as to which products are supported by www.UHCprovider.com.

You must submit your claims within 90 days of the date of service. After we receive your claim, if we request additional information in order to process your claim, you must submit this additional information within 90 days of our request. If your claim or the additional information is not submitted within these timeframes, you will not be reimbursed for the services, and you may not charge our customer.

You will submit claims only for services performed by you or your staff. Pass through billing is not payable under this agreement and may not be billed to our customer. For laboratory services, you will only be reimbursed for the services that you are certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform, and you must not bill our customers for laboratory services for which you are not certified.

You will submit claims that supply all applicable information. These claims are complete claims. Further information about complete claims is provided in our Administrative Guide.

If you disagree with our payment determination on a claim, you may submit an appeal as described in our Administrative Guide.

You will not charge our customers anything for the services you provide, if those services are covered services under their benefit contract, but the applicable co-pay, coinsurance or deductible amount. If the services you provide are denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or based on our reimbursement policies and methodologies, you may not charge our customer. If the services you

provide are denied for reason of not being medically necessary, you may not charge our customer unless our customer has, with knowledge of our determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges. If the services you provide are not covered under our customer's benefit contract, you may, of course, bill our customer directly. You will not require a customer to pay a "membership fee" or other fee in order to access you for covered services (except for co-payments, coinsurance and/or deductibles provided for under the customer's benefit contract) and will not discriminate against any customer based on the failure to pay such a fee.

You will cooperate with our reasonable requests to provide information that we need. We may need this information to perform our obligations under this agreement, under our programs and agreements with our customers, or as required by regulatory or accreditation agencies.

You will refer customers only to other network physicians and providers, except as permitted under our customer's benefit contract, or as otherwise authorized by us or the participating entity.

What we will do

We or the other applicable participating entity will promptly adjudicate and pay your complete claim for services covered by our customer's benefit contract. If you submit claims that are not complete,

- You may be asked for additional information so that your claim may be adjudicated; or
- Your claim may be denied, and you will be notified of the denial and the reason for it; or
- We may in our discretion attempt to complete the claim and have it paid by us or the other applicable participating entity based on the information that you gave in addition to the information we have.

If governing law requires us to pay interest or another penalty for a failure to pay your complete claim for covered services within a certain time frame, we will follow those requirements. The interest or other penalty required by law will be the only additional obligation for not satisfying in a timely manner a payment obligation to you. In addition, if we completed a claim of yours that was not complete, there shall be no interest or other late payment obligation to you even if we subsequently adjust the payment amount based on additional information that you provide.

The applicable participating entity will reimburse you for the services you deliver that our customer's benefit contract covers. The amount you receive will be based on the lesser of your billed charges or our fee schedule, which is described at Appendix 1 and is subject to the reimbursement (coding) policies and methodologies of us and the participating entities. Our reimbursement policies and methodologies are updated periodically and will be made available to you online or upon request. To request a copy of our reimbursement policies and methodologies, write to [UnitedHealthcare - Contract Support, Attention: Imaging Center, 2300 W Plano Pkwy #C1E105, Plano, TX 75075-8427]. Your reimbursement is also subject to our rules concerning retroactive eligibility, subrogation and coordination of benefits (as described in the Administrative Guide). We recognize CPT reporting guidelines as developed by the American Medical Association, as well as ICD diagnostic codes and hospital-based revenue codes. Following these guidelines does not imply a right to reimbursement for all services as coded or reported.

Ordinarily, fee amounts listed in the Payment Appendix(ices) are based upon primary fee sources. We reserve the right to use gap-fill fee sources where primary fee sources are not available.

We routinely update our fee schedule in response to additions, deletions and changes to CPT codes by the American Medical Association, price changes for immunizations and injectable medications, and in response to similar changes (additions and revisions) to other service coding and reporting conventions that are widely used in the health care industry, such as those maintained by the Centers for Medicare and Medicaid Services (for example, HCPCS). Ordinarily, our fee schedule is updated using similar methodologies for similar services. We will not generally attempt to communicate routine maintenance of this nature and will generally implement updates within 90 days from the date of publication.

We will give you 90 days written or electronic notice of non-routine fee schedule changes which will substantially alter the overall methodology or reimbursement level of the fee schedule. In the event such changes will reduce your overall reimbursement under this agreement, you may terminate this agreement by giving 60 days written notice to us, provided that the notice is given by you within 30 days after the notice of the fee schedule change.

