2025 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Michigan Medicaid Program

Healthy Michigan Plan

Michigan Coordinated Health (MICH)

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United Healthcare® Community Plan

Welcome

Welcome to the UnitedHealthcare Community Plan® care provider manual for our Michigan Medicaid Program and Healthy Michigan Plan. This up-to-date reference PDF 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 in the **How to Contact Us** section.

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 **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 **1-800-903-5253**.

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 use the Agreement instead.

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

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

This care provider manual will be amended as policies change.

Participation Agreement

Terms and definitions as used in this care provider manual:

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

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

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Chapter 1: Introduction

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com** Live chat available at **UHCprovider.com/contactus**	**1-800-903-5253**
Training	**UHCprovider.com/training**	**1-800-903-5253**
UnitedHealthcare Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID or go to **UHCprovider.com/portal** New users: **UHCprovider.com/access**	**1-800-903-5253**
CommunityCare Provider Portal training	**UnitedHealthcare CommunityCare Provider Portal user guide**	
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**
Resource library	**UHCprovider.com/resourcelibrary**	

UnitedHealthcare Community Plan supports the Michigan 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 old, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act
- Pregnant members eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act
- Children eligible for the Children's Health Insurance Program (CHIP)
- Blind and disabled children and adults who are not eligible for Medicare
- Healthy Michigan Plan - Adults 19–64 years old who are not eligible for another type of Medicaid and who have an income of less than 138% of the federal poverty level
- Medicaid-eligible families

UnitedHealthcare Community plan also support the state of Michigan by offering MI Coordinated Health (MICH) benefits to the following members:

- Age 21 or older at the time of enrollment including individuals age 21 and older served by the Children's Specialized Health Care Services (CSHCS) program
- Entitled to Medicare Part A, Medicare Part B, and Medicare Part D
- Receiving full Medicaid benefits (this includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(c) waiver or who reside in a Nursing Facility, including those who have a monthly Patient Pay Amount)

Michigan Department of Health and Human Services (MDHHS) will determine enrollment eligibility. MDHHS verifies which individuals must enroll, those that may voluntarily enroll and those excluded from enrollment. MDHHS employs a population health management framework and contracts with high-performing health plans to build a Medicaid managed care delivery system that maximizes the health status of beneficiaries, improves beneficiary experience and lowers cost. Through evidence- and value-based care delivery models, supported by health information technology/ health information exchange and a robust quality strategy, MDHHS will support us in achieving these goals.

Services include inpatient and outpatient hospital services, physician services, laboratory and X-ray services, and home health services, among others. See our member handbook for a complete list of covered services at **uhc.com**.

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com**, or call **Provider Services** at **1-800-903-5253**.

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.

All providers who serve Michigan Medicaid beneficiaries are required to be screened and enrolled in the Community Health Automated Medicaid Processing System (CHAMPS). For assistance in enrolling, please call 1-800-292-2550 option 4.

The State of Michigan's Community Health Automated Medicaid Processing System (CHAMPS) is the state's web-based Medicaid enrollment and billing system. MDHHS will prohibit UnitedHealthcare Community Plan from making payments to all typical rendering, referring, ordering and attending care providers not enrolled in CHAMPS. This requirement applies to all individuals who provide services of any type to Medicaid beneficiaries, including health care providers, social services workers and pharmacies.

Already in the provider 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.

Focusing on UnitedHealthcare Community Plan members with chronic complex conditions who often use health care services, the program helps address their needs holistically. Care Model examines medical, behavioral and social/environmental concerns and then provides interventions to help members get the right care.

The model provides interventions to address members' specific 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:

- Medical, behavioral and social care management using community resources
- An extended care team, including a 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 making and coordinating appointments. The community health worker (CHW) 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 needs, measured by number of behavioral health care provider visits within identified time frames
- Improve pharmacy access
- Identify and remove social and environmental barriers to care
- Improve health outcomes, measured by improved Healthcare Effectiveness Data and Information Set (HEDIS®) and Centers for Medicare & Medicaid Services (CMS) Star Ratings metrics
- Empower the member to manage their complex/chronic illness or problem and care transitions
- Improve coordination of care through dedicated staff

resources and to meet unique needs
- Engage community care and provider networks to help ensure access to affordable care and the appropriate use of services

To refer a UnitedHealthcare Community Plan member to the Care Model program, call **Provider Services** at **1-800-903-5253**, TTY **711**.

Compliance

The Health Insurance Portability and Accountability Act of 1996 (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/resourcelibrary** > 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**.

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

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

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

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

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

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

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

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

UnitedHealthcare Community Plan 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. We also use Michigan Medicaid policy and National Comprehensive Cancer Network® (NCCN) guidelines for chemotherapy. Call 1-800-903-5253 to request a copy of the guidelines.

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 that it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging in to different payer websites to manually request information. This is why EDI is usually the first choice for electronic transactions. It makes it possible to:

- 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**.

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.**
- **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.

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** **1-877-614-0484**	Review eligibility, claims, benefits, authorization and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	**UHCprovider.com/benefits** **1-800-903-5253**	Confirm a member's benefits and/or prior authorization.
Care Model (care management/disease management)	**1-800-903-5253**	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
Chiropractor care	**myoptumhealthphysicalhealth.com** **1-800-873-4575**	We provide members with up to 18 visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.
Claims	**UHCprovider.com/claims** **1-800-903-5253** **UnitedHealthcare Community Plan** P.O. Box 30991 Salt Lake City, UT 84130-0991 Payer ID: 95467 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. **1-800-903-5253** Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments. See the **Overpayment** section for requirements before sending your request.
Electronic Data Intake (EDI) Issues	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315**	Contact EDI Support for issues or questions.

Topic	Contact	Information
Eligibility	**UHCprovider.com/eligibility** **1-800-903-5253**	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 to speak with a contact center agent.
Fraud, waste and abuse (payment integrity)	Michigan.gov/fraud Office of Inspector General: 1-855-643-7283 Mailing address: **UnitedHealthcare Community Plan** Compliance Officer 3000 Town Center, Suite 1400 Southfield, MI 48075 or Office of Inspector General P.O. Box 30062 Lansing, MI 48909 Payment integrity information: **UHCprovider.com/MIcommunityplan** Reporting: **uhc.com/fraud** **1-844-359-7736** or **1-877-401-9430**	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Laboratory services	**UHCprovider.com/findprovider** > **Preferred Lab Network** JVHL 1-800-445-4979	Joint Venture Hospital Laboratories (JVHL) is the preferred lab care provider.

Topic	Contact	Information
Medical claim, reconsideration and appeal	**UHCprovider.com/claims** **1-800-903-5253** 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 30991 Salt Lake City, UT 84130-0991 Appeals mailing address: **UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	**myuhc.com®** **1-800-903-5253** or **1-877-542-9239**/TTY **711** for help accessing member account See "Website for Michigan Community Plan" for state's contact info.	Helps members with issues or concerns. Available 8:30 a.m - 5:30 p.m. ET, Monday–Friday.
Mental/behavioral health and substance abuse	OptumHealth Behavioral Solutions **providerexpress.com** **1-877-614-0484** P.O. Box 30760 Salt Lake City, UT 84130-0760	Behavioral health eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. (PCP referral is not required.)
Michigan ENROLLS	Medicaid.gov MIEnrolls: 1-888-367-6557 or 1-800-975-7630	The Michigan Department of Health & Human Services (MDHHS) contracts with Michigan ENROLLS, an enrollment services contractor, to educate Medicaid enrollees about managed care and how to enroll, disenroll and change enrollment for these beneficiaries.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	1-800-368-1019 or 1-800-537-7697 TDD **711**	Available 8:00 a.m.–5:30 p.m. ET, Monday–Friday, except state-designated holidays.

Topic	Contact	Information
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network management	**1-800-903-5253**	A team of provider relation advocates. Ask about contracting and care provider services.
Network management support	Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**.	Self-service functionality for medical network care providers to update or check credentialing information.
Obstetrics/pregnancy 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.
Oncology prior authorization	**UHCprovider.com/oncology** **1-888-397-8129** Monday–Friday, 7 a.m.–7 p.m. CT	For current list of CPT codes that require prior authorization for oncology.
One Healthcare ID support center	Chat, with a live advocate, is 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. ET, Monday–Friday 6 a.m.–6 p.m. ET, Saturday 9 a.m.–6 p.m. ET, 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.

Topic	Contact	Information
Prior authorization requests/advanced and 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 **1-800-903-5253**	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/MIcommunityplan** > Prior Authorization and Notification
Provider Services	**UHCprovider.com/MIcommunityplan** **1-800-903-5253**	Available 7:00 a.m.–5:00 p.m. ET, 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 **1-800-903-5253**	Submit new referral requests and check the status of referral submissions.
Reimbursement policy	**UHCprovider.com/MIcommunityplan** > **Policies and Protocols**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
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 Now	1-800-784-8669	Ask about services for quitting tobacco/smoking.
Transportation	ModivCare 1-877-892-3995	To arrange nonemergent transportation, please contact ModivCare at least 3 business days in advance.
Utilization management	Provider Services **1-800-903-5253**	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.

Topic	Contact	Information
Vaccines for Children (VFC) program	1-517-335-8159	Care providers must participate in the VFC Program administered by the Department of Health and Senior Services (DHSS) and must use the free vaccine when administering vaccine to qualified eligible children. Care providers must enroll as VFC care providers with DHSS to bill for the administration of the vaccine.
Vision services	marchvisioncare.com 1-800-903-5253	Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from MARCH Vision Care.
Website for Michigan Community Plan	**UHCprovider.com/MIcommunityplan**	Access your state-specific Community Plan information on this website.

Chapter 2: Care provider standards and policies

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com/MIcommunityplan**	**1-800-903-5253**
General provider assistance	Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**	
Eligibility	**UHCprovider.com/eligibility**	**1-800-903-5253**
Referrals	**UHCprovider.com/referrals**	**1-800-903-5253**
Provider Directory	**UHCprovider.com/findprovider**	**1-800-903-5253**

General care provider responsibilities

Nondiscrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them based on type of illness or condition or based on race, color, national origin, age, disability, sex, sexual orientation, gender identity, disability or other factors identified in 42 CFR 438.3(d) and will not use any policy or practice that has the effect of discriminating as such.

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

Communication between care providers and members

The UnitedHealthcare Community Plan Agreement is not intended to interfere with your relationship with members as patients or with our 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 representatives may take part in the planning and implementation of their care. To help ensure members and/or their representatives have this chance, UnitedHealthcare Community Plan requires that you:

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

Provide official notice

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

1. Bankruptcy or insolvency.
2. Indictment, arrest, felony conviction or any criminal charge related to your practice or profession.
3. Suspension, exclusion, debarment or other sanction

from a state or federally funded health care program.
4. Loss or suspension of your license to practice.
5. Departure from your practice for any reason.
6. Closure of practice.

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

Provider termination

When intending to terminate your contractual relationship with UnitedHealthcare Community Plan, refer to your care provider contract for the required notification period before terminating with or without cause. Send notification to your provider advocate or contract manager via mail:

UnitedHealthcare Community Plan
UnitedHealthcare Market VP
MN101-D003
9700 Healthcare Lane
Minnetonka, MN 55343

UnitedHealthcare Community Plan permits the member to continue an ongoing course of treatment with the terminating care provider if:

1. the member is in her second or third pregnancy trimester at the time of the care provider's termination, through postpartum care directly related to the pregnancy.
2. the member is determined to be terminally ill before a care provider's (knowledge of the) termination, and the care provider was treating the terminal illness before the termination date or knowledge of the termination.

By continuing treatment the terminating care provider agrees to accept UnitedHealthcare Community Plan reimbursement at applicable Medicaid rates as payment in full. The care provider also agrees to adhere to our quality standards, information submission and policies and procedures.

Arrange substitute coverage

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

You must have 24-hour on-call service for emergency and after-hours care, with back-up coverage arrangements as needed. You must notify your provider advocate of coverage arrangements.

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

Administrative terminations for inactivity

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

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

Changing an existing TIN or adding a care provider

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

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.

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

Participate in quality initiatives

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

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

Provide access to your records

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 7 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.**

You must adhere to the Michigan (MDHHS) Medicaid Provider Manual.

You must agree that the Michigan Department of Health & Human Services - Office of Inspector General (MDHHS-OIG) has the authority to conduct post payment evaluations of their claims paid by the health plan.

You must agree to follow the appeal process as outlined in Chapters 4 and 6 of the Administrative Procedures Act of 1969; MCL 24.271 to 24.287 and MCL 24.301 to 24.306 for post-payment evaluations conducted by MDHHS-OIG.

UnitedHealthcare Community Plan will immediately terminate individuals or entities excluded from MDHHS participation or other appropriate authorities.

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 HIPAA and associated regulations. In addition, you will comply with applicable state laws and regulations.

UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to stop unintentional disclosure of protected health

information (PHI). This includes passwords, screen savers, firewalls and other computer protection. The safeguards include shredding information with PHI and all confidential conversations. All staff members are trained on HIPAA and confidentiality requirements.

Follow medical record standards

Please reference **Chapter 9** for **medical record standards**.

Inform members of advance directives

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

Your Agreement

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

After following those procedures, if one of us remains dissatisfied, you may file for arbitration.

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

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

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

Appointment standards (Michigan DHHS access and availability standards)

Comply with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- Emergency care – immediately or referred to an emergency facility
- Urgent care appointment – within 48 hours
- Routine care appointment – within 30 business days
- Physical exam – within 180 calendar days
- EPSDT appointments – within 6 weeks
- New member appointment – within 30 calendar days
- Mental health routine care - available within 10 business days of request
- Mental health non-life threatening emergency - available within 6 hours of request
- Mental health urgent care - available within 48 hours of request
- Emergency dental services - available immediately 24 hours/day, 7 days a week
- Urgent dental care - available within 48 hours
- Routine dental care - within 21 business days of request
- Preventive dental services - within 6 weeks of request
- Initial dental appointment - within 8 weeks of request

In addition, PCPs must adhere to the following standards:

- After-hours care phone number – 24 hours, 7 days a week
- In-office waiting for appointments – not to exceed 15 minutes after the scheduled appointment time
- Telephone access - average seconds to answer must be 30 seconds or less. The abandonment rate must be 5% or less.

