Welcome

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

Click the following links to access different manuals:

• UnitedHealthcare Administrative Guide for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.

• A different Community Plan manual: go to UHCprovider.com. Click Menu on top left, select Administrative Guides and Manuals, then Community Plan Care Provider Manuals, select state.

Easily find information in this manual using the following steps:

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

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

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

Important information about the use of this manual

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

This manual will be amended as policies change.

Participation Agreement

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

Terms and definitions as used in this manual:

• “Member” or “customer” refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement.

• “You,” “your” or “provider” refers to any health care provider subject to this manual, including physicians, health care professionals, facilities and ancillary providers; except when indicated and all items are applicable to all types of health care providers subject to this guide.

• Community Plan refers to UnitedHealthcare’s Medicaid plan

• “Your Agreement,” “Provider Agreement” or “Agreement” refers to your Participation Agreement with us.

• “Us,” “we” or “our” refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this guide.

• Any reference to “ID card” includes a physical or digital card.
# Table of Contents

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 1: Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Chapter 2: Care Provider Standards and Policies</td>
<td>15</td>
</tr>
<tr>
<td>Chapter 3: Care Provider Office Procedures and Member Benefits</td>
<td>24</td>
</tr>
<tr>
<td>Chapter 4: Medical Management</td>
<td>29</td>
</tr>
<tr>
<td>Chapter 5: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)/Prevention</td>
<td>46</td>
</tr>
<tr>
<td>Chapter 6: Value-Added Services</td>
<td>49</td>
</tr>
<tr>
<td>Chapter 7: Mental Health and Substance Use</td>
<td>51</td>
</tr>
<tr>
<td>Chapter 8: Member Rights and Responsibilities</td>
<td>54</td>
</tr>
<tr>
<td>Chapter 9: Medical Records</td>
<td>57</td>
</tr>
<tr>
<td>Chapter 10: Quality Management (QM) Program and Compliance Information</td>
<td>59</td>
</tr>
<tr>
<td>Chapter 11: Billing and Submission</td>
<td>66</td>
</tr>
<tr>
<td>Chapter 12: Claim Reconsiderations, Appeals and Grievances</td>
<td>73</td>
</tr>
<tr>
<td>Chapter 13: Care Provider Communications and Outreach</td>
<td>82</td>
</tr>
<tr>
<td>Glossary</td>
<td>84</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

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 of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act.
- Pregnant women, eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act.
- Children eligible for the Children’s Health Insurance Program (MI Child).
- Categorically beedy — Blind and disabled children and adults 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.

Michigan Department of Health and Human Services (MDHSS) will determine enrollment eligibility. It verifies which individuals must enroll, those that may voluntarily enroll and those excluded from enrollment.

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
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</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>UHCprovider.com/MICommunityplan</td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>UHCprovider.com/training</td>
<td>800-903-5253</td>
</tr>
<tr>
<td>Provider Portal</td>
<td>UHCprovider.com, then Sign In using your One Healthcare ID or go to Provider Portal Self Service</td>
<td></td>
</tr>
<tr>
<td>Provider Portal Training</td>
<td>CommunityCare Provider Portal User Guide</td>
<td></td>
</tr>
<tr>
<td>Provider Portal Support</td>
<td>email: <a href="mailto:ProviderTechSupport@uhc.com">ProviderTechSupport@uhc.com</a></td>
<td>855-819-5909</td>
</tr>
<tr>
<td>Resource Library</td>
<td>UHCprovider.com &gt; Menu &gt; Resource Library</td>
<td></td>
</tr>
</tbody>
</table>

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

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

Prior authorization disclaimer

Prior authorization requirements may exist and should be considered for any services or other items we offer. Please refer to the prior authorization list at UHCprovider.com/MICommunityPlan > Prior Authorization and Notification for authorization requirements.

How to join our network

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

Care Model

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

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

- Market-specific care management encompassing medical, behavioral and social care.
- An extended care team including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist.
- Options that engage members, connecting them to needed resources, care and services.
- Individualized and multidisciplinary care plans.
- Assistance with appointments with PCP and coordinating appointments. The Clinical Health Advocate (CHA) refers members to an RN, Behavioral Health Advocate (BHA) or other specialists as required for complex needs.

- Education and support with complex conditions.
- Tools for helping members engage with providers, such as appointment reminders and help with transportation.
- Foundation to build trust and relationships with hard-to-engage members.

The Care Model goals are to:

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

To refer your patient to the Care Model program, call Provider Services at 800-903-5253 or Member Services at 877-542-9239, TTY 711.

Compliance

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

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. Linguistic and cultural barriers can negatively affect access to health care participation. You must support UnitedHealthcare Community Plan’s Cultural Competency Program.

UnitedHealthcare Community Plan offers the following support services:

- **Language Interpretation Line:** We provide oral interpreter services 24 hours a day, seven days a week to our members free of charge. More than 240 non-English languages and hearing impaired services are available. If a UnitedHealthcare Community Plan member needs interpreter services, we prefer care providers use a professional interpreter.