If either of us believes that a claim has not been paid correctly, either of us may seek correction of the payment within a 12-month period following the date the claim was paid, except that overpayments as a result of abusive or fraudulent billing practices may be pursued by us beyond the 12-month time frame mentioned above. In the event of an overpayment, we will correct these errors by adjusting future claim payment and/or by billing you for the amount of the overpayment.

How long our agreement lasts; how it gets amended; and how it can end

Assuming you are credentialed by us, and we execute this agreement, you will receive a copy from us with the effective date noted below the signature block. It continues until one of us terminates it.

We can amend this agreement or any of the appendices on 90 days written or electronic notice by sending you a copy of the amendment. Your signature is not required to make the amendment effective. However, if you do not wish to continue your participation with our network as changed by an amendment that is not required by law or regulation but that includes a material adverse change to this agreement, then you may terminate this agreement on 60 days written notice to us so long as you send this termination notice within 30 days of your receipt of the amendment.

In addition, either you or we can terminate this agreement, effective on an anniversary of the date this agreement begins, by providing at least 90 days prior written notice. Either you or we can terminate this agreement at any time if the other party has materially breached this agreement, by providing 60 days written notice, except that if the breach is cured before our agreement ends, the agreement will continue.

Either of us can immediately terminate this agreement if the other becomes insolvent or has bankruptcy proceedings initiated.

Finally, we can immediately terminate this agreement if any governmental agency or authority (including Medicare or Medicaid) sanctions you, if you no longer have your license to practice healthcare, if you no longer have hospital admitting privileges in any participating hospital, or in accordance with the terms of our Credentialing Plan.

We both agree that termination notices under this agreement must be sent by certified mail, return receipt requested, to [UnitedHealthcare - Contract Support, Attention: Imaging Center, 2300 W Plano Pkwy #C1E105, Plano, TX 75075-8427], or to the post office address you provided us. We both will treat termination notices as “received” on the third business day after they are sent.

About data and confidentiality

We agree that your medical records do not belong to us. You agree the information contained in the claims you submit is ours. We both will protect the confidentiality of our customers' information in accordance with applicable state and federal laws, rules, and regulations.

We are both prohibited from disclosing to third parties any fee schedule or rate information. There are three exceptions:

- You can disclose to our customer information relating to our payment methodology for a service the customer is considering (e.g., global fee, fee for service), but not specific rates (unless for purposes of benefit administration).
- We and the participating entities may use this information to administer our customers' benefit contracts and to pay your claims. We also may permit access to information by auditors and other consultants who need the information to perform their duties, subject to a confidentiality agreement.
- We both may produce this information in response to a court order, subpoena or regulatory requirement to do so, provided that we use reasonable efforts to seek to maintain confidential treatment for the information, or to a third party for an appropriate business purpose, provided that the disclosure is pursuant to a confidentiality agreement and the recipient of the disclosure is not a competitor of either of us.

What if we do not agree

The parties will work together in good faith to resolve any and all disputes between them ("Disputes") following the dispute procedures set out in our Administrative Guide. Disputes may include, but not be limited to the existence, validity, scope or termination of this Agreement or any term thereof, and all questions of arbitrability, with the exception of any question regarding the availability of class arbitration or consolidated arbitration, which is expressly waived below. Disputes also include any dispute in which you are acting as the assignee of one or more customer. In such cases, these procedures will apply, including without limitation the requirement for arbitration.

If the Dispute pertains to a matter which is generally administered by certain United procedures, such as a credentialing or quality improvement plan, the policies and procedures set forth in that plan must be fully exhausted by you before you may invoke any right to arbitration under this section.

For Disputes regarding payment of claims, a party must have timely initiated and completed the claim reconsideration and appeal process as set forth in the Administrative Guide in order to initiate the Dispute process.

If the parties are unable to resolve any Dispute within 60 days after notice, either party may submit the Dispute to binding arbitration conducted by the American Arbitration Association ("AAA"). The arbitrators will use the AAA Healthcare Payor Provider Arbitration Rules, as amended. However, if a case involves a Dispute in which a party seeks an award of $1,000,000 or greater or seeks termination of this Agreement, a panel of three arbitrators will be used. The arbitrator(s) will be selected from the AAA National Healthcare Roster or the AAA's National Roster of Arbitrators.

written notice of the Dispute was given, or any appeal process described in the Administrative Guide, whichever is later. If arbitration is not initiated in that time frame, the right to pursue the Dispute in any forum is waived.