Specialty care

Specialists should arrange appointments for routine appointments within 6 weeks of request/referral and acute specialty care within 5 business days of request/referral.

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.

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- First and second trimester – within 7 business days of request
- Third trimester – within 3 business days of request
- High-risk – within 3 business 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.

Long-Term Services & Supports wait times

Long-Term Services & Supports (LTSS)	Large metro, metro and micro areas	Rural areas and counties with extreme access considerations
Adaptive/enhanced durable medical equipment and supplies	21 calendar days	28 calendar days
Assistive technology devices		
Chore services	14 calendar days	21 calendar days
Community living supports	7 calendar days	14 calendar days
Home delivered meals	14 calendar days	21 calendar days
Personal care services (non-waiver)	7 calendar days	14 calendar days
Personal emergency response systems	30 calendar days	
Preventive nursing services (non-agency and agency)	7 calendar days	14 calendar days
Private duty nursing services (non-agency and agency)		
Respite services		
Respite services- non-waiver (provided in the home)		
Vehicle modifications	90 calendar days	120 calendar days

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 **1-800-903-5253**. 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. Services requiring prior authorization must have a certification number from UnitedHealthcare Community Plan before services are rendered. You must call prior authorization service request(s) to us at **1-800-903-5253** no less than 48 hours before the planned service date.

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

- Verify eligibility using **UHCprovider.com/eligibility** or by calling **Provider Services** at **1-800-903-5253**. 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 Sign In.
  2. Select the **Prior Authorization and Notification app.**
  3. View notification requirements.

Identify and bill other insurance carriers when appropriate.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

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

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

Specialists include internal medicine, pediatrics or obstetrics/gynecology

PCPs are an important partner in the delivery of care,

and Michigan Department of Health and Human Services (DHHS) members may seek services from any participating care provider. The MI DHHS program requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

The PCP plays a vital role as a case manager in the UnitedHealthcare Community Plan system by improving health care delivery in 4 critical areas: access, coordination, continuity and prevention. As such, the PCP manages initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide 24 hours a day, 7 days a week coverage and backup coverage when they are not available. Medical doctors (M.D.s), doctors of osteopathy (D.O.s), nurse practitioners (N.P.s) and physician assistants (P.A.s) from any of the following practice areas can be PCPs:

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

N.P.s and P.A.s may enroll with the state as solo care providers. To be considered a PCP, their practice agreement must be with a physician who is a PCP as well.

Members may change their assigned PCP by contacting **Member Services**.

Customer service is available 7 a.m.–7 p.m. ET, 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.

Members have direct access (without a referral or authorization) to any OB/GYNs for women's health care services and any nonwomen'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. This includes PCP availability of 24 hours a day, 7 days a week.

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

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

- Use lists supplied by the UnitedHealthcare Community Plan to identify members who may need preventive health procedures or testing
- Submit all accurately coded claims or encounters in a timely manner
- Provide all well-baby/well-child services
- Coordinate each UnitedHealthcare Community Plan member's overall course of care
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week
- Be available to members by telephone at any time
- Tell members about appropriate use of emergency services
- Discuss available treatment options with members

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

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

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

- Offer office visits on a timely basis, based on the standards outlined in the Timeliness Standards for **Appointment Scheduling** section of this manual
- Conduct a baseline exam during the UnitedHealthcare Community Plan member's first appointment

- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer advanced cardiac and cardiovascular studies, as well as cardiac and pulmonary rehabilitation services to an UnitedHealthcare Community Plan specialist if you are not board-certified in cardiology.
- Refer nerve conduction studies (NCVs) and electromyograms (EMGs) to an UnitedHealthcare Community Plan specialist if you are not board-certified in neurology.
- Refer services requiring prior authorization to Provider Services, UnitedHealthcare Community Plan Clinical or Pharmacy departments as appropriate
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care based on UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards
- Comply with the Michigan DHHS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment standards are covered in this chapter.

Children's Special Health Care Services

PCPs willing to serve Children's Special Health Care Services (CSHCS) members must meet the following qualifications:

- Is willing to accept new CSHCS members with potentially complex health conditions.
- Regularly serves children, youth or young adults with complex chronic health conditions.
- Has a mechanism to identify children, youth or young adults with chronic health conditions.
- Provides expanded appointments when children, youth or young adults have complex needs and require more time.
- Has experience coordinating care for children, youth or young adults who see multiple professionals (pediatric specialists, physical therapists, behavioral health professionals, etc.).
- Has a designated professional responsible for care coordination for children, youth or young adults who see multiple professionals. Provides services appropriate for youth transitioning into adulthood, including but not limited to; the use of a transition readiness assessment tool and adoption of a transition policy that is publicly posted and specifies:
  - the transition time frame
  - transition approach
  - legal changes that take place in privacy and consent at age 18

When you sign your contract with us, you can choose to attest that you are a qualified CSHCS provider.

Foster care

MDHHS requires all children and youth in foster care younger than 21 years of age to receive a full medical examination and screening for potential mental health issues by a PCP within the first 30 Days of entering foster care. This visit must be completed regardless of whether or not the child in foster care recently received a health maintenance visit prior to entry into the foster care system.

Primary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-800-903-5253**
- Check the member's ID card at the time of service. Verify member with photo identification. Plan participating specialists when needed.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit

UHCprovider.com/priorauth.

- Refer patients to UnitedHealthcare Community Plan care providers
- Identify and bill other insurance carriers when appropriate
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form

Rural health clinic and federally qualified health clinic

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

- **RHC**
  The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be in rural, underserved areas.
- **FQHC**
  An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a P.A., N.P., social worker and/or another care provider
  - Mental health services
  - Immunizations (shots)
  - Home nurse visits

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
- Perform diagnostic testing as medically necessary and within the specialist's scope of practice. Obtain additional authorization only if the service is on the plan's prior authorization list.
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care within 10 days after the service, or communicate immediately when medically necessary
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Coordinate the referral process with the PCP if it is determined that a member needs additional specialist referrals
- 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 Michigan DHHS Access and Availability standards for scheduling routine visits. Appointment standards are covered in this chapter.
- 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 care providers include:

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

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

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-800-903-5253**
- Check the member's ID card at the time of service. Verify member with photo identification.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth.**
- Identify and bill other insurance carriers when appropriate

Chapter 3: Care provider office procedures and member benefits

Key contacts

Topic	Link	Phone number
Member benefits	**UHCCommunityPlan.com/michigan**	**1-800-903-5253**
Member handbook	**UHCCommunityPlan.com/MI**> Plan Details > Member Resources > View Available Resources	**1-800-903-5253**
Provider Services	**UHCprovider.com**	**1-800-903-5253**
Prior authorization	**UHCprovider.com/priorauth**	**1-800-903-5253**
D-SNP	**UHCCommunityPlan.com/MI**> Medicare > Dual Complete Special Needs Plan	**1-800-903-5253**

Benefits

Go to **UHCCommunityPlan.com/MI** or **UHCprovider.com** > **Eligibility** for more information.

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, we remove it from auto-assignment. The state requires PCPs to send notice when their panels reach 85% capacity. To update the PCP panel limits, send a written request.

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

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

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 , enrollment in the Vaccine for Children program (members 18 years of age or younger) 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
- Obstetrics

The Michigan Department of Health & Human Services (MDHHS) contracts with Michigan Enrolls,

an enrollment services contractor, to enroll, disenroll and change a member's enrollment. Members requesting changes must contact Michigan Enrolls at Michigan Enrolls or 1-888-367-6557 or 1-800-975-7630.

Michigan Enrolls will reassign a member to UnitedHealthcare Community Plan if they were previously disenrolled due to no longer being Medicaid- eligible, and who are found eligible again within 3 months. We cannot request a member be disenrolled due to an adverse change in their health or because of a health condition.

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.

Capitation reimbursement will be pro-rated for members changing their PCP mid-month.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services. Medically necessary health care services or supplies are:

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

Member assignment

Assignment to UnitedHealthcare Community Plan

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

At enrollment time, each member receives a welcome packet instructing them how to obtain a UnitedHealthcare Community Plan member handbook. The handbook explains the member's health care rights and responsibilities through UnitedHealthcare Community Plan.

When the designated open enrollment month occurs during the 90-day Medicaid Health Plan (MHP) change period, the member will not receive an open enrollment letter. The next open enrollment period for these members will be 12 months from the date of their last open enrollment letter, or in their designated month the following year, whichever date results in the member receiving a plan change notification letter at least once during each 12 month period.

If a member's case number changes they may have 2 open enrollment periods in a 12-month period. Open enrollment letters will be mailed during November and December each year to those that did not receive a change plans notice within the past 12-month period.

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

Immediate enrollment changes

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

Get eligibility information by calling **Provider Services** at **1-800-903-5253**.

Unborn enrollment changes

Encourage your members to notify the Michigan DHHS when they know they are expecting. DHHS notifies managed care organizations (MCOs) daily of an unborn when Michigan Medicaid learns a member associated with the MCO is expecting. Individuals attaining eligibility due to a pregnancy are usually guaranteed eligibility for comprehensive services through 12 months post-partum or post-loss of pregnancy. The MCO or you may use the online change report through the Michigan website to report the baby's birth. With that information, DHHS verifies the birth through the member. The MCO and/or the care provider's information is taken as a lead.

To help speed up the process, the member should notify DHHS when the baby is born.

Members may call **1-800-903-5253**.

Newborns may get UnitedHealthcare Community Plan-covered health services beginning on their date of birth. Newborns are automatically assigned to their mother's health plan at birth. Check eligibility daily until the member has enrolled their baby in a managed care plan. Newborns are eligible for Medicaid coverage for their birth month, and may be eligible for up to 1 year or longer.

Primary care provider selection

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

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

Member eligibility

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

Member ID card

Our members receive 2 forms of Medicaid identification. The state of Michigan issues each member a plastic "MIhealth" Medicaid ID card and each member receives their own UnitedHealthcare Community Plan ID card during the first week of enrollment. Coverage can change monthly.

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

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

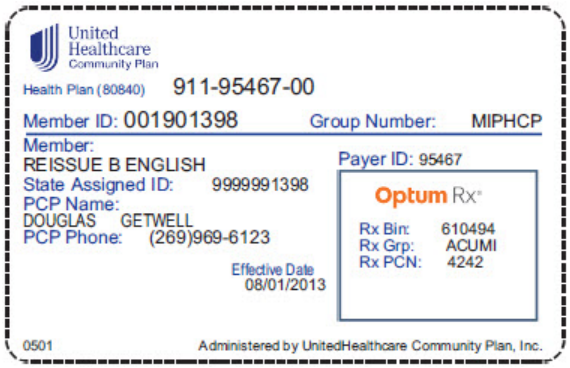
The member's ID card also shows the PCP assignment on the front of the card. If a member does not bring their card, call Provider Services. Also document the call in the member's chart.

Member identification numbers

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

Sample health member ID cards

Medicaid ID card - English


United Healthcare Community Plan

Health Plan (80840) 911-95467-00

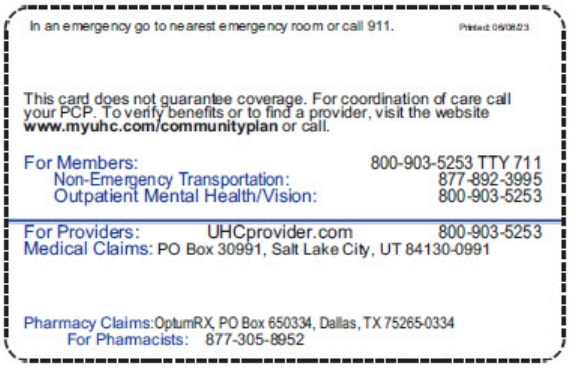
Member ID: 001901398 Group Number: MIPHCP

Member:
REISSUE B ENGLISH
State Assigned ID: 9999991398
PCP Name:
DOUGLAS GETWELL
PCP Phone: (269)969-6123

Effective Date
08/01/2013

Payer ID: 95467
Optum Rx
Rx Bin: 610494
Rx Grp: ACUMI
Rx PCN: 4242

0501 Administered by UnitedHealthcare Community Plan, Inc.


In an emergency go to nearest emergency room or call 911. Printed: 05/08/23

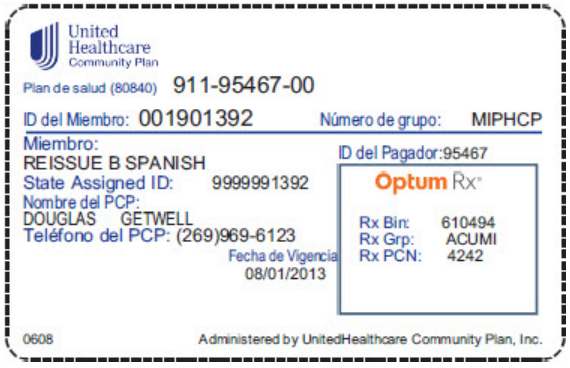
This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website **www.myuhc.com/communityplan** or call.