- **To access a professional interpreter during regular business hours, contact the Provider Call Center at 800-903-5253. After hours you may contact 877-261-6608.**

- **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.

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual (we previously used MCG Guidelines) for care determinations. We also use the Michigan Association of Health Plan (MAHP) Bariatric Surgery Guidelines for gastric procedure decisions for weight management control, and National Comprehensive Cancer Network® (NCCN) guidelines for chemotherapy. You can call 800-903-5253 to request a copy of the guidelines.

Online resources

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

### Electronic Data Interchange

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

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

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

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

### Getting started

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

Read our **Clearinghouse Options** page for more information.
Provider Portal - secure care provider website

UnitedHealthcare Community Plan provides a secure portal to network care providers, facilities and medical administrative staff called the Provider Portal at UHCprovider.com. This website offers an innovative suite of online health care management tools, including the ability to view all online transactions for UnitedHealthcare Community Plan members. It can help you save time, improve efficiency and reduce errors caused by conventional claims submission practices. For more information about all online services, go to Self Service Tools and Eligibility or go to the Provider Portal Self Service page at UHCprovider.com/en/resource-library/link-provider-self-service.html. For Provider Portal training, go to CommunityCare Provider Portal User Guide.

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

The secure care provider website lets you:

- Verify member eligibility including secondary coverage.
- Review benefits and coverage limits.
- Check prior authorization status.
- Access remittance advice and review recoveries.
- Review your preventive health measure report.
- Access the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) toolset.
- Search for CPT codes. Type the CPT code in the header search box titled “what can I help you find?” on UHCprovider.com, and the search results will display all documents and/or web pages containing that code.
- Find certain web pages more quickly using direct URLs. You’ll see changes in the way we direct you to specific web pages on our UHCprovider.com provider portal. You can now use certain direct URLs, which helps you find and remember specific web pages easily and quickly. You can access our most used and popular web pages on UHCprovider.com by typing in that page’s direct URL identified by a forward slash in the web address, e.g.

UHCprovider.com/claims. When you see that forward slash in our web links, you can copy the direct URL into your web page address bar to quickly access that page. You will conduct business with us electronically. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use both EDI and UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

To access the Provider Portal, go to UHCprovider.com, then Sign In.

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

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

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

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

**Direct Connect**

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

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

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

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

**5 reasons to use UHCprovider.com**

1. **Provider Portal**
   
   Use self-service to verify eligibility and claims, request prior authorization, provide notifications and access Document Vault.
   
   Click “Sign In” in the top right corner of UHCprovider.com

2. **Prior Authorization and Notification**

   Request approval for prescriptions, admissions and procedures.
   
   UHCprovider.com/paan

3. **EDI**

   Send batch transactions for multiple members and payers from one place, review claims and submit notifications.
   
   UHCprovider.com/edi

4. **Direct Connect**

   Communicate securely with payers to address errant claims. Email directconnectsupport@optum.com to get started.

5. **Policies and Protocols**

   Review guidelines that apply to UnitedHealthcare Community Plan and how you care for our members.
   
   UHCprovider.com/policies

Find more information about these online services and more at UHCprovider.com – your hub for online transactions, education and member benefit information.
Privileges

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

Provider Services

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

Provider Services can assist you with questions on Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more.

Provider Services works closely with all departments in UnitedHealthcare Community Plan.
# How to contact us