Any arbitration proceeding under this Agreement will be conducted in [name of county] County, [state]. The arbitrator(s) may construe or interpret but must not vary or ignore the terms of this Agreement and will be bound by controlling law. The arbitrator(s) have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for that relief.

Except as may be required by law, neither a party, including without limitation, the parties' representatives, consultants and counsel of record in the arbitration, nor an arbitrator may disclose the existence, content, or results of any arbitration hereunder, or any Confidential Arbitration Information without the prior written consent of all parties. "Confidential Arbitration Information" means any written submissions in an arbitration by either party, discovery exchanged, evidence submitted, transcriptions or other records of hearings in the matter and any orders and awards issued, and any reference to whether either party won, lost, prevailed, or did not prevail against the other party in any arbitration proceeding, as well as any settlement agreement related to an arbitration. However, judgment on the award may be entered under seal in any court having jurisdiction thereof, by either party.

The parties expressly intend that any arbitration be conducted on an individual basis, so that no third parties may be consolidated or joined or allowed to proceed with class arbitration. The parties agree that any arbitration ruling allowing class arbitration or requiring consolidated arbitration involving any third party(ies), would be contrary to the terms of this Agreement and require immediate judicial review. Notwithstanding anything in this Agreement to the contrary, this paragraph may not be severed from this provision of the Agreement under any circumstances, including but not limited to unlawfulness, invalidity or unenforceability.

The decision of the arbitrator(s) on the points in dispute will be binding. The parties acknowledge that because this Agreement affects interstate commerce, the Federal Arbitration Act applies. In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, the litigation. The litigation would instead proceed with the judge as the finder of fact.

In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for the termination exist, the matter will be resolved through arbitration under this provision. While the arbitration remains pending, the termination for breach will not take effect.

This provision will survive any termination of this Agreement.

What is our relationship to one another

You are an independent contractor. This means we do not have an employer-employee, principal-agent, partnership, joint venture, or similar arrangement. It also means that you make independent health care treatment decisions. We do not. We do not reserve any right to control those treatment decisions. It further means that each of us is responsible for the costs, damages, claims, and liabilities that result from our own acts.

You will look to the applicable participating entity for reimbursement for the products and services under our agreement. This means that we are not financially responsible for claims payment for groups that are self-funded or that are not affiliated with us.

We may assign this agreement to any entity that is an affiliate of UnitedHealthcare Insurance Company at the time of the assignment.

This is it

This contract, the appendices and the items referenced in the attached Appendix 1, constitute our entire understanding. It replaces any other agreements or understandings with regard to the same subject matter - - oral or written - - that you have with us or any of our affiliates.

Federal law and the applicable law of the jurisdiction where you provide health care services govern our agreement. Such laws and the rules and regulations promulgated under them, when they are applicable, control and supersede our agreement. The Regulatory Appendix referenced in Appendix 1, and any attachment to it, is expressly incorporated to govern our agreement and is binding on both of us. In the event of any inconsistent or contrary language between the Regulatory Appendix (when it applies) and any other part of our agreement, including but not limited to appendices, amendments and exhibits, the Regulatory Appendix will control.

Conclusion

If you agree with these terms, please execute both copies of the agreement below and return them to us. With your signature, you confirm you understand the contract, including the dispute resolution procedures described in the section of this agreement entitled “What if we do not agree”, the appendices and the items referenced in the attached Appendix 1.

Appendix 1

We include as part of our agreement the following additional materials that bind you and us:

Appendix 2	**Definitions, Products and Services** This appendix sets forth definitions for our "customer" and "participating entities" as well as lists the type of benefit contracts offered to our customers.
Payment Appendices	**Fee Information Document includes** Fee Specifications Document, Fee Schedule Sample, and Additional Information About Your Fee Schedule. Further information about the fee schedule (such as additional fee samples) can be requested by writing to [UnitedHealthcare - Contract Support, Attention: Imaging Center, 2300 W Plano Pkwy #C1E105, Plano, TX 75075-8427] or through our website at www.UHCprovider.com.
Appendix 3	**Locations**. This document provides information about your office, billing, and mailing locations. Please remember that, as described on page 2, this agreement applies to all of your locations even if you do not list all of your current locations or if you add a location in the future.
Medicaid and/or CHIP Regulatory Requirements Appendix(ices)	(These appendixes(ices) apply only if you are in our Medicaid and/or CHIP network.) Your participation in our network for customers with Medicaid or CHIP benefit contracts is subject to additional requirements set forth in this appendix(ices).
Administrative Guide	Our Administrative Guide governs the mechanics of our relationship. Our Administrative Guide may be viewed by going to www.UHCprovider.com, and it will also be made available to you upon request. We may make changes to the Administrative Guide or other administrative protocols upon 30 days electronic or written notice to you. Additionally, for some of the benefit contracts for which you may provide covered services under this agreement, you are subject to additional requirements of one or more additional provider manuals ("Additional Manuals"). When this agreement refers to protocols or reimbursement policies it is also referring to the Additional Manuals. An Additional Manual may be a separate document, or it may be a supplement to the UnitedHealthcare Care Provider Administrative Guide ("UnitedHealthcare Administrative Guide"). For benefit contracts subject to an Additional Manual, the Additional Manual controls if it conflicts with any of the following: (1) a provision of this agreement or of the UnitedHealthcare Administrative Guide; or (2) a United protocol or reimbursement policy. However, the Additional Manual does not control where it conflicts with applicable statutes or regulations.