For Members: 800-903-5253 TTY 711
Non-Emergency Transportation: 877-892-3995
Outpatient Mental Health/Vision: 800-903-5253

For Providers: UHCprovider.com 800-903-5253
Medical Claims: PO Box 30991, Salt Lake City, UT 84130-0991

Pharmacy Claims:OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 877-305-8952

Medicaid ID card - Spanish


United Healthcare Community Plan

Plan de salud (80840) 911-95467-00

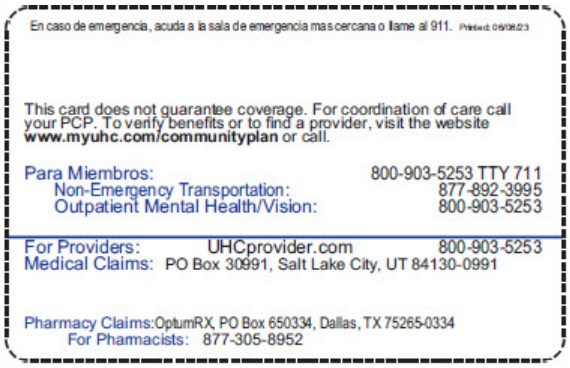
ID del Miembro: 001901392 Número de grupo: MIPHCP

Miembro:
REISSUE B SPANISH
State Assigned ID: 9999991392
Nombre del PCP:
DOUGLAS GETWELL
Teléfono del PCP: (269)969-6123

Fecha de Vigencia
08/01/2013

ID del Pagador:95467
Optum Rx
Rx Bin: 610494
Rx Grp: ACUMI
Rx PCN: 4242

0608 Administered by UnitedHealthcare Community Plan, Inc.


En caso de emergencia, acuda a la sala de emergencia mas cercana o llame al 911. Printed: 05/08/23

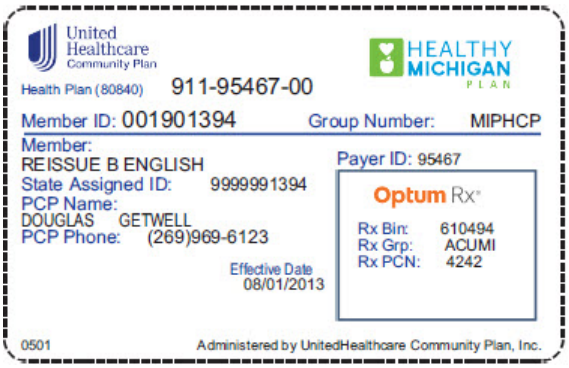
This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website **www.myuhc.com/communityplan** or call.

Para Miembros: 800-903-5253 TTY 711
Non-Emergency Transportation: 877-892-3995
Outpatient Mental Health/Vision: 800-903-5253

For Providers: UHCprovider.com 800-903-5253
Medical Claims: PO Box 30991, Salt Lake City, UT 84130-0991

Pharmacy Claims:OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 877-305-8952

Healthy Michigan Plan ID card - English


United Healthcare Community Plan

HEALTHY MICHIGAN PLAN

Health Plan (80840) 911-95467-00

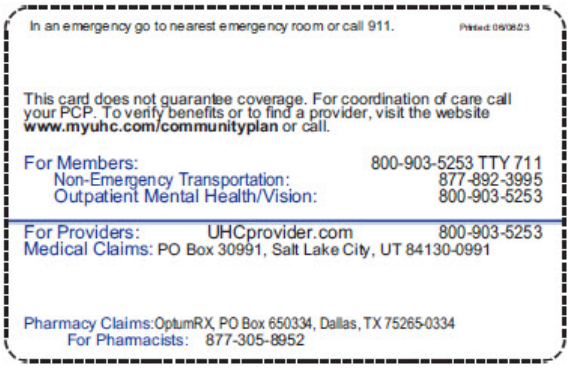
Member ID: 001901394 Group Number: MIPHCP

Member:
REISSUE B ENGLISH
State Assigned ID: 9999991394
PCP Name:
DOUGLAS GETWELL
PCP Phone: (269)969-6123

Effective Date
08/01/2013

Payer ID: 95467
Optum Rx
Rx Bin: 610494
Rx Grp: ACUMI
Rx PCN: 4242

0501 Administered by UnitedHealthcare Community Plan, Inc.


In an emergency go to nearest emergency room or call 911. Printed: 05/08/23

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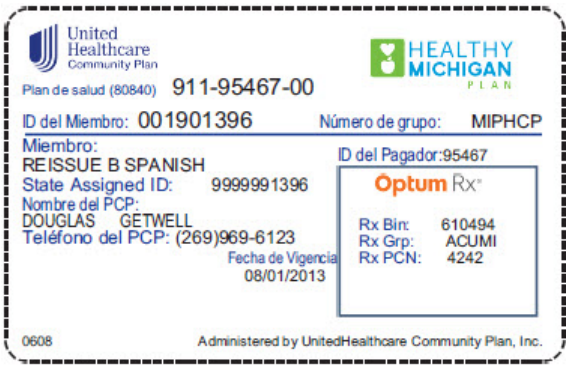
Non-Emergency Transportation: 877-892-3995
Outpatient Mental Health/Vision: 800-903-5253

For Providers: UHCprovider.com 800-903-5253
Medical Claims: PO Box 30991, Salt Lake City, UT 84130-0991

Pharmacy Claims:OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 877-305-8952

Healthy Michigan Plan ID card - Spanish


United Healthcare Community Plan

HEALTHY MICHIGAN PLAN

Plan de salud (80840) 911-95467-00

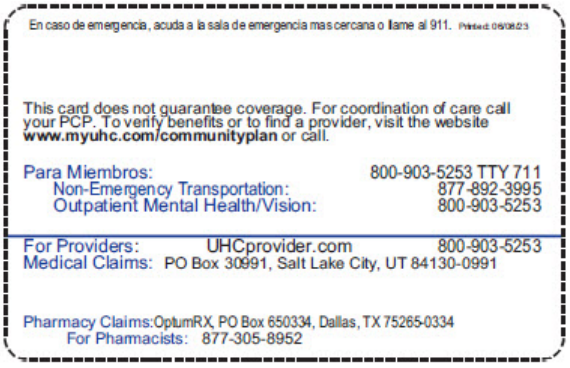
ID del Miembro: 001901396 Número de grupo: MIPHCP

Miembro:
REISSUE B SPANISH
State Assigned ID: 9999991396
Nombre del PCP:
DOUGLAS GETWELL
Teléfono del PCP: (269)969-6123

Fecha de Vigencia
08/01/2013

ID del Pagador:95467
Optum Rx
Rx Bin: 610494
Rx Grp: ACUMI
Rx PCN: 4242

0608 Administered by UnitedHealthcare Community Plan, Inc.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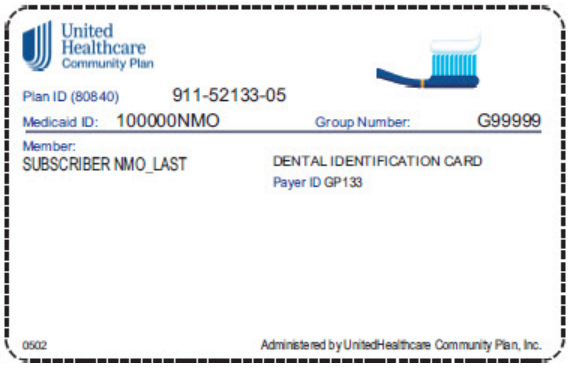
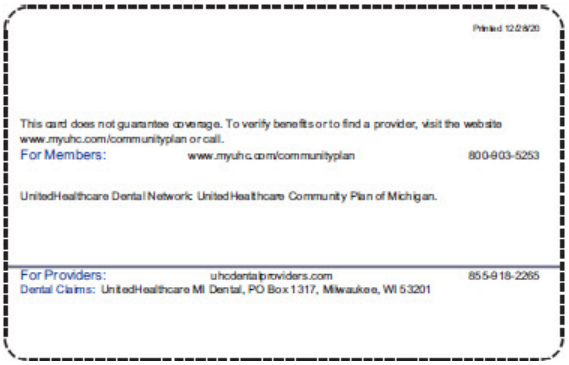
For Providers: UHCprovider.com 800-903-5253
Medical Claims: PO Box 30991, Salt Lake City, UT 84130-0991

Pharmacy Claims:OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 877-305-8952

Dental ID card





Primary care providers initiated transfers

Non-compliance with treatment recommendations may not be adequate reason to transfer a member out of your practice.

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

1. To transfer the member call the **Member Services** number on the back of the member's card, or mail with the specific event(s) documentation. Documentation includes a detailed account of reasons for termination request (i.e., violent or life-threatening behaviors, fraud or misrepresentation), member name, date of birth, Medicaid number, current address, current phone number and the care provider's name.

   Mailing address:
   UnitedHealthcare Community Plan
   Attn: Health Operations
   3000 Town Center, Suite 1400
   Southfield, MI 48075

2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have 5 business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

Verifying member enrollment

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

- Access the UnitedHealthcare Provider Portal through **UHCprovider.com/eligibility**
- **Provider Services** is available from 7:00 a.m.–5:00 p.m. CT, Monday–Friday
- Michigan Medicaid Eligibility System (MES)

UnitedHealthcare Dual Complete

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

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

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

Chapter 4: Medical management

Key contacts

Topic	Link	Phone number
Referrals	**UHCprovider.com/referrals**	**1-800-903-5253**
Prior authorization	**UHCprovider.com/priorauth**	
Pharmacy	**professionals.optumrx.com**	
Dental	**dbp.com**	**1-855-918-2265**
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.

Transition of care policy

UnitedHealthcare Community plan assists members transitioning to the health plan. As soon as they become an active member, they will have access to all the services we offer.

Members will be provided with access to services the entire time they are a part of UnitedHealthcare Community Plan.

If you need help transitioning care for your member, call **Provider Services** at **1-800-903-5253**.

To get a copy of our transition of care policy go to **UHCprovider.com**.

Ambulance services

Air ambulance

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

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

Nonemergent air ambulance requires prior authorization.

For authorization, go to **UHCprovider.com/priorauth** or call **Provider Services** at **1-800-903-5253**.

Emergency ambulance transportation

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

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

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

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

Nonemergent stretcher/ambulance requests are accepted between 8 a.m. and 5 p.m. ET.

Nonemergency medical transportation

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

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

Routine NEMT requests are accepted between 8 a.m. and 5 p.m.

Calls for trips to urgent/same-day critical care services, facility discharges and ride assist are available 24/7 365 days.

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**, 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.

Communicable diseases

You must report communicable diseases per the time frames specified by the Michigan Department of Health & Human Services (MDHHS).

Mail, call, or fax your local health department with the member demographics, diagnosis and onset date.

If you have a question, need a form or want information, contact:

Michigan Department of Community Health
Communicable Disease Epidemiology
Division 201 Townsend St.
5th Floor
Lansing, MI 48913

- **Phone –** 1-517-335-8165
- **Fax –** 1-517-335-8121
- **After hour emergency calls only –** 1-517-335-9030
- **Online –**
  - Michigan.gov/mdhhs: for more communicable disease information, resources and reporting
  - Find a county health department and contact information at Michigan.gov/mdhhs

Dental services

Covered

UnitedHealthcare Community Plan offers dental coverage to all beneficiaries ages 19 and older enrolled in Healthy Michigan Plan, as well as all enrollees ages 21 and older, enrolled in Medicaid.

The following services are covered:

- Periodontal services
- Preventive services
- Diagnostic services
- Restorative services
- Oral surgery

Children under age 21 and enrolled in Medicaid are automatically enrolled into the Healthy Kids Dental program. The 2 plans available are Blue Cross Blue Shield of Michigan and Delta Dental of Michigan.

For more information, call Blue Cross Blue Shield of Michigan Health Insurance Plans at 1- 800-936-0935 or Delta Dental of Michigan Individual Dental Plans (deltadentalmi.com) at 1-866-696-7441.

For more details, go to **uhcdental.com**.

To find a dental care provider, go to **UHCprovider.com** > Our Network > Find a Provider > **Dental Directory**.

Disease management programs

UnitedHealthcare Community Plan has disease management programs to meet the needs of our members with chronic illnesses, and to support your efforts for member self-management and optimal health status. These programs are based on nationally recognized and evidence-based clinical practice guidelines. There is no cost to our members to participate in these 4 programs:

- Asthma
- CHF
- COPD
- Diabetes

We automatically enroll members who have one of these diagnoses, but you may also refer a newly diagnosed member by calling **1-800-903-5253** and asking to speak with a Disease Management Nurse.

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 that 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**.

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 ER use. A PCP should treat nonemergency services such as sprains/strains, stomachaches, earaches, fevers, coughs, colds and sore throats.

Covered services include:

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

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.

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 (nonemergent)

Urgent care services are covered.

For a list of urgent care centers, contact **Provider Services** at **1-800-903-5253**.

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 **1-800-903-5253**.

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

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

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

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

Family planning

Family planning services are preventive health, medical, counseling and educational services that help members manage their fertility and achieve the best reproductive and general health. UnitedHealthcare Community Plan members may access these services without a referral.

They may also seek family planning services at the care provider of their choice. The following services are included:

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

Parenting/child birth education programs

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

Voluntary sterilization

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

Out-of-network services require prior authorization.

View the DHHS regulations for more information on sterilization.

Care coordination/ health education

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

The program goals are to:

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

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

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

Facility admission notification requirements

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

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

Hearing services

Monaural and binaural hearing aids are covered. This includes fitting, follow-up care, batteries and repair. Bilateral cochlear implants – including implants, parts, accessories, batteries, charges and repairs – are also covered.

View prior authorization information and notification requirements at **UHCprovider.com/MICommunityPlan** > Prior Authorization and Notification.

Hospice

UnitedHealthcare Community Plan covers in-home hospice and short-stay inpatient hospice. Please refer to the **prior authorization list** for authorization requirements.

Hospital admissions

Base hospital admissions on medical necessity and appropriateness of care. The hospital/admitting facility must verify that UnitedHealthcare Community Plan authorized an admission. Contact UnitedHealthcare Community Plan by calling **1-800-903-5253**, Monday - Friday, 8:30 a.m. - 5:30 p.m.

Elective admission

UnitedHealthcare Community Plan must prior authorize all elective admissions. Inpatient and outpatient elective procedures require prior authorization if they are on the **prior authorization list**. Please call at least 72 hours before the procedure.

Admit non-emergent surgery patients on the day of surgery, unless pre-op days are medically necessary and authorized by our Health Services department in advance.

Perform diagnostic and laboratory tests before admission. Results and copies of pertinent medical records should accompany the member to the hospital.

Hospital admission notification by the primary care provider

When a member's condition requires hospitalization, the admitting care provider should obtain admission authorization by calling UnitedHealthcare Community Plan and providing the needed information.