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

<table>
<thead>
<tr>
<th>Topic</th>
<th>Contact</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits</td>
<td><strong>UHCprovider.com/benefits</strong></td>
<td>Confirm a member’s benefits and/or prior authorization.</td>
</tr>
<tr>
<td></td>
<td>800-903-5253</td>
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<tr>
<td>Cardiology</td>
<td>For prior authorization or a current list of CPT codes that require prior authorization, visit <a href="https://uhcprovider.com/cardiology">UHCprovider.com/cardiology</a>  Click Menu on top left, select Prior Authorization and Notification, then Cardiology  800-903-5253</td>
<td>Request prior authorization of the procedures and services outlined in this manual’s prior authorization requirements.</td>
</tr>
<tr>
<td>Chiropractor Care</td>
<td><strong>myoptumhealthphysicalhealth.com</strong> 800-873-4575</td>
<td>We provide members older than 21 with up to six visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.</td>
</tr>
<tr>
<td>Claims</td>
<td>Use the Provider Portal at <a href="https://uhcprovider.com/claims">UHCprovider.com/claims</a> 800-903-5253 Mailing address: UnitedHealthcare Community Plan Attn: Claims P.O. Box 30991 Salt Lake City, UT 84130-0991</td>
<td>Verify a medical claim status or get information about proper completion or submission of claims.</td>
</tr>
<tr>
<td>Claim Overpayments</td>
<td>See the Overpayment section for requirements before sending your request. Sign in to <a href="https://uhcprovider.com/claims">UHCprovider.com/claims</a> to access the Provider Portal, then select the UnitedHealthcare Online app 800-903-5253 Mailing address: UnitedHealthcare Community Plan ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800</td>
<td>Ask about claim overpayments.</td>
</tr>
<tr>
<td>Electronic Data</td>
<td><strong><a href="mailto:ac_edi_ops@uhc.com">ac_edi_ops@uhc.com</a></strong> 800-210-8315</td>
<td>Ask about claims issues or questions.</td>
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<tr>
<td>Intake Claim Issues</td>
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<tr>
<td>Topic</td>
<td>Contact</td>
<td>Information</td>
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<tr>
<td>Electronic Data</td>
<td>800-842-1109</td>
<td>Information is also available at UHCprovider.com/edi.</td>
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<tr>
<td>Intake Log-on Issues</td>
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<tr>
<td>Eligibility</td>
<td>To access eligibility information, go to UHCprovider.com then Sign In to the Provider Portal or go to UHCprovider.com/eligibility. 800-903-5253</td>
<td>Confirm member eligibility.</td>
</tr>
<tr>
<td>Fraud, Waste and Abuse (Payment Integrity)</td>
<td>800-903-5253</td>
<td>Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.</td>
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<tr>
<td></td>
<td>Office of Inspector General: 855-643-7283</td>
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<tr>
<td></td>
<td>michigan.gov/fraud</td>
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<td></td>
<td>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</td>
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<tr>
<td></td>
<td>Payment Integrity Information: UHCprovider.com/Mlcommunityplan &gt; Integrity of Claims, Reports, and Representations to the Government.</td>
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<td></td>
<td>Reporting: uhc.com/fraud</td>
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<td></td>
<td>800-455-4521 or 877-401-9430</td>
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<tr>
<td>Lab Services</td>
<td>800-445-4979</td>
<td>Joint Venture Hospital Laboratories (JVHL) is the preferred lab provider.</td>
</tr>
<tr>
<td>Medical Claim, Reconsideration and Appeal</td>
<td>Sign in to the Provider Portal at UHCprovider.com or go to UHCprovider.com/claims for more information. Reconsiderations and appeals mailing address: UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 30991 Salt Lake City, UT 84131-0991</td>
<td>Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.</td>
</tr>
<tr>
<td>Topic</td>
<td>Contact</td>
<td>Information</td>
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</tr>
<tr>
<td>Member Services</td>
<td>800-903-5253 or 877-542-9239 / TTY 711</td>
<td>Assist members with issues or concerns. Available 8:30 a.m. – 5:30 p.m. ET, Monday through Friday.</td>
</tr>
<tr>
<td></td>
<td>myuhc.com *see “Website for Michigan Community Plan” for state’s contact info.</td>
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<tr>
<td>Mental/Behavioral Health &amp; Substance Abuse</td>
<td>OptumHealth Behavioral Solutions 800-888-2998 (toll-free) P.O. Box 30760 Salt Lake City, UT 84130-0760 providerexpress.com</td>
<td>Behavioral health eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. (PCP referral is not required.)</td>
</tr>
<tr>
<td>Michigan ENROLLS</td>
<td>Medicaid.gov MIEnrolls: 888-367-6557 or 800-975-7630</td>
<td>The Michigan Department of Health &amp; 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.</td>
</tr>
<tr>
<td>Multilingual/Telecommunication Device for the Deaf (TDD) Services</td>
<td>800-368-1019 or 800-537-7697 TDD 711</td>
<td>Available 8 a.m. – 5 p.m. ET, Monday through Friday, except state-designated holidays.</td>
</tr>
<tr>
<td>Network Management Resource Team (NMRT)</td>
<td>877-842-3210 <a href="mailto:Networkhelp@uhc.com">Networkhelp@uhc.com</a></td>
<td>Self-service functionality to update or check credentialing information.</td>
</tr>
<tr>
<td>National Plan and Provider Enumeration System (NPPES)</td>
<td>nppes.cms.hhs.gov 800-465-3203</td>
<td>Apply for a National Provider Identifier (NPI).</td>
</tr>
<tr>
<td>Obstetrics and Baby Care</td>
<td>Healthy First Steps uhchealthyfirststeps.com 800-599-5985</td>
<td>Refer pregnant members to this program.</td>
</tr>
<tr>
<td>One Healthcare ID Support Center</td>
<td>email: <a href="mailto:ProviderTechSupport@uhc.com">ProviderTechSupport@uhc.com</a> 855-819-5909</td>
<td>Contact if you have issues with your ID. Available 7 a.m. – 9 p.m. ET, Monday through Friday; 6 a.m. – 6 p.m. ET, Saturday; and 9 a.m. – 6 p.m. ET, Sunday.</td>
</tr>
<tr>
<td>Topic</td>
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<td>Information</td>
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</tr>
<tr>
<td>Pharmacy Services</td>
<td>professionals.optumrx.com 877-305-8952 (OptumRx)</td>
<td>OptumRx oversees and manages our network pharmacies.</td>
</tr>
<tr>
<td>Prior Authorization/Notification for Pharmacy</td>
<td>UHCprovider.com &gt; Prior Authorization and Notification &gt; Clinical Pharmacy and Specialty Drugs 800-310-6826</td>
<td>Request authorization for medications as required.</td>
</tr>
</tbody>
</table>
| Prior Authorization Requests/Advance & Admission Notification | To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N Online Tool: UHCprovider.com/paan Phone: Call Care Coordination at the number on the member’s ID card (self-service available after hours) and select “Care Notifications” or call 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: Visit UHCprovider.com/MIcommunityplan > Prior Authorization and Notification |
| Provider Services                         | UHCprovider.com/MIcommunityplan 800-903-5253 | Available 7 a.m. – 5 p.m. Eastern Time, Monday through Friday.              |
| Technical Support                         | 866-209-9320                                  | Call this number if you have issues logging in the Provider Portal, you cannot submit a form, etc. |
| Tobacco Free Quit Line                    | 800-784-8669                                  | Ask about services for quitting tobacco/smoking.                            |
| Transportation                            | ModivCare 877-892-3995                       | To arrange non-emergent transportation, please contact ModivCare at least three business days in advance. |
| Utilization Management                    | Provider Services 800-903-5253                | UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines.  
Request a copy of our UM guidelines or information about the program.  
For UM Policies and Protocols, go to: UHCprovider.com, then select Policies and Protocols. |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Contact</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccines for Children (VFC) program</td>
<td>517-335-8159</td>
<td>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. Providers must enroll as VFC providers with DHSS to bill for the administration of the vaccine.</td>
</tr>
<tr>
<td>Vision Services</td>
<td>marchvisioncare.com 800-903-5253</td>
<td>Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from MARCH® Vision Care.</td>
</tr>
<tr>
<td>Care Model (Care Management/ Disease Management)</td>
<td>800-903-5253</td>
<td>Refer high-risk members (e.g., asthma, diabetes, obesity).</td>
</tr>
<tr>
<td>Website for Michigan Community Plan (state website)</td>
<td>To reach Healthy Michigan Plan for member enrollment, call 844-445-7231/TTY 711 More information about member enrollment, go to michigan.gov/healthymiplan</td>
<td>Access your state’s specific community plan information on this website, including enrollment information.</td>
</tr>
</tbody>
</table>
Chapter 2: Care Provider Standards and Policies