The Additional Manuals will be made available to you on a designated website and upon request. The names of the Additional Manuals, the websites to view and download them, and the benefit contracts to which they apply, are listed in Table 1 below. We may change the location of a website, or the customer identification card identifier used to identify customers subject to a given Additional Manual; if we do so, we will inform you.

We may make changes to the Additional Manuals subject to this provision in accordance with the provisions of this agreement relating to protocol and reimbursement policy changes.

Table 1.

Benefit Contract	Description of Applicable Additional Manual	Website
[No Additional Manuals Apply]		
Kansas Medicaid Benefit Contracts	UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for KanCare Program	www.UHCprovider.com
Kansas CHIP Benefit Contracts	UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for KanCare Program	www.UHCprovider.com

Credentialing Plan	To review our credentialing plan, visit www.UHCprovider.com. This plan requires you to carry malpractice insurance in amounts with carriers and on terms and conditions that are customary for [physicians][practitioners] like you in your community. To request access to, or a copy of, our credentialing plan, write to [UnitedHealthcare - Contract Support, Attention: Imaging Center, 2300 W Plano Pkwy #C1E105, Plano, TX 75075-8427].

Appendix 2
Definitions, Products and Services

Section 1. Customer. Individuals who are enrolled in benefit contracts insured or administered by us or any participating entity are included in our use of the phrase "customer" in this agreement.

Section 2. Participating entities. The following entities have access to our agreement:

– UnitedHealthcare Insurance Company and its affiliates.

– Groups receiving administrative services from UnitedHealthcare Insurance Company or its affiliates or that have arranged for network access through an entity that has contracted with UnitedHealthcare Insurance Company or one of its affiliates.

Section 3. Products and services.

a. We may allow participating entities to access your services under this agreement for the benefit contract types described in each line item below, unless otherwise specified in section 3b of this Appendix

- [Kansas Medicaid Benefit Contracts.]

- [Kansas CHIP Benefit Contracts.]

b. Notwithstanding the above section 3a of this Appendix 2, this agreement will not apply to the benefit contract types described in the following line items:

- [Kansas Medicaid Benefit Contracts.]

- [Kansas CHIP Benefit Contracts.

- Medicaid and CHIP Benefit Contracts other than those separately addressed in this Appendix 2.

Note: Excluding certain benefit contracts or programs from this agreement does not preclude the parties or their affiliates from having or entering into a separate agreement providing for your participation in a network for such benefit contracts or programs.

Section 4. Definitions:

Note: We may adopt a different name for a particular benefit contract, and/or may modify information referenced in the definitions in this Appendix 2 regarding customer identification cards. If that happens, section 3a or section 3b of this Appendix 2 will continue to apply to those benefit contracts as it did previously, and we will provide you with the updated information. Additionally, we may revise the definitions in this Appendix 2 to reflect changes in the names or roles of our business units, provided that doing so does not change your participation status in benefit contracts impacted by that change, and further provided that we provide you with the updated information.

- **Medicare and Medicaid Enrollees (MME) Benefit Contracts** means the CMS sponsored Financial Alignment Demonstration Plan providing integrated care benefits for individuals eligible for both the state Medicaid program and the Medicare program (Parts A, B, C and D). At such time as this benefit contract is no longer a demonstration project and is fully implemented in the state, this definition will be interpreted to refer to the fully implemented plan.

MEDICAID, CHIP AND OTHER STATE PROGRAMS:

- **Medicaid Benefit Contracts** means benefit contracts that offer coverage to beneficiaries of a program that is authorized by Title XIX of the federal Social Security Act, and jointly financed by the federal and state governments and administered by the state.