You must observe the following utilization management inpatient admission requirements:

• The hospital or attending care provider must contact us for each admission.

• We inform you or the facility of the date we must receive clinical information (if applicable).

Hospital admission notification by the facility

The facility must verify member eligibility. Contact UnitedHealthcare Community Plan for inpatient admissions within 24 hours or the next business day.

UnitedHealthcare Community Plan authorizes additional days when the facility contacts us by phone for concurrent review, before the exhaustion of the initial or approved length of stay.

The facility must contact us with discharge information by phone to help ensure coordination of care between health care settings.

The facility must notify us when a UnitedHealthcare Community Plan member is transferred to another facility.

Laboratory

Joint Venture Hospital Laboratories (JVHL) is the preferred lab provider. Contact JVHL directly.

Process outpatient laboratory services through a UnitedHealthcare Community Plan contracted care provider.

Contact JVHL at 1-800-445-4979 for assistance in arranging services with a JVHL or UnitedHealthcare Community Plan hospital provider.

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

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

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 strives to:

- Identify expectant members early and enroll them in case management
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it
- Multidisciplinary support for pregnant members to overcome social and psychological barriers to prenatal care
- Increase the member's understanding of pregnancy and newborn care
- Encourage pregnancy and lifestyle self-management and informed health care decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits
- Foster a care provider-member collaboration before and after delivery as well as for nonemergent settings
- Encourage members to stop smoking with our Quit For Life tobacco cessation program
- Help identify and build the member's support system, including referrals to community resources and pregnancy support programs

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

Pregnancy/maternity

Bill the initial pregnancy visit as a separate office visit. You must bill antepartum care, delivery and postpartum care visits separately using the following codes:

Antepartum visits: all prenatal visit dates, along with LMP or EDD/EDC, must be included with the claim

- 59425 - Antepartum care only, 4-6 visits

OR

- 59426 - Antepartum care only, 7 or more visits

*HEDIS® & ACOG Guidelines state the first prenatal care visit must be completed in the first trimester or the first 42 days the member is enrolled in a health plan.

Postpartum visit: 59430 - postpartum care only (required 7-84 days from delivery)

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

For prior authorization maternity care, including out-of-plan and continuity of care, call **1-800-903-5253** or go to **UHCprovider.com/priorauth**. For more information about prior authorization requirements, go to **UHCprovider.com/MIcommunityplan** > Prior Authorization and Notification.

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

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

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

A UnitedHealthcare Community Plan member does not need a referral from their PCP for OB/GYN care. You must notify UnitedHealthcare Community Plan if a member's pregnancy is determined to be high risk.

Perinatal home care services are available for UnitedHealthcare Community Plan members when medically necessary.

Doula care

Doulas are available to UnitedHealthcare Community Plan members at no cost. Doulas offer non-clinical care and guidance to members, from pregnancy though delivery. They are there for physical and emotional support.

A doula may assist members with the following:

- Prenatal visits - A doula can help talk to members about their questions, fears and concerns before their baby arrives. Together, they can start putting together a birth plan.
- Labor and delivery - A doula can use positioning, massage, emotional support and more to try and help facilitate an easier labor.
- Postpartum visits - A doula can help guide members and families to care for their newborn. They may also assist with breastfeeding.

To locate a doula, please visit MI Doula Directory or MDHHS Doula Registry.

Maternity admissions

All maternity admissions require notification. Days in excess of 48 hours for vaginal deliveries and 96 hours for Caesarean section require clinical information and medical necessity review. ER labor checks do not require prior authorization. A labor check is a stay for maternity purposes of less than 6 hours.

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 **1-800-903-5253**.

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

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

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

- Date of delivery
- Sex
- Birth weight
- Gestational age
- Baby name
- Method of delivery
- Apgar scores and discharge date, if known

Nonroutine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires prior authorization. Infants remaining in the hospital after the member's discharge require separate notification and will be subject to medical necessity review.

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

Newborn enrollment

The hospital must notify MDHHS 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. It is supported by the U.S. DHHS, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

The Bright Futures Guidelines informs all preventive care screenings and well-child visits. You may incorporate Bright Futures into health programs such as home visits, child care and school-based health clinics. 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
- Other primary care facilities

A complementary goal is to provide home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the Bright Futures Guidelines. This objective will ensure that patients receive information and support that is consistent from family and youth perspectives.

Hysterectomies

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

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

Find the form on the Michigan Department of Social Services website at Michigan.gov.

See “Sterilization consent form” section below for more information.

Exception: MI DHHS does not require informed consent if:

- 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.
- 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:

UnitedHealthcare Community Plan
P.O. Box 30991
Salt Lake City, UT 84130-0991

Reimbursement is made upon completion of documentation requirements and UnitedHealthcare Community Plan review. You cannot bill members if you do not submit consent forms.

Pregnancy termination services

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

Allowable pregnancy termination services do not require a referral from the member’s PCP. Members must use the UnitedHealthcare Community Plan provider network. Prior authorization is required for abortions, regardless if the member uses an in-network or out-of-network care provider.

Sterilization and hysterectomy procedures

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

Sterilization consent form

- Obtain an informed consent to sterilization form through the state of Michigan Medical Services Administration by calling 1-800-292-2550. Before claim submission, mail the UnitedHealthcare Community Plan's consent submission form to:

  UnitedHealthcare Community Plan
  P.O. Box 30991
  Salt Lake City, UT 84130-0991
- Complete all applicable sections of the consent form before submitting it with the billing form. The Michigan Medical Assistance Program cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.
- Complete your statement section after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.
- The state's definition of "shortly before" is not more than 30 days before the procedure. Explain the procedure to the member within that time frame. However, do not sign and date the form until after you perform the procedure.

You may also find the form on the Michigan Department of Social Services website at Michigan.gov.

Have 3 copies of the consent form:

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

Maternal Infant Health Program

The Maternal Infant Health Program (MIHP) program promotes healthy pregnancies, infant growth and development, while seeking to reduce maternal and infant mortality. Pregnant Medicaid members can qualify for MIHP at any time during their pregnancy, while newborns may qualify at birth.

MIHP services are not intended to supplement regular prenatal/ infant care rather assist health care providers in managing the mother and baby's health and wellbeing. These services provide assistance to help support families' basic needs, prenatal and parenting education, and referrals to community resources.

Screen all pregnant members to determine if they qualify for MIHP. Members must meet certain criteria to qualify for services.

For more information and program documents, go to the Michigan MIHP website at Michigan.gov/mihp.

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.

Inhaled nitric oxide

Use the guidelines for inhaled nitric oxide (iNO) therapy at **UHCprovider.com/policies** > For Community Plans > Medical and Drug Policies for Community Plan. Search for "Inhaled Nitric Oxide Therapy."

Oncology

Prior authorization

For information about our oncology prior authorization program, including radiation and chemotherapy guidelines, requirements and resources, go to **UHCprovider.com/oncology** or call **1-888-397-8129** Monday–Friday, 7 a.m.–7 p.m. CT.

Pharmacy

Pharmacy Preferred Drug List/ Prescription Drug List

UnitedHealthcare Community Plan with Michigan Department of Health and Human Services (MDHHS) and other Michigan Medicaid Health Plans determine and maintain the Preferred Drug List/Prescription Drug List (PDL) of covered medications. This list applies to all UnitedHealthcare Community Plan of MI 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 nonpreferred medication, call Pharmacy Prior Authorization at **1-800-310-6826** or use the online Prior Authorization and Notification tool at **UHCprovider.com**.

We communicate PDL updates through prescriber mailings and website updates. Access to the PDL and formulary updates are posted on **UHCprovider.com**. Find the PDL and Pharmacy Prior Notification Request form at **UHCprovider.com/priorauth**.

Request to add medications to the Preferred Drug List/Prescription Drug List

Send Preferred Drug List/Prescription Drug List (PDL) suggestions to the UnitedHealthcare Community Plan Director of Pharmacy at:

Attn: Director of Pharmacy Services
UnitedHealthcare Community Plan
Unison Plaza
1001 Brinton Road
Pittsburgh, PA 15221

Provide adequate clinical documentation, such as clinical necessity, as well as therapeutic advantages over current PDL products. UnitedHealthcare Community Plan's Pharmacy and Therapeutics Committee will review submitted suggestions at the subsequent P&T meeting.

Prescription guidelines and pharmacy authorizations

Prescriptions may cover up to a maximum 30-day medication supply. Some everyday used medications are available for a 3-month supply. Refills are permitted as medically necessary, but will only be dispensed if the member is UnitedHealthcare Community Plan eligible. All medications (prescription and OTC) require a valid prescription from the prescribing care provider. The member must first have tried and failed listed PDL agent(s) before authorization being reviewed for non-PDL agents.

Health care providers may request a pharmacy prior authorization (PA) or a medical exception for a non-PDL medication. Find pharmacy prior authorization forms on our website. Submit prior authorization or exception requests to Pharmacy Services by completing and calling **1-800-310-6826**.

Upon approval, Pharmacy Services places a system override to allow the claim to pay online at the UnitedHealthcare Community Plan participating pharmacy. If the requested medication criteria is not met, Pharmacy Services sends a notification to the requesting care provider, which will include member appeal rights.

Pharmacy appeal requests

UnitedHealthcare Community Plan decisions may be

appealed by the member or the member's health care provider on behalf of the member, if the member has given the care provider power of attorney.

Mail appeal requests to UnitedHealthcare Community Plan at:

UnitedHealthcare Community Plan
Grievance and Appeals Department
P.O. Box 30991
Salt Lake City, UT 84130-0991

Pharmacy prior authorization

Medications can be dispensed as an emergency 5-day supply when drug therapy must start before prior authorization is secured, and the prescriber cannot be reached. The rules apply to nonpreferred PDL drugs and to those affected by a clinical prior authorization edit.

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

Specialty pharmacy medications

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

Screening, brief interventions and referral to treatment services

Screening, brief interventions and referral to treatment (SBIRT) services are covered when provided by, or under the supervision of, a certified care provider or other certified licensed care provider within the scope of their practice. Care providers:

- Determine risk factors related to alcohol and other drug use disorders
- Provide interventions to enhance patient motivation to change
- Make appropriate referrals as needed

SBIRT screening will occur during an Evaluation and Management (E/M) exam and is not billable with a separate code. You may provide a brief intervention on the same day as a full screen in addition to the E/M exam. You may also perform a brief intervention on subsequent days. Brief interventions are limited to 4 sessions per patient, per care provider per calendar year.

What is included in Screening, brief interventions and referral to treatment services?

Screening

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

Brief intervention

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

Referral to treatment

Refer members whose screening indicates a severe problem or dependence to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. **This includes coordinating with the alcohol and drug program in the county where the member resides for treatment.**

SBIRT services will be covered when all are met:

- The billing care provider and servicing care provider are SBIRT-certified
- The billing care provider has an appropriate taxonomy to bill for SBIRT

- The diagnosis code is Z71.41
- The treatment or brief intervention does not exceed the limit of 4 encounters per client, per care provider, per year

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

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

For more information about E/M services and outreach, see the DHHS Evaluation and Services at cms.gov > Medicare > Payment > Fee schedules > Physician Fee Schedule > Evaluation & Management Visits > Evaluation and Management Services MLN Publication > Evaluation and Management Services-Updated 08/29/2023.

Medication-assisted treatment

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

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

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

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. Type "Medication Assisted Treatment" in the search bar and click "search."

If you have questions about MAT, please call **Provider Services** at **1-800-903-5253** and enter your TIN. Say "Representative," and "Representative" a second time. Then say "Something Else" to speak to a representative.

Vision

Vision services are covered by March Vision Care. Please see the March Vision Care reference guide for information such as compliance, electronic payment information, safety resources and training. You can also call 1-844-516-2724.

- Diabetic members may obtain a retinal eye exam annually
- Help ensure your assigned members with diabetes obtain a dilated eye exam annually
- We contract with ophthalmologists for management of non-routine eye diseases and conditions; PCPs may refer members for these services and care.
- Submit claims to MARCH Vision Care, not to UnitedHealthcare Community Plan

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 number
- Rendering care provider and TIN/NPI number

- 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 number, when applicable

Prior authorization information

UnitedHealthcare Community Plan can add or delete required prior authorization procedures. We will post updates on **UHCprovider.com/MICommunityPlan** > Prior Authorization and Notification.

- Services requiring prior authorization must have a certification number from UnitedHealthcare Community Plan before you render services
- For services requiring prior authorization, specialists and PCPs must request authorization no less than 3 business days before the planned service date
- If services will be performed within 48 hours of the prior authorization request, you must call the request in to us at **1-800-903-5253**
- If requesting prior authorization services by telephone, you will receive a certification number based on clinical information supporting the request at the time of call
- If requesting prior authorization services by telephone, you will receive a reference number for requests that have to be pended for clinical review. For requests that can be approved immediately, a prior authorization number will be provided at the time of call.

For behavioral health and substance use disorder authorizations, please contact OptumHealth Behavioral Solutions.

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

Type of request	Decision turn-around time	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent pre-service	Within 14 days from date of receipt	Within 14 days from date of receipt	Within 14 days from date of receipt
Urgent/expedited pre-service	Within 72 hours after receipt of the request	Within 72 hours after receipt of the request	Within 72 hours after receipt of the request
Concurrent review	Within 72 hours after receipt of the request	Within 72 hours after receipt of the request	Within 72 hours after receipt of the request
Retrospective review	Within 30 calendar days from receipt of request	Within 30 calendar days from receipt of request	Within 30 calendar days from receipt of request

Concurrent review guidelines

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

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

Concurrent review details

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

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

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

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

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

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

This includes:

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

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

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

We don't consider experimental treatments medically necessary.