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
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</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>UHCprovider.com/Mlcommunityplan</td>
<td>800-903-5253</td>
</tr>
<tr>
<td>Enterprise Voice Portal</td>
<td>UHCprovider.com/eligibility</td>
<td>877-842-3210</td>
</tr>
<tr>
<td>Eligibility</td>
<td>UHCprovider.com/eligibility</td>
<td></td>
</tr>
<tr>
<td>Referrals</td>
<td>UHCprovider.com &gt; Menu &gt; Referrals</td>
<td>800-903-5253</td>
</tr>
<tr>
<td>Provider Directory</td>
<td>UHCprovider.com &gt; Find Dr.</td>
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</tbody>
</table>

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

General care provider responsibilities

**Non-discrimination**

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

**Communication between care providers and members**

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

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

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

**Provide official notice**

Write to us within 10 calendar days if any of the following events happen:
1. Bankruptcy or insolvency.
2. Indictment, arrest, felony conviction or any criminal charge related to your practice or profession.
3. Suspension, exclusion, debarment or other sanction from a state or federally funded health care program.
4. Loss or suspension of your license to practice.
5. Departure from your practice for any reason.
6. Closure of practice.
You may use the care provider demographic information update form for demographic changes or to update NPI information for care providers in your office. This form is located at the Provider Portal at UHCprovider.com then Sign In > Provider Practice Profile.

### Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This may include providing service(s) for a reasonable time at the 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, to:

UnitedHealthcare Community Plan  
Attn: Network Management  
3000 Town Center, Suite 1400  
Southfield, MI 48075

If the affiliation between a PCP/group and UnitedHealthcare Community Plan terminates, the PCP must provide written termination notice to each member who has chosen them as their PCP, within 15 days of the PCP’s awareness of the termination. We will notify and assign affected members to a new PCP.

If you are a specialist/specialist group and you/group initiate(s) the Agreement termination, you must notify affected UnitedHealthcare Community Plan members before the effective termination date. Affected UnitedHealthcare Community Plan members are those who have had at least three visits to you in a one year period, and/or who have a chronic condition such as COPD, ESRD or diabetes and whom you have seen at least three times in the previous 12 month period.

You should provide a written termination notice to members in an ongoing course of treatment with any other UnitedHealthcare Community Plan-affiliated care provider, within 15 days of your awareness of the affiliation termination between the care provider and UnitedHealthcare Community Plan. 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.

**Please note:** Non-contracted care providers are paid the published Medicaid Fee Screen rates applicable on the service date.