- **Kansas Medicaid Benefit Contracts** means Medicaid Benefit Contracts issued in Kansas under the KanCare program (which also incorporates long term care benefit plans) that include a reference to "UnitedHealthcare Community Plan" on the face of the valid identification card of any customer eligible for and enrolled in that benefit contract.

- **Kansas CHIP Benefit Contracts** means CHIP Benefit Contracts issued in Kansas under the KanCare program that include a reference to "UnitedHealthcare Community Plan" on the face of the valid identification card of any customer eligible for and enrolled in that benefit contract.

- **Other Governmental Benefit Contracts** means benefit contracts that are funded wholly or substantially by a state or district government or a subdivision of a state (such as a city or county), but do not include benefit contracts for:
  i) employees of a state government or a subdivision of a state and their dependents.
  ii) students at a public university, college or school.
  iii) employer-based coverage of private sector employees, even if the employer receives a government subsidy to help fund the coverage.
  iv) Medicaid beneficiaries.
  v) Children's Health Insurance Program (CHIP) beneficiaries; and
  vi) Medicare and Medicaid Enrollees (MME).

Appendix 3 - LOCATIONS

Please remember that, as described on page 2, this agreement applies to all of your locations even if you do not list all of your current locations or if you add a location in the future.

Provider:

Primary Service Location Address:	Address:		
	City:	State:	Zip:
	Tel #:	Fax #:	TIN:
Billing Address:	Address:		
	City:	State:	Zip:
	Tel #:	Fax #:	TIN:

Additional Service Location Address:	Address:		
	City:	State:	Zip:
	Tel #:	Fax #:	TIN:
Billing Address:	Address:		
	City:	State:	Zip:
	Tel #:	Fax #:	TIN:

Mailing Address:	Address:		
	City:	State:	Zip:
	Tel #:	Fax #:	

KANSAS MEDICAID AND CHIP REGULATORY

REQUIREMENTS APPENDIX PROVIDER

THIS KANSAS MEDICAID AND CHIP REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between UnitedHealthcare Insurance Company or one of its Affiliates and the party named in the Agreement ("Provider").

SECTION 1 APPLICABILITY

The requirements of this Appendix apply to KanCare, Kansas' Medicaid and Children's Health Insurance Program ("CHIP") benefit plans sponsored, issued or administered by UnitedHealthcare of the Midwest, Inc. (referred to in this Appendix as "United") under the State of Kansas' Medicaid and/or CHIP program (the "State Program") as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, United will unilaterally initiate such additions, deletions or modifications.

SECTION 2 DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the applicable State Program, the definitions shall have the meaning set forth under the applicable State Program.

2.1 **Affiliate:** Those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company.

2.2 **Covered Person:** An individual who is currently enrolled with United for the provision of services under a State Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.3 **Covered Services:** Health care services or products for which a Covered Person is enrolled with United to receive coverage under a State Contract.

2.4 **Department:** The Kansas Department of Health and Environment – Division of Health Care Finance (KDHE-DHCF). KDHE-DHCF is responsible for administering the State Program.

2.5 **KanCare:** The Department's prepaid managed care health program for Medicaid-eligible persons and persons enrolled in the State Children's Health Insurance Program.

2.6 **State:** The State of Kansas or its designated regulatory agencies.

2.7 **State Contract:** United's contract with the Department for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program that requires United to meet certain performance standards while doing so.

2.8 **State Program:** KanCare, the Kansas Medicaid and CHIP program developed and administered by the State of Kansas. For purposes of this Appendix, State Program may refer to the State agency(ies) responsible for administering the applicable State Program.

SECTION 3
PROVIDER REQUIREMENTS

The State Program, through contractual requirements and federal and State statutes and regulations, requires the Agreement to contain certain conditions that United and Provider agree to undertake, which include the following:

3.1 **Definitions Related to the Provision of Covered Services.** Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

i) **Clean Claim**: A claim that can be processed without obtaining additional information from the provider of the service or from a third party. "Clean Claim" does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

ii) **Emergency Medical Condition**: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
b) Serious impairment to bodily functions.
c) Serious dysfunction of any bodily organ or part.

iii) **Emergency Services**: Covered inpatient and outpatient services that are as follows:
a) Furnished by a provider qualified to furnish those health services.
b) Needed to evaluate or stabilize an emergency medical condition.

iv) **Medically Necessary or Medical Necessity**: As defined in K.A.R. 30-5-58 (ooo), (1) a health intervention that is otherwise a Covered Service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:
a) "Authority." The health intervention is recommended by the treating physician and is determined to be necessary.