Determination process

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

Evidence-based clinical guidelines

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

Medical and drug policies and 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 do not require a hard copy referral form when you are referring a UnitedHealthcare Community Plan member to another participating UnitedHealthcare Community Plan care provider. Non-participating UnitedHealthcare Community Plan care providers must contact us at **1-800-903-5253** to obtain prior approval. Either the specialist or the referring PCP can contact us for prior approval. It is the responsibility of the specialist to:

- Verify member eligibility prior to rendering the service
- Communicate outcomes to the referring PCP to help ensure coordination of care

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.

General referral information

- Pediatric members may self-refer to any UnitedHealthcare Community Plan participating pediatrician
- Female members may self-refer to any UnitedHealthcare Community Plan contracted OB/GYN for well woman care
- Direct glucometer referrals to the designated UnitedHealthcare Community Plan pharmacy vendor with a prescription
- Refer advanced cardiac and cardiovascular studies, as well as cardiac and pulmonary rehabilitation services to an UnitedHealthcare Community Plan specialist if you are not board-certified in cardiology
- Refer nerve conduction studies (NCVs) and electromyograms (EMGs) to an UnitedHealthcare Community Plan specialist if you are not board-certified in neurology

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 our Provider Services department, or the Michigan 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
- Noncovered services
- Services provided to members not enrolled on the date(s) of service

Second opinion benefit

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the Michigan DHHS. 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 their report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a nonparticipating care provider. The participating care provider should contact UnitedHealthcare Community Plan at **1-800-903-5253**.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations
- If follow-up care is recommended, the member meets with the PCP before receiving treatment

Services requiring prior authorization

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

Direct access services – Native Americans

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

Seek prior authorization within the following time frames

- Emergency or urgent facility admission – 1 business day
- Inpatient admissions; after ambulatory surgery – 1 business day
- Nonemergency admissions and/or outpatient services (except maternity) – at least 14 business days beforehand; if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time

Utilization management guidelines

Call **1-800-903-5253** to discuss the guidelines and utilization management.

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

Utilization management appeals

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

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

Key contacts

Topic	Links	Phone number
Provider Services	**UHCprovider.com** Live chat available at **UHCprovider.com/contactus**	**1-800-903-5253**
Provider advocate	**UHCprovider.com/chat**	**1-800-903-5253**
Training	**UHCprovider.com/training**	**1-800-903-5253**
UnitedHealthcare Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID or go to **UHCprovider.com/portal** New users: **UHCprovider.com/access**	**1-800-903-5253**
CommunityCare Provider Portal training	**UnitedHealthcare CommunityCare Provider Portal user guide**	
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**
Resource library	**UHCprovider.com/resourcelibrary**	

Home and Community-Based Services

MI Coordinated Health (MICH)will be available to individuals enrolled in both Medicare and Medicaid in select counties in 2026 before expanding statewide in 2027.

MI Coordinated Health (MICH) is the successor to the Michigan Health Link program, which ends Dec. 31, 2025.

Current Michigan Health Link enrollees will have the option of moving into MI Coordinated Health (MICH) with no break in coverage.

Home and Community-Based Services credentialing

Participation in the HCBS provider network require credentialing to validate state issued licenses and/or certifications for services provided.

How to join our network

To request participation in HCBS provider network, visit **UHCprovider.com/MIcommunityplan** >

How to Join the UnitedHealthcare network > Home and Community-Based Services or email UnitedHealthcare Community Plan at **hcbsprovidernetwork@uhc.com**.

Electronic visit verification system

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

- Personal Care Service providers: Home and community assistance (homemaker) and attendant care
- Home Health Service providers: Home Health (PT, OT, ST, Evals)

Benefits of an electronic visit verification system

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

Do you have to use electronic visit verification system?

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

Home and Community-Based Services waiver services

HCBS waiver benefits are available to members who meet a specified level of care. Member benefits should be reviewed to ensure coverage of the following benefits. HCBS waiver services and definitions included in the Michigan:

Adaptive medical equipment and supplies

This service includes devices, controls, or appliances specified in the IICSP that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and medical supplies not available under the Medicaid State Plan and Medicare that are necessary to address individual functional limitations. This will also cover the costs of equipment maintenance. The coverage includes training the individual and/or caregivers in the operation and/or maintenance of the equipment and the use of a supply when initially purchased. The ICO shall not authorize payment for herbal remedies, nutraceuticals, and/or other over-the-counter medications for uses not approved by the United States Food and Drug Administration (FDA).

Adult day program

Adult Day Program services are furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week, or as specified in the IICSP, in a noninstitutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen," i.e., 3 meals per day. Physical, occupational and speech therapies may be furnished as component parts of this service.

Assitive technology devices

The Assistive Technology service includes technology items used to increase, maintain, or improve an individual's functioning and promote independence. The service may include assisting the individual in the selection, design, purchase, lease, acquisition, application, or use of the technology item. This service also includes vehicle modifications to the vehicle that is the individual's primary method of transportation. This service includes repairs and maintenance of assistive technology devices. Vehicle modifications must be of direct medical or remedial benefit to the individual and specified under the IICSP. Some

examples of assistive technology include, but are not limited to, van lifts, hand controls, computerized voice system, communication boards, voice activated door locks, power door mechanisms, adaptive or specialized communication devices, assistive dialing device, adaptive door opener and specialized alarm or intercom.

Chore services

Chore Services include those duties needed to maintain the home in a clean, sanitary, and safe environment to provide safe access inside the home, and yard maintenance and snow plowing to provide access to and egress outside of the home. This service includes tasks such as heavy household chores (washing floors, windows, and walls), tacking loose rugs and tiles, moving heavy items of furniture, mowing, raking, cleaning hazardous debris such as fallen branches and trees, weatherization, and pest control. The service may include materials and disposable supplies used to complete chore tasks. The ICO may also use waiver funds to purchase or rent the equipment or tools used to perform chore tasks for waiver individuals.

Environmental Modifications

The Environmental Modifications service covers physical adaptations to the home, required in the individual's IICSP, that are necessary to ensure the health and welfare of the individual or that enable the individual to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual. Complex kitchen and bathroom modifications may be completed if medically necessary for the individual. Environmental modifications are those which are installed in the residence versus enhanced equipment or assistive technology which are portable from residence to residence. A ramp or lift will be covered for only one exterior door or other entrance.

Community Living Supports

To receive ECLS, individuals MUST need prompting, cueing, observing, guiding, teaching, and/or reminding to independently complete ADLs. ECLS does not include hands on assistance for ADLs unless something occurs incidental to this service. ECLS includes social/community participation, relationship maintenance, and attendance at medical appointments.

Fiscal Intermediary

Fiscal Intermediary (FI) services assist the individual to live independently in the community while controlling his/her individual budget and choosing the staff to work with him/her. The FI helps the individual to manage and distribute funds contained in the individual budget. The individual uses funds to purchase home and community-based services authorized in the IICSP. FI services include, but are not limited to, the facilitation of the employment of service workers by the individual, including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements; fiscal accounting; tracking and monitoring individual-directed budget expenditures and identify potential over and under expenditures; ensuring compliance with documentation requirements related to management of public funds. The FI helps the individual manage and distribute funds contained in the individual budget. The FI also assists with training the individual and providers, as necessary, in tasks related to the duties of the FI including, but not limited to, billing processes and documentation requirements.

Home delivered meals

This service is the provision of 1 to 2 nutritious meals per day to individuals who are unable to care for their nutritional needs. This service must include and prioritize healthy meal choices that meet any established criteria under state or federal law. Meal options must meet individual preferences in relation to specific food items, portion size, dietary needs, and cultural and/or religious preferences. ICOs must follow the minimum operating standards for this service as provided by MDHHS.

Non-medical transportation (waiver service only)

This service is offered to enable individuals to gain access to waiver and other community services,

activities, and resources, specified by the Individual Integrated Care and Supports Plan (IICSP). Whenever possible, the ICO shall utilize family, neighbors, friends, or community agencies that can provide this service free of charge. Need for this service and details as to whom and how it will be provided should be discussed in the person-centered planning meeting and documented in the IICSP.

Personal care services (non-agency and agency

For individuals enrolled in the MI Health Link program, State Plan personal care services will be provided and paid for by the ICO and will no longer be provided through the Medicaid Home Help program. Personal care services are available to individuals who require hands-on assistance in activities of daily living (ADLs) (i.e., eating, toileting, bathing, grooming, dressing, mobility, and transferring) as well as hands-on assistance in instrumental activities of daily living (IADLs) (i.e., personal laundry, light housekeeping, shopping, meal preparation and cleanup, and medication administration).

Personal Emergency Response System

A Personal Emergency Response System (PERS) is an electronic device that enables individuals to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the individual's phone and programmed to signal a response center once the "help" button is activated. The PERS provider may offer this service for cellular or mobile phones and devices. The device must meet industry standards. The individual must reside in an area where cellular or mobile coverage is reliable. When the individual uses the device to signal and otherwise communicate with the PERS provider, the technology for the response system must meet all other service standards. The PERS provider must ensure at least monthly testing of each PERS unit to maintain proper functioning.

Preventive nursing services (non-agency and agency)

Preventive nursing services are covered on a part-time, intermittent (separated intervals of time) basis for an individual who generally requires nursing services for the management of a chronic illness or physical disorder in the individual's home and are provided by a RN or a licensed practical nurse (LPN) under the supervision of a RN. Nursing services are for individuals who require more periodic or intermittent nursing than otherwise available for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the individual such as hospitalizations and nursing facility admissions. An individual using this service must demonstrate a need for observation and evaluation.

Private Duty Nursing (non-agency and agency)

Private Duty Nursing (PDN) services are skilled nursing interventions provided to an individual age 21 or older on an individual and continuous basis, up to a maximum of 16 hours per day, to meet the individual's health needs directly related to the individual's physical disability.

Respite services

Respite services are provided on a short-term, intermittent basis to relieve the individual's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

Self-direction care services

Member-directed attendant care

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

Clean claims and submission requirements

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

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

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

Electronic claims submission and billing

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

- Our payer ID is 87726
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit
- We follow CMS National Uniform Claim Committee (NUCC) guidelines for CMS-1500 forms

Authorization/notice of action for Home and Community-Based Services

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

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

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

Home and Community-Based Services provider advocate roles and responsibilities

Home and Community-Based Services provider advocate overview

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

The assigned HCBS provider advocate is an important resource when you have questions.

They are your single point of contact across all lines of business and medical benefit plans to help make your interactions with us easier and more efficient.

The assigned provider advocate:

- Serves as primary contact for provider with UnitedHealthcare Community Plan
- Keeps providers advised on new and amended programs and processes
- Specializes in issue resolution

If you don't know who your provider advocate is, connect with a live advocate on **UHCprovider.com/chat**, available Monday-Friday, 7:00 a.m. - 7:00 p.m. CT.

Health Insurance Portability and Accountability Act compliance – your responsibilities

Health Insurance Portability and Accountability Act (HIPAA) aims to improve the efficiency and effectiveness of the United States health care system. While the act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have

had the greatest impact on how the health care industry works. UnitedHealthcare Community Plan is a "covered entity" under these regulations—so are all care providers who conduct business electronically.

Timely filing

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

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

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

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

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

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

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

UnitedHealthcare Provider Portal

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

Submitting a claim reconsideration

- A claim reconsideration request is the quickest way to address your concerns regarding claim payments
- Preferred method for submitting a claim reconsideration: the UnitedHealthcare Provider Portal at **UHCprovider.com/claims**
- Call **Provider Services** at **1-800-903-5253** or use the telephone number on the back of the member's ID card

Submit claim reconsideration form by mailing to:

UnitedHealthcare Community Plan
P.O. Box 30991
Salt Lake City, UT 84130-0991

- Access the Single Paper Claim Reconsideration Request Form at **UHCprovider.com/claims** > Documents and forms

3-step process for Michigan:

1. Claim reconsideration.
2. Informal dispute.
3. Formal appeal.

Balance billing

Balance billing is not allowed.

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

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

Billable noncovered services

If the member chooses to receive the service without an approved notice of action, a provider must use a waiver to establish member responsibility for payment, and the waiver must meet the following requirements:

- The waiver is signed only after the member receives the appropriate notification
- The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment
- A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services
- The waiver must specify the date the services are provided and the services that fall under the waiver's application

Critical Incident Reporting

A Critical Incident is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of an Enrollee, including Serious Reportable Events as defined by the National Quality Forum.

The following are specific critical incidents or serious events that must be reported to MDHHS:

- Care provider no show, particularly when the beneficiary is bed-bound all day or there is a critical need for the service to be provided
- Exploitation
- Illegal activity in the home with potential to cause a serious or major negative event
- Medication error
- Neglect
- Physical abuse
- Sexual abuse
- Suicide attempts
- Unexpected/unexplained death related to providing services, supports, or care
- Theft
- Verbal abuse
- Worker consuming drugs/alcohol on the job
- Restraints, seclusion or restrictive interventions

Every health care professional must follow the Critical Incident & Adverse Event reporting and related requirements listed in your LTSS Contract.

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

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. The goal of the program is to break down linguistic and cultural barriers to build trust and improve health outcomes. You must support UnitedHealthcare Community Plan's Cultural Competency Program.

For more information, go to **UHCprovider.com/resourcelibrary** > 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**.

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

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

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

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

  Document the refusal of professional interpretation services in the member's medical record.

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

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

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

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

MI Coordinated Health (MICH)Plan provides the following:

- **Language interpretation line**
  - We provide oral interpreter services Monday–Friday from 8:00 a.m.– 8:00 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.**

Chapter 6: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/prevention

Key contacts

Topic	Links	Phone number
EPSDT	brightfutures.aap.org	1-517-484-3013
Vaccines for Children	Michigan.gov/vfc	1-517-335-8159

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

Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members up to age 21, including pregnant members. EPSDT screening includes the following:

- Immunizations
- Hearing
- Vision
- Speech screening and nutritional assessments
- Dental screening
- Growth and development tracking

Find care provider resources and information on EPSDT/ Well Child Exam forms, billing codes, Developmental Screening tools, Immunization Tools and Resources for Women, Infants & Children (WIC) at msu.edu.

Abuse examinations

Medicaid covers sexual assault findings examination (SAFE) and child abuse resource education (CARE) exams. 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. Information on SAFE-CARE examinations is located at Michigan.gov. Call 1-517-373-7373 for more information.