### Arrange substitute coverage

If you cannot provide care and must find a substitute, arrange for care from other UnitedHealthcare Community Plan care providers and care professionals. 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 listing of network care providers and health care professionals, review our care provider and health care professional directory at UHCprovider.com > Find Dr.

### Administrative terminations for inactivity

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

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

Changing an existing TIN or adding a health care provider

Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the email address listed on the bottom of the form when updating a single care provider practitioner. Practices with two or more care provider practitioners, please use the Group/Organization Demographic Information Update form. The W-9 form and the Demographic Information Update Forms are available at UHCprovider.com > sign in to Provider Portal > My Practice Profile.

Otherwise, complete detailed information about the change, the effective date of the change and a W-9 on your office letterhead. Send this information to the email listed on the bottom of the Demographic Information Update Forms. For tax ID changes, please contact your provider advocate or contract manager.

Updating your practice or facility information

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

- Completing the Provider Demographic Change Form and emailing it to the appropriate address listed on the bottom of the form.
- Calling our Enterprise Voice Portal at 877-842-3210.

After-hours care

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

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

Participate in quality initiatives

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

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

Provide access to your records

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

Performance data

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

Comply with protocols

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

You 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 postpayment 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.

You may view protocols at UHCprovider.com.

Office hours

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

Protect confidentiality of member data

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

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

Follow medical record standards

Please reference Chapter 9 for Medical Record Standards.

Inform members of advance directives

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

Your Agreement

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

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

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

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

Also reference Chapter 12 of this manual for information on 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:
- After-hours care phone number: 24 hours, 7 days a week
- Emergency care: Immediately or referred to an emergency facility
- Urgent care appointment: same day
- Non-urgent or symptomatic care appointment: within three days
- Routine care appointment: within 30 calendar days
- Physical exam: within 180 calendar days
- EPSDT appointments: within 6 weeks
- New member appointment: within 30 calendar days
- Telephone access: average seconds to answer must be 30 seconds or less. The abandonment rate must be 5% or less.
- In-office waiting for appointments: take members to the exam room within 15 minutes of the scheduled appointment time

### Specialty care

Specialists should arrange appointments for routine appointments within 30 working 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.

### Care provider directory

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

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

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

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

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

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

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

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

### Provider attestation

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

### Online care provider directory

The medical, dental and mental health care provider directory is located at UHCprovider.com. Click Find Dr. icon.

### 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 no less than three business days before the planned service date. Call us at 800-903-5253 if services will be performed within 48 hours of the prior authorization request.

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

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

Requirements for PCP and specialists serving in PCP role

Specialists include internal medicine, pediatrics, or obstetrician/gynecology

PCPs are an important partner in the delivery of care, and Michigan Department of Health and Human Services (DHHS) members may seek services from any participating care provider. The Michigan 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 four critical areas: access, coordination, continuity and prevention. As such, the PCP manages initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide 24 hours a day, seven days a week coverage and backup coverage when they are not available.

Medical doctors (MDs), doctors of osteopathy (DOs), nurse practitioners (NPs) and physician assistants (PAs) from any of the following practice areas can be PCPs:

- General practice
- Internal medicine
- Family practice
- Pediatrics

NPs and PAs may enroll with the state as solo providers; however, to be considered a PCP, their supervising physician must be a PCP as well.

Members may change their assigned PCP by contacting Member Services at any time during the month. Customer Service is available 8:30 a.m. – 5:30 p.m., Monday through Friday.

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

Females have direct access (without a referral or authorization) to any OB/GYNs, for women’s health care services.

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

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

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.
- Provide all well baby/well-child services.
- Coordinate each UnitedHealthcare Community Plan member’s overall course of care.
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week.
- Document and communicate practice hours to members.
- Be available to members by telephone any time.
- Tell members about appropriate use of emergency services.
- Discuss available treatment options with members.

### Responsibilities of PCPs and specialists serving in PCP role

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

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

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

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

Members may choose a care provider who meets the PCP requirements and performs PCP-type services within a Rural Health Clinic or Federally Qualified Health Center as their PCP.

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

- **Federally Qualified Health Center**: An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a care provider, PA, NP and/or social worker.
  - Mental health services.
  - Immunizations (shots).
  - Home nurse visits.

### Specialist care providers responsibilities

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

- Contact the PCP to coordinate the care/services.
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer.
- Verify the eligibility of the member before providing covered specialty care services.
- Provide only those covered specialty care services, unless otherwise authorized.
- 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 one UnitedHealthcare Community Plan participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the Michigan DHHS Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PCPs and specialists

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**PCP checklist**

- Verify eligibility and benefits on [UHCprovider.com](http://UHCprovider.com). Click “Sign In” in the top right corner to access the Provider Portal, or call Provider Services.
- Check the member’s ID card at the time of service. Verify member with photo identification.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit [UHCprovider.com/pan](http://UHCprovider.com/pan).
- Refer patients to UnitedHealthcare Community Plan participating specialists when needed.
- Identify and bill other insurance carriers when appropriate.
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form.
serving in the PCP role must be available to members by phone 24 hours a day, seven days a week.

Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

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

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

Ancillary care provider responsibilities

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

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

Children’s Special Health Care Services (CSHCS)

PCPs willing to serve CSHCS members must meet the following qualifications:

- a. Is willing to accept new CSHCS members with potentially complex health conditions.
- b. Regularly serves children or youth with complex chronic health conditions.
- c. Has a mechanism to identify children/youth with chronic health conditions.
- d. Provides expanded appointments when children have complex needs and require more time.
- e. Has experience coordinating care for children who see multiple professionals (pediatric specialists, physical therapists, behavioral health professionals, etc.).
- f. Has a designated professional responsible for care coordination for children who see multiple professionals.
- g. Provides services appropriate for youth transitioning into adulthood, including but not limited to; the use of a transition assessment tool and adoption of a transition policy that is publicly posted and specifies:
  - i. the transition time frame.
  - ii. transition approach.
  - iii. 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.

Ancillary care provider checklist

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

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<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Member Benefits</td>
<td>UHCcommunityplan.com/mi</td>
<td>800-903-5253</td>
</tr>
<tr>
<td>Provider Services</td>
<td>UHCprovider.com/MIcommunityplan</td>
<td>800-903-5253</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>UHCprovider.com/paan</td>
<td>800-903-5253</td>
</tr>
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<td>DSNP</td>
<td>UHCprovider.com &gt; Health Plans by State &gt; Michigan &gt; Medicare &gt; <strong>Michigan Dual Complete Special Needs Plans</strong></td>
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Assignment to PCP panel roster

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

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

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

The Community Care Roster has member contact information, clinical information to include HEIDIS 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 Vault for member contact information in a PDF at the individual practitioner level.


Choosing a PCP

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

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 888-367-6557 or 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 three 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. We allow members to change their PCP one time per month, unless there are extenuating circumstances.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

Medically necessary definition

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

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

Member assignment

Assignment to UnitedHealthcare Community Plan

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 at times may occur mid-month.

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

Medicaid members are locked into a health plan for 12 months. The Centers for Medicare & Medicaid Services (CMS) requires members to have the opportunity to change health plans once per year. The case number’s last digit designates the member’s open enrollment month. For example, if the case number ends in two, the designated open enrollment month is every February.

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 two open enrollment periods in a 12-month period. Open enrollment letters will be mailed during Nov. and Dec. each year to those that did not receive a change plans notice within the past 12-month period.

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

Immediate enrollment changes

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

Get eligibility information by calling Provider Services.

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 woman associated with the MCO is expecting. Individuals attaining eligibility due to a pregnancy are usually guaranteed eligibility for comprehensive services through 60 days 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
mother. The MCO and/or the care provider’s information is taken as a lead. To help speed up the process, the mother should notify DHHS when the baby is born.

Members may call 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 mother has enrolled her baby in a managed care plan. Newborns are eligible for Medicaid coverage for their birth month, and may be eligible for up to one year or longer.

PCP selection

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

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 two forms of Medicaid identification. The state of Michigan issues each member a plastic “Mihealth” Medicaid ID card. 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 cards against some form of photo ID, such as a driver’s license, if this is your office practice.

Verify enrollment and eligibility by:

- Reviewing the member’s “Mihealth” Medicaid ID card and UnitedHealthcare Community Plan ID card.
- Accessing the Netwerkes website at netwerkes.com.
- Accessing UnitedHealthcare Community Plan’s secure online provider portal, UHCprovider.com.
- Calling our automated eligibility system at 800-903-5253. This option allows you to receive a fax confirmation.

If a fraud, waste and abuse event arises from a care provider or a member, go to UHC.com/fraud. Or you may call the Fraud, Waste and Abuse Hotline.

The member’s ID card shows the PCP assignment on the front of the card, and “Medicaid” will show on the front lower right corner 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 nine-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.
PCP-initiated transfers

Non-compliance with treatment recommendations may not be adequate reason to transfer a member out of your practice. It is UnitedHealthcare Community Plan’s responsibility to work with you to help coordinate care.

UnitedHealthcare Community Plan PCPs may request a member transfer for the following reasons:

- The member displays violent or life-threatening behavior involving physical acts of violence, physical or verbal threats of violence against you or your staff, threats or violence at your location, or when the member is determined to be an excessive menace to you or your staff.
- You and/or UnitedHealthcare Community Plan have documented evidence of fraud or misrepresentation involving alteration or theft of prescriptions, misrepresentations of UnitedHealthcare Community Plan membership or unauthorized use of benefits.
- Other non-compliance situations such as repeated failure to follow treatment plans, repeated use of non-contracted care providers, repeated ER use and other situations impeding care.