b) "Purpose." The health intervention has the purpose of treating a medical condition.

c) "Scope." The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.

d) "Evidence." The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided in paragraph (3). For existing interventions, effectiveness shall be determined as provided in paragraph (4).

e) "Value." The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this definition of medical necessity. Interventions that do not meet this definition of medical necessity may be covered at the choice of United. An intervention shall be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of

resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

The following definitions shall apply to these terms only as they are used in this subsection 3.1(iv);

(a) "Effective" means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

(b) "Health intervention" means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For this definition of medical necessity, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

(c) "Health outcomes" means treatment results that affect health status as measured by the length or quality of a person's life.

(d) "Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

(e) "New intervention" means an intervention that is not yet in widespread use for the medical condition and patient indications under consideration.

(f) "Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. However, if controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be considered to be suggestive but shall not by themselves be considered to demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

(g) "Treat" means to prevent, diagnose, detect, or palliate a medical condition.

(h) "Treating physician" means a physician who has personally evaluated the patient.

Each new intervention for which clinical trials have not been conducted because of epidemiological reasons, including rare or new diseases or orphan populations, shall be evaluated on the basis of professional standards of care or expert opinion as described below in the next paragraph.

The scientific evidence for each existing intervention shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be deemed to meet this definition of medical necessity in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion.

3.2 **Medicaid or CHIP Participation.** Provider must be enrolled with the State as a Medicaid/CHIP provider to participate in United's Medicaid and CHIP network. Upon notification from the State that Provider's enrollment has been denied or terminated, United must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. United will exclude from its network any provider who is on the State's exclusion list or has been suspended from the Medicare, Medicaid or CHIP program in any state.

3.3 **Accessibility Standards.** Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, as further described in the applicable provider manual.

3.4 **Hours of Operation; Appointments.** Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.5 **Hold Harmless.** Except for applicable cost-sharing requirements under the State Contract, Provider shall look solely to United for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that United cannot or will not pay for such Covered Services. In accordance with 42 CFR Section 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which United is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. Neither the State, the Department nor Covered Persons shall be in any manner liable for the debts and obligations of United and under no circumstances shall Provider, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

If the medical assistance services are not Covered Services, prior to providing the service, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If United determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.6 **Indemnification.** To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend and hold the Department and Covered Persons harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the Agreement. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency. The Department may waive this requirement for itself, but not for Covered Persons, for damages in excess of the statutory cap on damages for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. All such waivers must be approved in writing by the Department.

3.7 **Provider Selection.** To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the

selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If United delegates credentialing to Provider, United will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with United's and the State Contract's credentialing requirements.

3.8 **Restrictions on Referrals.** Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.9 **Subcontracts.** If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement, the subcontract or delegation must be in writing and must include all of the requirements of this Appendix, applicable requirements of the State Contract, and applicable laws and regulations. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by United, to meet any additional State Program requirements that may apply to the services.

3.10 **Records Retention.** As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Provider shall retain all records including, as applicable, grievance and appeal records and any other records related to data, information, and documentation for a period of not less than 10 years from the close of the Agreement, or such other period as specified by the State Contract or required by law. If records are under review or audit, they must be retained for a minimum of 10 years following resolution of such action. Prior approval for the disposition of records must be requested and approved by United if the Agreement is continuous.

3.11 **Records Access.** Provider acknowledges and agrees that the State, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have the right to evaluate through audit, inspection or other means, any records pertinent to the State Contract, including records pertaining to the quality, appropriateness and timeliness of services performed under the State Contract.

3.12 **Government Audit; Investigations.** Provider acknowledges and agrees that the State, CMS, the Office of Inspector General, the Comptroller General, and the U.S. Department of Health and Human Services and their designees or their authorized representatives shall at any time, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the State Contract or from the date of completion of any audit, whichever is later. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

3.13 **Privacy; HIPAA.** Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time.

3.14 **Protected Health Information (PHI).** Provider and its employees, providers, agents and subcontractors shall maintain reasonable and appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of all protected health information ("PHI") it receives or possesses in the course of carrying out the responsibilities of the Agreement. Data containing Private Health Information or Personal Identification Information shall not be transmitted to or processed at any site outside of the United States. Provider acknowledges and agrees that PHI related to Covered Services performed under the Agreement remains the ownership of the Department and the Department shall have the right to review any agreements that use or disclose the PHI. Provider shall notify United immediately of any use or disclosure of PHI or other confidential information not allowed by the provisions of the Agreement of which it becomes aware and of any instance where the PHI is subpoenaed, copied or removed by anyone except an authorized representative of the Department or United.