Development disability services - Early On

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.

Early On® Michigan offers early intervention services for infants and toddlers, birth to 3 years of age, with developmental delays and/or disabilities, and their families.

If you think your infant or toddler may have a developmental delay, contact Early On at 1-800-Early-On or visit 1800earlyon.org to learn more.

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
- 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. 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

The state of Michigan requires all Medicaid-eligible children be tested for lead at 12 and 24 months of age, or between 36 and 72 months if not tested previously. Call Provider Services at **1-800-903-5253** 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.

For blood lead testing, a sample may be obtained by either capillary (heel-prick/finger stick) or venipuncture and sent to the MDHHS Bureau of Laboratories Trace Metals section or to any Michigan Medicaid-enrolled qualified lab for lead testing.

For samples to be submitted to the Trace Metals section: call 1-517-335-8059 and obtain a Submitter Clinic Code and obtain the Blood Lead Test Requisition form (DHHS-0696) prior to sending the sample(s). The form may also be downloaded at Michigan.gov.

For blood lead testing supplies, call 1-517-335-9040 or email mdhhslab@Michigan.gov.

For technical questions, call 1-517-335-8244 or visit Michigan.gov.

Find more information on lead testing and the proper sample collection technique on the MDHHS website at Michigan.gov.

Labs must submit a copy of the blood lead level results to the Michigan Lead Registry. More information on lead testing and lead poisoning can be found on the Michigan Department of Community Health site at Michigan.gov/lead.

Vaccines for Children

The Vaccines for Children (VFC) program provides immunizations. Michigan Medicaid requires you to register with the federal VFC program to obtain free vaccines for Michigan Medicaid members. 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. State of Michigan Division of Communicable Disease and Immunizations: 1-517-335-8159.

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

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

Michigan Childhood Immunization Registry

You are required by law to report to Michigan Childhood Immunization Registry (MCIR) each immunization provided to a child born after December 31, 1993. MCIR is an electronic database for care provider immunization data. You may only use this data for immunization purposes and blood lead results. You may use MCIR to access a child's record to determine the completeness of their immunizations.

An optional Vaccine Inventory Module can assist you with vaccine inventory management and generate reports for VFC program documentation.

You can access MCIR by modem, direct line, or a fax-back system. For more information, visit the MCIR website at mcir.org.

Chapter 7: Value-added services

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com/MIcommunityplan**	**1-800-903-5253**
Healthy First Steps	**uhchealthyfirststeps.com**	**1-800-599-5985**
Value-added services	**UHCCommunityPlan.com/MI** > View plan details	**1-800-903-5253**

We offer the following services to our UnitedHealthcare Community Plan members. if you have questions or need to refer a member, call UnitedHealthcare **Provider Services** at **1-800-903-5253** unless otherwise noted.

Adult pain management/ chiropractic services

Evidence-based medicine supports chiropractic care to help lower back pain. In some cases, a visit to the chiropractor can reduce or eliminate the need for pain medication. It can even help combat opioid addiction and overuse.

We provide members older than 21 with up to 6 visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.

Use the following steps to access the fee schedules online:

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

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

Chronic condition management

We use educational materials and newsletters to remind members to get their immunizations, check-ups and screenings. For those members with chronic conditions, we provide specific information, including recommended routine appointment frequency, necessary testing, monitoring, and self-care through our disease management (DM) program. All materials are based upon evidence-based guidelines or standards. All printed materials are written at a 5th grade reading level. They are available in English as well as other languages. They provide information necessary to successfully manage their condition and live a healthy lifestyle.

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

Identification

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

Referral

PCPs may make referrals to support practice-based interventions by contacting the Health Services team at **1-800-903-5253**

Early Intervention program

Early Intervention promotes the development of infants and toddlers with developmental challenges and delays. It also covers certain disabling conditions. The program provides services to eligible children from birth to 3 years old and their families.

Foster care

Peer support specialist

We have a foster care peer support specialist working with youth in the foster care system and their families. The specialist works with the member and the family to define the member's recovery goals. The specialist helps the member develop life skills and provides phone and/or face-to-face communications to members. The member and foster family receive support and help improve the member's overall physical and behavioral health. This benefit can also help to reduce hospitalizations and ER visits related to behavioral conditions in youth in foster care services.

Healthy First Steps

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

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

How it works

Care providers and UnitedHealthcare Community Plan reach out to members to enroll them.

Members enter information about their pregnancy and upcoming appointments online. They get reminders of upcoming appointments and record completed visits.

How you can help

1. Identify UnitedHealthcare Community Plan members during prenatal visits.
2. Share the information with the member to talk about the program.
3. Encourage the member to enroll in Healthy First Steps Rewards.

Just Plain Clear Glossary

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

Mobile apps

Apps are available at no charge to our members. They include:

- **Health4Me®** – enables users to review health benefits, access claims information and locate in-network care providers.

Quit For Life

The Quit For Life® program is the nation's leading phone-based tobacco cessation program. It uses physical, psychological and behavioral strategies to help members take responsibility for and overcome their tobacco addiction. Using a mix of medication support, phone-based coaching and web-based learning tools, the Quit For Life program produces an average quit rate of 25.6% for a Medicaid population. It also has an 88% member satisfaction. Quit For Life is for members 18 years and older.

Substance use disorder recovery coaching

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

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

UHC Doctor Chat—virtual visits

Members have access to **UHC Doctor Chat**, an innovative, chat-first platform supported by live video to connect with a doctor from their computer or mobile device for nonemergent care. A board-certified emergency medicine physician assesses the severity of the enrollee's situation, provides treatment (including prescriptions) and recommends additional care. Virtual visits can improve access to care, reduce health disparities and reduce avoidable use of the ED. This program highlights our commitment to expand and deliver access to care.

UHC Latino

Latino | UnitedHealthcare (uhc.com) our award-winning Spanish language site, provided more than 600 pages of health and wellness information and reminders on important health topics.

Women, Infants and Children Supplemental Nutrition

State-funded program

The state also has programs such as the Women, Infants, and Children Supplemental Nutrition program (WIC) to help with nutritional needs for low-income families. For more information about WIC, go to wiccp.state.mi.us.

Chapter 8: Mental health and substance use

Key contacts

Topic	Link	Phone number
Behavioral health/Provider Express	**providerexpress.com**	**1-877-614-0484**
Provider Services	**UHCprovider.com/MIcommunityplan**	**1-800-903-5253**

OptumHealth Behavioral Solutions (OBH) provides UnitedHealthcare Community Plan members with unlimited outpatient mental health visits for members with mild to moderate mental health diagnoses, and some outpatient substance use disorder treatment in outpatient settings. Mental health and substance use disorders that require higher or more intense levels of care are covered through the State of Michigan, or through a specialized plan called a pre-paid inpatient health plan (PIHP).

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

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

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

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

Chronic mental health conditions and substance abuse

Refer a member with a chronic condition meeting the MSA criteria for Serious and Persistent Mental Health Illness (SPMI-adults) or Severe Emotional Disturbance (SED children) to the Community Mental Health (CMH) agency in the member's county of residence.

The Substance Abuse Coordinating Agency in the member's county of residence is responsible for most substance abuse treatment services, however, office-based treatment services may be covered by OBH if providers are not contracted with PIHPs.

Please visit Michigan.gov for county contact number for SPMI and substance abuse referrals.

Eligibility

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

Authorizations

Prior authorization is required for out-of-network care providers. Get prior authorization by going to **UHCprovider.com/priorauth** or calling **Provider Services** at **1-800-903-5253**.

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

Website: **UHCprovider.com**

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

View the Prior Authorization list, find forms and access the care provider manual. Or call the Provider Services at **1-800-903-5253** to verify eligibility and benefit information (available 8:30 a.m. - 5:30 p.m., ET, Monday through Friday).

Website: **providerexpress.com**

Update your practice information, review guidelines and policies, and view the national Optum Network Manual. Or call OBH **Provider Services** at **1-877-614-0484.**

Claims

Submit claims using the CMS 1500 claim form (v 02/12) or UB-04 form, whichever is appropriate. Use applicable coding, including ICD diagnosis code(s), CPT, revenue and HCPCS coding. Include all necessary data to process a complete claim including rendering/billing provider information including NPI and taxonomy. 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.

Training resources and materials

We provide the following resources to assist you in your practice and to help your patients.

- **Behavioral health toolkits**
- **Provider training materials**
- **Network provider manuals**
- **State-specific (Michigan) provider manuals**

Addressing the opioid epidemic

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

Brief summary of framework

- **Prevention**
  Prevent OUD before they occur through pharmacy management, care provider practices and education
- **Treatment**
  Access and reduce barriers to evidence-based and integrated treatment
- **Recovery**
  Support case management and referral to person-centered recovery resources
- **Harm reduction**
  Access to naloxone and facilitating safe use, storage and disposal of opioids
- **Strategic community relationships and approaches**
  Tailor solutions to local needs
- **Enhanced solutions for pregnant members and their children**
  Prevent neonatal abstinence syndrome and supporting birth parents 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/pharmacy.** Click "Opioid Programs and Resources-Community Plan" to find a list of tools and education.

Prescribing opioids

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

Pharmacy lock-in

Pharmacy lock-ins minimize drug abuse. Pharmacy lock-ins identify and manage members who meet criteria indicative of potential prescription medication misuse or abuse, and specific therapeutic categories with the potential for high abuse, (e.g., narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances). When lock-in is determined appropriate, a member is placed into a lock-in where they can only receive prescriptions from a single pharmacy for at least 2 years.

Expanding medication assisted treatment access and capacity

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

To find a behavioral health MAT care provider in Michigan:

1. Go to **UHCprovider.com/findprovider.**
2. Click on "Behavioral Health Directory."
3. Click on "Medicaid plans."
4. Select "Michigan."
5. Click on the applicable plan name.
6. In the search field, type "Medication Assisted Treatment" and click "Search."

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

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

Chapter 9: Member rights and responsibilities

Key contacts

Topic	Link	Phone number
Member Services	**UHCCommunityPlan.com/michigan**	**1-800-903-5253**
Member handbook	**UHCCommunityPlan.com/michigan** > Community Plan > Member benefits	**1-800-903-5253**

Our member handbook **UHCCommunityPlan.com/michigan** 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 the 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 right and responsibilities

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

Native American access to care

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

Members rights

Members have the right to:

- Receive information about your health care services
- Be treated with dignity and respect
- Receive Culturally and Linguistically Appropriate Services (CLAS)
- Have your personal and medical information kept private
- Participate in decisions regarding your health care, including the right to refuse treatment and express preferences about treatment options
- Have a candid discussion on appropriate or medically necessary treatment options for your conditions, regarding of cost or benefit coverage
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of your medical records, and request those be amended or corrected
- Be furnished with health care services consistent with State and federal regulations
- Be free to exercise your rights without adversely affecting the way the Contractor, care providers, or the State treats you
- To file a grievance, to request a State Fair Hearing, or have an external review, under the Patient's Right to Independent Review Act
- Be free from other discrimination prohibited by State and federal regulations
- Receive information on available treatment options and alternatives, presented in a manner
- appropriate to your condition and your ability to understand
- Receive Federally Qualified Health Center and Rural Health Center services
- To request information regarding provider incentive arrangements including those that cover referral services that place the care provider at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided
- To request information on the structure and operation of the UnitedHealthcare Community Plan
- To make suggestions about our services and care providers
- To make suggestions about member rights and responsibilities policy
- To request information about our providers, such as: license information, how care providers are paid by the plan, qualifications, and what services need prior approval

Member responsibilities

Members should:

- Review this handbook and UnitedHealthcare Community Plan Certificate of Coverage
- Make and keep appointments with your UnitedHealthcare Community Plan doctor
- Treat doctors and their staff with respect
- Protect your Medicaid ID cards against misuse
- Contact us if you suspect fraud, waste, or abuse
- Give your health plan and your doctors as much info about your health as possible
- Learn about your health status
- Work with your doctor to set care plans and goals
- Follow the plans for care that you have agreed upon with your doctor
- Live a healthy lifestyle
- Make responsible care decisions
- Contribute towards your health by taking responsibility, including appropriate and inappropriate behavior
- Apply for Medicare or other insurance when you are eligible
- Report changes to your local MDHHS office if your contact info (like your address or phone number) changes
- Report changes that may affect your Medicaid eligibility to your local MDHHS office (like changes in income or changes to your family size). You can call your local MDHHS office or go to https://newmibridges.michigan.gov/

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

1. Supply information (to the extent possible) to UnitedHealthcare Community Plan and to you that is needed for you to provide care.
2. Follow through with 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 10 : Medical records

Medical record charting standards

You are required to keep complete and orderly medical records in paper or electronic format, which fosters efficient and quality member care. You must establish and enforce policies and procedures for saving, storing, securing, protecting and retrieving medical records if using a computerized medical records system. You are subject to our periodic quality medical record review. The review could include any of the following items to determine compliance:

Topic	Contact
Confidentiality of record	Office policies and procedures exist for: • Privacy of the member medical record • Initial and periodic training of office staff about medical record privacy • Release of information • Record retention • Availability of medical record if housed in a different office location • Process for notifying UnitedHealthcare Community Plan upon becoming aware of a patient safety issue or concern • Coordination of care between medical and behavioral health care providers
Record organization and documentation	• Have a policy that provides medical records upon request. Urgent situations require you to provide records within 24 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, 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 and tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review • There is evidence of care provider follow-up of abnormal results • Unresolved issues from a previous visit are followed up on the subsequent visit • There is evidence of coordination with behavioral health care provider • Education, including lifestyle counseling, is documented • Member input and/or understanding of treatment plan and options is documented • Copies of hospital discharge summaries, home health care reports, emergency room care and practitioner are documented

***Critical element**

Member copies

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

Medical record review

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

- Problem list with:
  - Biographical data with family history
  - Past and present medical and surgical intervention
  - Significant medical conditions with date of onset and resolution
  - Documentation of education/counseling regarding HIV pre- and post-test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions (or note if none are known) clearly and easily identify any agents causing a negative response
- 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 note the member does not want one
- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits; diagnosis and treatment plans consistent with finding
- Lab and other studies as appropriate
- Member education, counseling and/or coordination of care with other care providers
- Notes regarding the date of return visit or other follow-up
- Consultations, lab, imaging and special studies initialed by PCP to indicate review
- Consultation and abnormal studies, including follow-up plans
- Document "no shows" or missed appointments along with follow-up efforts to reschedule the appointment

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)

If 85% of the records we sample vary significantly from established standards, we will work with you and your staff to help ensure medical record documentation and record keeping practices comply with requirements.