To transfer the member, contact UnitedHealthcare Community Plan by mail or call Provider Services with the specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, including prior warning notice(s) to the member that a continued behavior may result in a PCP transfer request, member name, date of birth, Medicaid number, current address, current phone number and the care provider’s name. Send certified notification to the member, and mail the request and supporting documentation to:

Mailing address:
UnitedHealthcare Community Plan
Attn: Health Services
P.O. Box 30991
Salt Lake City, UT 84130

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

Verifying member enrollment

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

- Provider Portal: access the Provider Portal through UHCprovider.com/eligibility
- UnitedHealthcare Provider Services is available from 7 a.m. - 5 p.m. Central Time, Monday through Friday.
- Michigan Medicaid Eligibility System (MES)
UnitedHealthcare Dual Complete (HMO DSNP)

DSNP is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid.

For general information about DSNP, go to uhc.com > Insurance Plans > Medicaid > Dual Eligible Special Needs Plans (DSNP).

For information regarding UnitedHealthcare Dual Complete, please see Chapter 4 of the Administrative Guide for Commercial, Medicare Advantage and DSNP. For state-specific information, go to UHCprovider.com/Mlcommunityplan > UnitedHealthcare Dual Complete Special Needs Plans.
Chapter 4: Medical Management

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>UHCprovider.com &gt; Menu &gt; Referrals</td>
<td>800-903-5253</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>UHCprovider.com/paan</td>
<td></td>
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<tr>
<td>Pharmacy</td>
<td>professionals.optumrx.com</td>
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<tr>
<td>Healthy First Steps</td>
<td>800-599-5985</td>
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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 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.
- Non-emergent air ambulance requires prior authorization.

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

Emergency ambulance transportation

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

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

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

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

Non-emergency 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.

Cardiology

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

You must obtain prior authorization for the following cardiology procedures:
- Diagnostic catheterizations
- Electrophysiology implant procedures (including inpatient)
- Echocardiograms
- Stress echocardiograms

Cardiology procedures do not require prior authorization if performed in the following places of service:
- ER
- Observation unit
- Urgent care
- Inpatient stay (except for electrophysiology implants)

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

Request prior authorization online or by phone:
- Online: UHCprovider.com/cardiology; select the Go to Prior Authorization and Notification Tool.
- Phone: 866-889-8054 from 7 a.m. – 7 p.m., Monday through Friday. Make sure the medical record is available.

Communicable diseases

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

How to report

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:
Discharge planning

Discharge planning helps ensure the member’s home needs will be anticipated and met. The facility discharge planner should notify our Health Services department of issues that may affect discharge. This may include:

- Member’s ability to care for self after discharge, including ability to understand instructions
- Member’s home support system (family, chore worker)
- Member’s home situation (house, apartment, shelter, street, stairs, etc.)
- Member’s social situation (drug abuse, other abuse)
- Needed discharge equipment (or equipment already at home)
- Needed discharge services (Home Health, Infusion, SNF, Rehab)
- Previous non-compliance or failure to follow-up with you
- Discharge medications

Our Health Services department is available to assist you and/or the facility in making discharge arrangements and outpatient care plans, such as difficult placements or case management for catastrophic illnesses or injuries.

Prior authorization is required for some post-hospital outpatient services such as home health, home IV infusion, etc. Use our in-network care providers when available.

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 four 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 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 which are:

- Primarily used to serve a medical purpose
- Not useful to a person in the absence of illness, disability, or injury
- Ordered or prescribed by a care provider
- Reusable
- Repeatedly used
- Appropriate for home use
- Determined to be medically necessary
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 non-emergency services such as sprains/strains, stomachaches, earaches, fevers, cough, colds and sore throats.

Covered services include:

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

Emergency 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.

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

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

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

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

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

For Policies and Protocols, go to UHCprovider.com, then select Policies and Protocols > For Community Plans.
If a member meets an acute inpatient level of stay, admission starts at the time you write the order.

**Facility admission notification requirements**

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

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

**Family planning**

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

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

**Voluntary sterilization**

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization. View the DHHS Regulations for more information on sterilization.

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**Hearing services**

Monaural and binaural hearing aids are covered, including fitting, follow-up care, batteries and repair. Bilateral cochlear implants, including implants, parts, accessories, batteries, charges and repairs are covered. Prior authorization requirements may apply. View prior authorization information and notification requirements at UHCprovider.com/MICommunityPlan > Prior Authorization and Notification.

**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 800-903-5253, Monday – Friday, 8:30 a.m. – 5:30 p.m.

**Elective admissions**

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 PCP**

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.

Hospice

UnitedHealthcare Community Plan covers in-home hospice and short-stay inpatient hospice. Please refer to the prior authorization list at UHCprovider.com/MICommunityPlan > Prior Authorization and Notification for authorization requirements.

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 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 a PCP, other care providers or dentist in one of these laboratories do not require prior authorization except as noted on our prior authorization list.

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

See the Billing and 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.