3.15 **Compliance with Law.** Provider shall comply with all applicable federal and State laws and regulations, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

i) Title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Americans with Disabilities Act; section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

ii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

iii) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

iv) The Immigration and Reform Control Act of 1986 (IRCA), as may be amended from time to time. This Act, with certain limitations, requires the verification of the employment status of all individuals who were hired on or after November 6, 1986.

3.16 **Compliance with Medicaid Laws and Regulations.** Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to United constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service

provided. United performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to United upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.17 **Physician Incentive Plans.** In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.3, 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither United nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

3.18 **Lobbying.** Provider agrees to comply with the following requirements related to lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.19 **Excluded Individuals and Entities.** By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its principals, nor any providers, subcontractors or consultants with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

i) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

ii) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR §1001.1901(b) and Provider is obligated to screen its employees and contractors to determine whether any of them have been excluded from participation in Medicare, Medicaid, CHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security

Act). Provider shall not employ or contract with an individual or entity that has been excluded. Provider shall immediately report to United any exclusion information discovered. Provider acknowledges and agrees that pursuant to 42 CFR §1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Provider can search the HHS- OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. Applicable state exclusion databases can be accessed through the State's Medicaid website. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. United will terminate the Agreement immediately and exclude from its network any provider who has been terminated from the Medicare, Medicaid or CHIP program in any state. United may also terminate the Agreement if Provider or Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

3.20 **Disclosure.** Provider must be screened and enrolled in the State's Medicaid or CHIP program, as applicable, and submit disclosures to the Department on ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subparts B and E. Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with the Department for submission of fingerprints upon a request from the Department or CMS in accordance with 42 CFR 455.434.

3.21 **Cultural Competency and Access.** Provider shall participate in United's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds, and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand.

Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.22 **Marketing.** As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to United to submit to the State Program for prior approval.

3.23 **Fraud, Waste and Abuse Prevention.** Provider shall cooperate fully with United's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the State contract and shall cooperate and assist the Department and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and/or federal health care programs.

In accordance with United's policies and the Deficit Reduction Act of 2005 (DRA), if Provider receives annual Medicaid payments of at least five million dollars ($5,000,000) (cumulative, from all sources), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code); (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining

to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.24 **Electronic Visit Verification (EVV).** Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.25 **Data; Reports.** Provider shall cooperate with and release to United any information necessary for United to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by United, in the format specified by United and the State. Such reports shall include child health check-up reporting, if applicable. Provider shall also submit timely, complete and accurate encounter data to United in accordance with the requirements of United and the State Contract. Data must be provided at the frequency and level of detail specified by United or the State. By submitting data to United, Provider represents and attests to United and the State that the data is accurate, complete and truthful, and upon United's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.26 **Encounter Data.** Provider agrees to cooperate with United to comply with United's obligation to prepare timely encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets United and State requirements. By submitting encounter data to United, Provider represents to United that the data is accurate, complete and truthful, and upon United's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.27 **Claims Information.** Provider shall promptly submit to United the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third-party liability payment before submitting claims to United. Provider understands and agrees that each claim Provider submits to United constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim.

3.28 **Insurance Requirements.** Provider shall secure and maintain during the term of the Agreement, as applicable, general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with State Workers' Compensation Law. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by United pursuant to the Agreement or as required under the State Contract.

3.29 **Licensure.** Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with the Department that is terminated, suspended, denied, or not renewed as a result of any action of the Department, CMS, HHS, or the

Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by United under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons.

3.30 **Staff Qualifications; Clinical Laboratory Improvements Act (CLIA) certification or waiver.** Provider shall ensure that all staff performing Covered Services under the Agreement are appropriately licensed and qualified to perform such services. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.31 **Quality; Utilization Management.** Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with United's quality assessment, performance improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by United or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by United or Provider. Provider shall adhere to the quality assurance and utilization review standards of the applicable State Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.32 **Non-Discrimination.** Provider will not discriminate against Covered Persons on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, gender identity, or disability.

3.33 **Health Care Acquired/Preventable Conditions.** Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to United any provider preventable conditions in accordance with 42 CFR Part 438, including but not limited to 438.6(f)(2)(i).

3.34 **Immediate Transfer; Transition of Covered Persons.** Provider shall cooperate with United in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Covered Person's health or safety is in jeopardy, as may be required under law. In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Provider shall work with United to ensure quality-driven health outcomes for such Covered Persons to the extent required by the State Contract or otherwise required by law.