Chapter 11: 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 and PT/OT/ST providers: **myoptumhealthphysicalhealth.com**	
Fraud, waste and abuse (payment integrity)	**uhc.com/fraud**	**1-844-359-7736**

What is the Quality Improvement program?

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

The program 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 QI committee and your Provider Services representative/provider advocate.

Cooperation with quality-improvement activities

You must comply with all QI activities. These include:

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

We require your cooperation and compliance to:

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

Quality Improvement Program

UnitedHealthcare Community Plan considers all QI activities privileged and confidential, consistent with state and federal laws. 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)

You are not required to obtain prior consent from members to share medical records with us. State law MCL 400.111b(7) permits state-contracted qualified health plans to obtain a Medicaid member's medical records for quality of care and utilization management purposes. Any other medical record disclosure by you to an outside party should be consistent with applicable laws.

Corrective action plans

We may ask you to submit a corrective action plan if you are not in compliance with UnitedHealthcare Community Plan standards or do not cooperate with quality improvement initiatives. Required corrective actions may include changes in policies, practices or providing written verification of compliance with standards.

The Quality Improvement department reviews all corrective action plans and is available to assist you in developing and implementing plans. You may appeal findings or corrective action plan requests through written correspondence to the UnitedHealthcare Community Plan CMO.

Quality of care case referral

If you suspect a quality concern, report the incidence to the UnitedHealthcare Community Plan Quality Management department, which will investigate concerns with strict confidentiality. Report concerns to the Quality Management department by:

Phone: **1-800-903-5253**

In writing to:

UnitedHealthcare Community Plan
Quality Management Department
3000 Town Center
Suite 1400
Southfield, MI 48075

Care provider satisfaction

Every year, we conduct care provider satisfaction assessments as part of our QI 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 QI committee. It compares the results year over year as well as to other UnitedHealthcare Community Plan plans across the country. The survey results include key strengths and improvement areas. Additionally, we carry out improvement plans as needed.

Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. You are encouraged to visit **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 Michigan statutes and the NCQA. The following items are required to begin the credentialing process:

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

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

Based on state policy, all network care providers, or any person with a 5% or more direct or indirect ownership interest in the provider, must consent to criminal background checks, including fingerprinting, as a condition of participation.

MDHHS will conduct criminal background checks and will require submission of fingerprints from care providers designated as "high" categorical risk when directed by CMS.

Credentialing and recredentialing process

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

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- M.D.s (Doctors of Medicine)
- D.O.s (Doctors of Osteopathy)
- D.D.S.s (Doctors of Dental Surgery)
- D.M.D.s (Doctors of Dental Medicine)
- D.P.M.s (Doctors of Podiatric Surgery)
- D.C.s (Doctors of Chiropractic)
- C.N.M.s (Certified Nurse Midwives)
- C.R.N.P.s (Certified Nurse Practitioners)
- 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
- N.P.s and P.A.s who practice under a credentialed UnitedHealthcare Community Plan care provider

Health facilities

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

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

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

The National Credentialing Center (NCC) completes these reviews. Find applications on the Council for Affordable Quality Healthcare (CAQH) website 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 ensure you update time-limited documentation and identify legal and health status changes. We also verify that you follow the UnitedHealthcare Community Plan 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 QI database for information about your performance. This includes member complaints and quality of care issues.

Applicant rights and notification

You have the right to review information you submitted to support your credentialing/recredentialing application. This excludes personal or professional references or peer review protected information. You have the right to correct erroneous information you find. Submit updated information directly to your CAQH credentialing application. If the NCC finds erroneous information, a representative will contact you by phone or in writing. You must submit corrections 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; please connect with a live advocate via chat. It is available 7:00 a.m.-7:00 p.m. CT at **UHCprovider.com/chat**.

Confidentiality

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

Failure to meet recredentialing requirements

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

Resolving disputes

Contract concerns

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

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

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

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

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

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

Health Insurance Portability and Accountability Act compliance – your responsibilities

The Health Insurance Portability and Accountability Act (HIPAA) aims to improve the efficiency and effectiveness of the United States health care system.

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

Transactions and code sets

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

Unique identifier

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

National Provider Identifier

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

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

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

UnitedHealthcare Community Plan expects you to comply with all HIPAA regulations. Find additional information on 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.

The UnitedHealthcare Community Plan 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 Michigan 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 Michigan Department of Health and Human Services (MDHHS).

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 Michigan program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. The Michigan Public Health Code Act 368 of 1978, Section 333.16213 requires you to retain medical records for a minimum of 7 years from the service date.

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 within 60 days.

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 Michigan program standards.

You must cooperate with the state or any of its authorized representatives, the MDHHS, CMS, the Office of Inspector General (OIG), or any other agency prior-approved by the state, at any time during your Provider Agreement.

These entities may, at all reasonable times, enter your premises. You agree to allow access to and the right to audit, monitor and examine any relevant books, documents, papers and records to otherwise evaluate (including periodic information systems testing) your performance and charges. We will perform reviews and audits without delaying your work. If you refuse to allow access, this will constitute a breach of your Provider Agreement.

Delegating and subcontracting

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

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of care (QOC) and service concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set clinical site standards for all 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 12: Billing and submission

Key contacts

Topic	Link	Phone number
Claims	**UHCprovider.com/claims**	**1-866-903-5253**
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	1-800-465-3203
EDI	**UHCprovider.com/edi**	**1-800-210-8315**
Payment policies	**UHCprovider.com/policies** > For Community Plans	

Our claims process

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

We follow the same claims process as UnitedHealthcare. See the Claims Process chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) on **UHCprovider.com/guides**.

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 **1-800-903-5253**. Your clean claims must include your NPI and federal TIN.

General billing guidelines

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

providers are paid the published Medicaid Fee Screen rates applicable on the service date.

Fee schedule

UnitedHealthcare Community Plan routinely updates fee schedules in response to changes published by the state of Michigan, such as fee amount changes. We will use reasonable efforts to implement the fee schedule changes in our system within 30 days after the final publication, and make them effective in our system on the effective date of the change as designed by the state. Reimbursements also depend on the fee schedule and the procedure performed. Refer to your bulletins for correct coding.

Modifier codes

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

Member ID card for billing

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

Acceptable claim forms

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

- Use the CMS 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services
- Use the UB-04 form for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other care providers
- Claims must be computer-generated or typed. Hand writing, white-out and/or correction tape are not acceptable on the claim form. We return claims submitted with these items.

Clean claims and submission requirements

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

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

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

Submit any services completed by N.P.s or P.A.s who are part of a collaborative agreement. Use their tax ID and NPI, and we will process the claims according to their agreement.

Care provider coding

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

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 UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) 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 87726
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for CMS 1500 and UB-04 forms

For more information, see the **EDI Claims** section.

Electronic data interchange companion documents

The UnitedHealthcare Community Plan electronic data interchange (EDI) 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
- Provide general information and specific details pertinent to each transaction

Share these documents with your software vendor for any programming and field requirements.

The companion documents are located on **UHCprovider.com/edi** > **EDI 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 **1-800-903-5253** for help with online billing, claims, electronic remittance advices (ERAs) and electronic funds transfers (EFTs).

For all of our claims and payment options, such as business support and EDI claims, see **Chapter 1** under **Online resources**.

For further information about EDI online, go to **UHCprovider.com/resourcelibrary** to find Electronic Data Interchange menu.

Electronic payment solution: Optum Pay

UnitedHealthcare Community Plan sends electronic care provider payments instead of paper checks. You can sign up for automated clearinghouse (ACH)/direct deposit, our preferred method of payment, or to receive a virtual card payment. The only alternative to a virtual card is direct deposit. Both of these options allow you to get paid quickly and securely.

Why choose automated clearinghouse/ direct deposit?

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

What does this mean to you?

- If your practice/health care organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a virtual card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**
- If your practice/health care organization is already enrolled and receiving your claim payments through ACH/direct deposit from Optum Pay™ or receiving virtual cards, you don't need to take action
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically,

your remittance and virtual card statement will be available online through Document Library
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

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

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on **UHCprovider.com/resourcelibrary** to find the **EDI** section.

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

Claim submissions must use data elements consistent with the Medical Service Administration's CMS Uniform Billing Guidelines. These guidelines can be found in the Michigan Medicaid Provider Manual. Visit the National Uniform Claim Committee website to learn how to complete the CMS 1500 form.

Completing the UB-04 form

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

- Include ICD-10-CM diagnosis codes
- Identify other services by the CPT/HCPCS and modifiers

Capitated services

Capitation is a payment arrangement for care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period. We pay you whether or not that person seeks care. In most instances, the capitated care provider is either a medical group or an independent practice association (IPA). In a few instances, however, the capitated care provider may be an ancillary care provider or hospital.

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

1. Who have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare Community Plan for such member.
2. Who are covered under an applicable benefit plan insured by or receiving administrative services from UnitedHealthcare Community Plan.

Additionally, capitated care providers may be subject to any or all delegated activities. Capitated care providers should refer to their delegation grids within their participation agreements to determine which delegated activities the capitated care providers are performing on behalf of UnitedHealthcare Community Plan.

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

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

A capitation payment report is included with the capitation payment made to capitated care providers. The capitation payment is prorated on a daily basis and computed from the member's effective date of eligibility with the PCP. Newborns are prorated from their date of birth. If a member changes PCPs at any time during a month, each PCP will receive capitation for each day the member was assigned to them.

Form reminders

- Note the attending care provider name and identifiers for the member's medical care and treatment on institutional claims for services other than nonscheduled transportation claims
- Send the referring care provider NPI and name on outpatient claims when this care provider is not the attending care provider
- Include the attending care provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims

- Behavioral health care providers can bill using multiple site-specific NPIs

Subrogation and coordination of benefits

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

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

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

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.

National Correct Coding Initiative

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

Comprehensive and component codes

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

- **Separate procedures**
  Only report these codes when performed independently
- **Most extensive procedures**
  You can perform some procedures with different complexities, reporting only the most extensive service
- **With/without services**
  Don't report combinations where 1 code includes and the other excludes certain services
- **Medical practice standards**
  Services part of a larger procedure are bundled
- **Laboratory panels**
  Don't report individual components of panels or multichannel tests separately unless directed by the Michigan Department of Health and Human Services

Clinical Laboratory Improvements Amendments

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

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. For more information about the CLIA number, contact the CMS CLIA Central Office at 1-410-786-3531 or go to cms.gov.

Billing multiple units

When billing multiple units:

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

Billing guidelines for obstetrical services

You must bill antepartum care, delivery and postpartum care visits separately using the following codes:

- Antepartum visits - all prenatal visit dates, along with LMP or EDD/EDC, must be included with the claim
  - 59425 - Antepartum care only, 4 -6 visits

  OR
  - 59426 - Antepartum care only, 7 or more visits

*HEDIS® & ACOG Guidelines state the first prenatal care visit must be completed in the first trimester or the first 42 days the member is enrolled in a health plan.

- Postpartum visits
  - 59430 - postpartum care only (required 7-84 days from delivery)

Billing guidelines for transplants

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

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

Ambulance claims (emergency)

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

National drug code

Claims must include:

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

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

Billing codes

Non-specific CPT or HCPCS codes must be submitted with supporting documentation (manufacturer's invoice, medical records, operative notes, etc.) as a claim attachment if these codes must be used for delivered services.

We will pay covered not otherwise classified (NOC) codes that do not have a published MDHHS fee at 20% of billed charges, unless you and the health plan mutually agree to other payment terms before rendering the service. Ask to negotiate a rate through the authorization intake process.

Medical necessity

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

Place of Service codes

Go to cms.gov for Place of Service codes.

Asking about a claim

You can ask about claims through Provider Services and the **UnitedHealthcare Provider Portal.**

Provider Services

Call **Provider Services** at **1-800-903-5253**. 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/portal** 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 screenshot from your accounting software that shows when you submitted the claim. The screenshot must show the correct:

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

Timely filing

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

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

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

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

Balance billing

Do not balance bill members if:

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

You may balance bill the member for noncovered 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 EOB from any other insurance or health care coverage resource before billing UnitedHealthcare Community Plan, as required by contract. Refer to your agreement for third-party claim submission deadlines. Once you bill the other carrier and receive an EOB, you may submit the claim to UnitedHealthcare Community Plan. Please attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or denial reason.

Electronic visit verification system

Electronic visit verification (EVV) is a technology-based validation of home health care services (HHCS) that is required when a provider begins or ends a visit in the home. This information helps to ensure that beneficiaries receive their authorized care. The Michigan Department of Health and Human Services requires EVV for home health care services providers.

The following HHCS codes review EVV:

- G0151 - Physical therapy
- G0152 - Occupational therapy
- G0153 - Speech/language therapy
- G0156 - Home health aide
- G0299 - Skilled nursing services, RN
- G0300 - Skilled nursing services, LPN

The EVV-required codes for HHCS are listed on the home health billing and reimbursement website, which can be accessed on the MDHHS website at Michigan.gov/medicaidproviders > Billing & Reimbursement > Provider Specific Information > Home Health.

EVV HHCS exclusions:

- Hospice services
- Durable medical equipment services
- HHCS visits for beneficiaries who are dually enrolled with Medicare and Medicaid are excluded from EVV requirements. Providers do not need to collect EVV data for HHCS visits for these beneficiaries.