3.35 **Continuity of Care.** Provider shall cooperate with United and provide a Covered Person with continuity of treatment, including coordination of care to the extent required under law, in the event Provider's participation with United terminates during the course of a Covered Person's treatment by Provider.

3.36 **Termination.** In the event of termination of the Agreement, Provider shall promptly supply to United all information necessary for the reimbursement of any outstanding Medicaid claims.

3.37 **Health Records**. Provider agrees to cooperate with United to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards.

3.38 **Advance Directives.** When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 489, subpart I, and 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.39 **National Provider ID (NPI).** If applicable, Provider shall obtain a National Provider Identification Number (NPI).

3.40 **Overpayment.** Provider shall to report to United when it has received an overpayment and will return the overpayment to the United within 60 calendar days after the date on which the overpayment was identified. Provider will notify United in writing of the reason for the overpayment.

3.41 **Home and Community Based Services Providers.** If Provider is a Home and Community Based Services provider, Provider shall comply with State and federal laws and regulations applicable to Home and Community Based Settings including, but not limited to, 42 CFR § 441.301(c)(4).

3.42 **Provider Merger.** Notwithstanding any provision in the Agreement, any merger, reorganization, or change in ownership of Provider shall require an Amendment to Provider's Agreement with United, and prior approval of KDHE-DHCF in writing.

SECTION 4 UNITED REQUIREMENTS

4.1 **Prompt Payment.** United will accept claims electronically by batch file upload or by direct data entry and shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR
447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Provider, United will be responsible for third party collections in accordance with the terms of the State Contract.

4.2 **Time to file claims**. Claims shall be received by United within the timeframe set forth in the Agreement but in no event shall United impose a timeframe such that United must receive claims from Provider less than 90 days from the date of service, or, in the event United is a secondary payer, in no event shall United impose a timeframe such that United must receive claims from Provider less than 90 days from the date Provider receives notice of adjudication from the primary payer. Provider may request an additional 30 days to submit a claim if good cause is shown and United shall not unreasonably deny Provider's request for an extension. Claims shall be submitted for Medicaid beneficiaries with retroactive eligibility in accordance with United's policy on retroactive eligibility as specified in the Provider Administrative Guide.

4.3 **Prior Authorizations**. All prior authorization reviews and communications will be conducted by United in compliance with all applicable state and federal laws, the State Contract and applicable attachments. United will establish a process that will allow Provider to submit and receive determination via a secure electronic transmission.

4.4 **No Incentives to Limit Medically Necessary Services.** United shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

In addition, United shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the Member.

4.5 **Provider Discrimination Prohibition.** United shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. Further, United shall not discriminate with respect to the participation, reimbursement or indemnification of any provider who serves high-risk Covered Persons or specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

4.6 **Communications with Covered Persons.** United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

i) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

ii) Any information the Covered Person needs in order to decide among all relevant treatment options.

iii) The risks, benefits, and consequences of treatment or non-treatment; or

iv) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

United also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

4.7 **Termination, Revocation and Sanctions.** In addition to United's termination rights under the Agreement, United shall have the right to revoke any functions or activities United delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in United's reasonable judgment Provider's performance under the Agreement is inadequate. United shall also have the right to suspend, deny, refuse to renew or terminate Provider in accordance with the terms of the State Contract and applicable law and regulation.

SECTION 5 OTHER REQUIREMENTS

5.1 **Compliance with State Contract.** All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that United has provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves United of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

5.2 **Amendments.** Any amendments or changes to United's Provider Manual and policies must be first approved

by the State before promulgation. The State, also, requires United to communicate any approved amendments or changes in accordance with the relevant provisions of the State Contract. Amendments or changes will be communicated to Provider after State approval and in a manner consistent with the State Contract.

5.3 **Monitoring.** United shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, United shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and United shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by United and/or required by the State Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which United and Provider practice and/or the performance standards established under the State Contract.

5.4 **Enrollment.** The parties acknowledge and agree that the State Program is responsible for enrollment, reenrollment and disenrollment of Covered Persons.

5.5 **No Exclusivity.** Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than United or as prohibiting or penalizing United for contracting with other providers.

5.6 **Delegation.** The parties agree that, prior to execution of the Agreement, United evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. United shall have the right to revoke any functions or activities United delegates to Provider under the Agreement if in United's reasonable judgment Provider's performance under the Agreement is inadequate.