Chapter 13: Claim reconsiderations, appeals and grievances

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your agreement. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

For claims, billing and payment questions, go to **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 for Michigan Medicaid and the Healthy Michigan Plan

Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider claim correction (resubmission)	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will receive a duplicate claim rejection on your resubmission.	Care provider	**UnitedHealthcare Community Plan** P.O. Box 30991 Salt Lake City, UT 84130-0991	**UHCproviders.com/claims**	**1-800-903-5253**	Use Claims Management or Claims on the UnitedHealthcare Provider Portal or **UHCproviders.com/claims**..	Re-submit corrected claims within 12 months from service date. If UnitedHealthcare Community Plan recoups the claim and the provider is over the regular filing limit for corrected claims, the care provider has 90 days from the date of recoupment to submit a corrected claim.	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 30991 Salt Lake City, UT 84130-0991		**1-800-903-5253**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**..	Must receive within 365 calendar days of the claim processing date.	30 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 reconsideration	Care provider	Most care providers in your state must submit reconsideration requests electronically. For further information on appeals, 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		**1-800-903-5253**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**.	Level 1 appeal: within 180 calendar days of the reconsideration decision letter Level 2 appeal: within 60 calendar days from the level 1 appeal decision letter	30 business days
Care provider grievance	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member	Care provider	**UnitedHealthcare Community Plan** P.O. Box 30991 Salt Lake City, UT 84130-0991		**1-800-903-5253**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**.	120 business days	30 business days

Appeals and grievances standard definitions and process requirements for Michigan Medicaid and the Healthy Michigan Plan

Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Member appeal	A request to change an adverse benefit determination that we made	• Member • Member's authorized representative (such as friend or family member) with written member consent • Care provider on behalf of a member with member's written consent	**UnitedHealthcare Community Plan** P.O. Box 30991 Salt Lake City, UT 84130-0991	**providerforms.uhc.com/ProviderAppealsandGrievance.html** • AOR Consent Form on this site for member appeals	**1-800-903-5253** TTY **711**		60 calendar days	Urgent appeals – 72 hours Standard appeals – 30 days (non CSHCS members) / 10 days (CSHCS members)
Member grievance	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns	• Member • Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent	**UnitedHealthcare Community Plan** P.O. Box 30991 Salt Lake City, UT 84130-0991		**1-800-903-5253** TTY **711**		Grievance can be filed at any time.	90 calendar days

Appeals and grievances standard definitions and process requirements for Michigan Coordinated Health (MICH)

Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider claim correction (resubmission)	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will receive a duplicate claim rejection on your resubmission.	Care provider	**UnitedHealthcare Community Plan** P.O. Box 30991 Salt Lake City, UT 84130-0991	**UHCproviders.com/claims**	**1-844-368-6885**	Use Claims Management or Claims on the UnitedHealthcare Provider Portal or **UHCproviders.com/claims**..	Re-submit corrected claims within 12 months from service date. If UnitedHealthcare Community Plan recoups the claim and the provider is over the regular filing limit for corrected claims, the care provider has 90 days from the date of recoupment to submit a corrected claim.	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 30991 Salt Lake City, UT 84130-0991		**1-844-368-6885**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**.	Must receive within 365 calendar days of the claim processing date.	30 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 reconsideration	Care provider	Most care providers in your state must submit reconsideration requests electronically. For further information on appeals, 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		**1-844-368-6885**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**.	Level 1 appeal: within 180 calendar days of the reconsideration decision letter Level 2 appeal: within 60 calendar days from the level 1 appeal decision letter	30 business days

Appeals and grievances standard definitions and process requirements for Michigan Coordinated Health (MICH)

Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Member appeal	A request to change an adverse benefit determination that we made	• Member • Member's authorized representative (such as friend or family member) with written member consent • Care provider on behalf of a member with member's written consent	**UnitedHealthcare Dual Complete Plan** Attn: Complaint and Appeals Department P.O. Box 6103, MS CA120-0360 Cypress, CA 90630-0023 Fax: 1-866-373-1081	**providerforms.uhc.com/ProviderAppealsandGrievance.html** AOR Consent Form on this site for member appeals	**1-844-368-6885**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**.	65 calendar days	Expedited appeals Part C/Part B 72 hours Part C Standard 30 calendar days (non CSHCS members) / 10 calendar days (CSHCS Members) Part B Standard 7 calendar days..
Member grievance	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns	• Member • Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent	**UnitedHealthcare Dual Complete Plan** Attn: Complaint and Appeals Department P.O. Box 6103, MS CA120-0360 Cypress, CA 90630-0023 Fax: 1-866-373-1081	A member grievance can be filed over the phone or in writing. Members and their representatives can call the Member Service number on the back of their ID card, submit their grievance in writing or via **www.uhc.com/communityplan**	**1-844-368-6885**		Grievances can be filed at any time.	30 calendar days

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

UnitedHealthcare Community Plan and its in-network care providers may agree to more stringent requirements within care provider contracts than described in the standard process.

Denial

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

- **Administrative denial**
  When we didn't get notification before the service, or the notification came in too late
- **Medical necessity**
  The level of care billed wasn't approved as medically necessary

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

Other top reasons for denial include:

- **Duplicate claim**
  One of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.
- **Claim lacks information**
  Basic information is missing, such as a person's date of birth; or information is incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information.
- **Eligibility expired**
  Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired, and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.
- **Claim not covered by UnitedHealthcare Community Plan**
  Another claim denial you can avoid is when procedures are not covered by us. You can easily avoid this problem by using real-time verification.
- **Time limit expired**
  This is when you don't send the claim in time

Claim correction

What is it?

You may need to update information on a claim you've already submitted. A corrected claim replaces a previously processed or denied claim submitted in error.

When to use:

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

How to use:

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

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.

Claim reconsideration (step 1 of dispute)

What is it?

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

a reconsideration, please send additional support information.

When to use:

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

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:

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

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved
- Call **Provider Services** at **1-800-903-5253** if you can't verify a claim is on file
- Do not resubmit validated claims on file unless submitting a corrected claim
- File adjustment requests and claims disputes within contractual time requirements
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Valid proof of timely filing documentation (reconsideration)

What is it?

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

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

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

How to use:

Submit a reconsideration request electronically or by mail.

UnitedHealthcare Community Plan For Michigan Medicaid Program and the Healthy Michigan Plan
View the **appeals and grievances grid** for submission information.

UnitedHealthcare Dual Complete Plan For Michigan Coordinated Health (MICH)
View the **appeals and grievances grid** for submission information.

- Submit a screenshot from your accounting software that shows the date you submitted the claim. The screenshot must show:
  - Correct member name
  - Correct date of service
  - Claim submission date

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

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your contract or within 60 days. If your payment is not received by that time, we may apply the overpayment against future claim payments based on our Agreement and applicable law.

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

If you prefer to mail a refund, send an overpayment return check or the Overpayment Refund/Notification form.

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

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

Where to send:

Mail refunds with an overpayment return check or the Overpayment Refund/Notification form to:

UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0800

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

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

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See **Chapter 10, Resolving disputes** section.

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	01/31/4	$115.03	$115.03	Double payment of claim
222222	02/02/42	14A000000002	03/15/24	$77.29	$27.29	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
555555555	05/05/24	14A000000005	06/15/24	$332.63	$332.63	Member terminated

Appeals (step 2 of dispute)

What is it?

An appeal is a review of a reconsideration claim. It is a one-time formal review of a processed claim that was partially paid or denied.

When to use:

If you do not agree with the outcome of the claim reconsideration decision in step 1, use the claim appeal process.

How to use:

Submit related documents with your appeal. These may include a cover letter, medical records and additional information.

UnitedHealthcare Community Plan For Michigan Medicaid Program and the Healthy Michigan Plan
View the **appeals and grievances grid** for submission information.

UnitedHealthcare Dual Complete Plan For Michigan Coordinated Health (MICH)
View the **appeals and grievances grid** for submission information.

Questions about your appeal or need a status update?

Call **Provider Services** at **1-800-903-5253** for questions about your appeal or if you need a status update. If you filed your appeal online, you should receive a confirmation email or feedback through the secure UnitedHealthcare Provider Portal.

Discussion with care provider reviewer

Contact us at **1-800-903-5253** to discuss an adverse determination with an UnitedHealthcare Community Plan care provider or care provider reviewer, depending on the case type.

Care provider grievance

What is it?

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

When to file:

You may file a grievance about:

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

How to file:

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

You may only file a grievance on a member's behalf with the written consent of the member.

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

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

Member appeals and grievances

For information regarding member appeals and grievances, refer the member to the UnitedHealthcare Community Plan Member Handbook at **UHCCommunityPlan.com/Michigan**.

State fair hearings

For information regarding member state fair hearings, refer the member to the UnitedHealthcare Community Plan Member Handbook at **UHCCommunityPlan.com/Michigan**.

Processes related to reversal of our initial decision

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

1. As quickly as the member's health condition requires.
2. No later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal.

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

Fraud, waste and abuse

Call the **Fraud, Waste and Abuse Hotline** to report questionable incidents involving plan members or care providers. You can also go to **uhc.com/fraud** to learn more or to report and track a concern.

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

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its work. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners.

This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

An important aspect of the compliance program is reviewing our operation's high-risk areas. Then we implement reviews and audits to help ensure compliance with law, regulations and contracts.

You are contractually obligated to cooperate with the company and government authorities.

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

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

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

Exclusion checks

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

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

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.

Standards of conduct awareness

You must provide a copy of your own code of conduct, or the UnitedHealth Group's Code of Conduct at **unitedhealthgroup.com** > About > Ethics & Integrity > UnitedHealth Group's Code of Conduct.

You must maintain distribution standards records (i.e. in an email, website portal or contract) for 10 years. We, or CMS, may request documentation to verify compliance.

Fraud, waste, and abuse and general compliance training

You should provide and administer FWA and general compliance training to employees and contractors.

Distinction between and examples of Fraud, waste, and abuse

Please refer to the Glossary at the end of this manual for definitions of fraud, waste or abuse.

FWA examples include, but are not limited to the following:

- **Back filling**: Billing for part of the global fee before the claim is received for the actual global code
- **Billing for services not rendered**: Billing for services or supplies that were not provided to the member.
- **Double billing**: Billing more than once for the same service
- **Falsified documents**: Submitting falsified or altered claims, or supporting claims with falsified or altered medical records and/or supporting documentation
- **Misrepresentation**: Misrepresenting the diagnoses and/or services provided to obtain higher payment or payment for non-covered services
- **Patient brokering**: Using "brokers" who offer money to subscribers for the use of their ID cards

- **Unbundling**: Billing each component of a service when one comprehensive code is available
- **Up-coding**: Billing at a higher level of service than was actually provided
- **Waiver of copay**: Choosing not to collect copayments or deductibles as part of the payment Agreement

Prevention and detection

We help prevent and detect potential FWA through many sources, including:

- UnitedHealthcare Payment Integrity functions
- Optum companies within UnitedHealth Group
- Health care providers
- Health plan members
- Federal and state regulators and task forces
- News media
- Professional anti-fraud and compliance associations
- CMS websites: sam.gov/SAM

False Claims Act information

UnitedHealthcare Community Plan of Michigan participating providers must comply with federal and state False Claims Acts. The federal False Claims Act prohibits you from knowingly presenting or causing the presentation of a fraudulent claim payment. The Act also protects reporters from retaliation, including harassment, demotion and wrongful termination. In addition to the federal False Claims Act, the state of Michigan has enacted a Michigan Medicaid False Claims Act to discourage fraud against state government programs.

Citation: False Claims Acts (31 U.S.C. §§ 3729-3733).

Corrective action plans

We evaluate the appropriateness of paid claims as part of our payment integrity responsibility. We may initiate a formal corrective action plan if you do not comply with our billing guidelines or performance standards. We monitor the plan to confirm that it is in place and address any billing/ performance problems.

Penalties for submitting fraudulent or abusive claims

All violations of company policies, contractual obligations, or laws, including the False Claims Act, will be taken seriously. Submitting fraudulent or abusive claims may result in discipline, up to and including legal action and suspension from UnitedHealthcare Community Plan of Michigan.

Health care provider self-disclosures

UnitedHealthcare Community Plan of Michigan participating health care providers, suppliers, or other individuals or entities subject to civil monetary penalties can use the Provider Self Disclosure Protocol to voluntarily disclose self-discovered evidence of potential fraud. Self-disclosure gives you the opportunity to avoid the costs and disruptions of a government-directed investigation and civil or administrative litigation. For more information visit the United States Department of Health & Human Services online at oig.hhs.gov.

Reporting potential Fraud, waste, and abuse to us

UnitedHealthcare Community Plan has a legal responsibility to report incidents to CMS and the Office of Health Services Inspector General. If you suspect fraud, waste or abuse of the Medicaid program, call or send correspondence to either of the following:

UnitedHealthcare Community Plan Compliance Officer
3000 Town Center, Suite 1400
Southfield, MI 48075
1-800-903-5253

Office of Inspector General
P.O. Box 30062
Lansing, MI 48909
1-855-643-7283
michigan.gov/fraud

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

Chapter 14: Care provider communications and outreach

Key contacts

Topic	Link	Phone number
Provider education	**UHCprovider.com/resourcelibrary**	**1-800-903-5253**
News and bulletins	**UHCprovider.com/news**	**1-800-903-5253**
Care provider manuals	**UHCprovider.com/guides**	**1-800-903-5253**

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/MIcommunityplan**
  The UnitedHealthcare Community Plan of Michigan 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)
- **Michigan health plans**
  UHCprovider.com/MI is the fastest way to review all of the health plans UnitedHealthcare offers in Michigan. 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. 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.

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 and 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/MIcommunityplan** > Contact Us.

Care provider manual

UnitedHealthcare Community Plan publishes this care provider manual online. It includes an overview of the program, a toll-free number for Provider Services and a list of additional care provider resources. You can request a hard copy of this care provider manual by contacting **Provider Services** at **1-800-903-5253.**

State websites and forms

Find the following forms on the state's website at Michigan.gov:

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