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

Healthy First Steps strives to:

- Increase early identification of expectant mothers and facilitate case management enrollment.
- Assess the member’s risk level and provide member-specific needs that support the care provider’s plan of care.
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it.
- Multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care.
- Increase the member’s understanding of pregnancy and newborn care.
- Encourage pregnancy and lifestyle self-management and informed healthcare decision-making.
- Encourage appropriate pregnancy, postpartum and infant care provider visits.
- Foster a care provider-member collaboration before and after delivery as well as for non-emergent settings.
- Encourage members to stop smoking with our Quit
Chapter 4: Medical Management

Pregnancy/maternity

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 (completed 21–56 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 three obstetrical ultrasounds per pregnancy. The fourth and subsequent obstetrical ultrasound procedures will only be allowed for identified high-risk members. High-risk member claims must include the corresponding diagnosis code.

Pregnant UnitedHealthcare Community Plan members should receive care from UnitedHealthcare Community Plan care providers only. UnitedHealthcare Community Plan considers exceptions to this policy if:
1. the woman was in her second or third trimester of pregnancy when she became a UnitedHealthcare Community Plan member, and
2. if she has an established relationship with a non-participating obstetrician.

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. You must notify UnitedHealthcare Community Plan if a member’s pregnancy is determined to be high risk.

To notify UnitedHealthcare Community Plan of pregnancies, call Provider Services.

Maternity admissions

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

Submit maternity admission notification by using the EDI 278N transaction at [UHCprovider.com/edi](http://UHCprovider.com/edi), the online Prior Authorization and Notification tool at [UHCprovider.com/paan](http://UHCprovider.com/paan), or by calling Provider Services.

Provide the following information within one business day of the admission:
- Date of admission.
- Member’s name and Medicaid ID number.
- Obstetrician’s name, phone number, care provider ID.
- Facility name (care provider ID).
- Vaginal or cesarean delivery.

If available at time of notification, provide the following birth data:
- Date and time of delivery.
- Gender.
- Birth weight.
- Gestational age.
- Baby name.
- Method of delivery.
- Apgar scores and discharge date, if known.

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

A UnitedHealthcare Community Plan member does not need a referral from her PCP for OB/GYN care.
## Newborn enrollment

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

## Bright Futures assessment

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

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

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

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

## Hysterectomies

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

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

Find the form on the Michigan Department of Social Services website at [michigan.gov](http://michigan.gov).

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

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

Before claim submission, mail the completed consent form and UnitedHealthcare Community Plan’s Consent Submission Form 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. The member may not be billed if consent forms are not submitted.

## Pregnancy termination services

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

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

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

**Sterilization informed consent**

A member has only given informed consent if the Michigan 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 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

Use the consent form for sterilization:

- Complete all applicable sections of the form.
- Complete all applicable sections of the consent form before submitting it with the billing form. The 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.
- Your statement section should be completed after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.
- The state’s definition of “shortly before” is not more than 30 days before the procedure. Explain the procedure to the member within that time frame. However, do not sign and date the form until after you perform the procedure.

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

Have three copies of the consent form:

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

**Maternal Infant Health Program (MIHP)**

The 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 intend to supplement regular prenatal/infant care and 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 (NICU) case management

The 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 NRS guideline for Inhaled Nitric Oxide (iNO) therapy at UHCprovider.com > Menu > Policies and Protocols > For Community Plans > Clinical Guidelines.

### Pharmacy programs

#### Preferred Drug List

We provide UnitedHealthcare Community Plan’s formulary, or Preferred Drug List (PDL), to assist in the selection of cost-effective therapies. Prescription benefit includes some over-the-counter (OTC) products. Find covered OTC products in the complete PDL.

We communicate PDL updates through prescriber mailings and monthly website updates. Obtain the UnitedHealthcare Community Plan PDL by contacting your provider advocate or view the UnitedHealthcare Community Plan PDL.

**Pharmacy PDL**

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

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

If a member requires a non-preferred medication, call the Pharmacy Provider Services at 800-310-6826 or use the online Prior Authorization and Notification tool on the Provider Portal at UHCprovider.com.

**Requests to add medications to the PDL**

Send 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. 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 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

**Injectable outpatient chemotherapy drugs**

Injectable outpatient chemotherapy drugs given for a cancer diagnosis require prior authorization.

**Specialty pharmacy medications**

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

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

Specialty pharmacy medications are available through our specialty pharmacy network.

For more information about Specialty Pharmacy Medications, go to UHCprovider.com > Prior Authorization and Notification > Clinical Pharmacy and Specialty Drugs.

**Screening, Brief Interventions, and Referral to Treatment (SBIRT) services**

SBIRT services are covered when:

- Provided by, or under the supervision of, a certified care provider or other certified licensed healthcare professional within the scope of their practice.
- Determining risk factors related to alcohol and other drug use disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed.
- SBIRT screening will occur during an Evaluation and Management (E/M) exam and is not billable with a
What is included in SBIRT?

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

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

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

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

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

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

- Office
- Urgent care facility
- Outpatient hospital
- ER – hospital
- FQHC

• Community mental health center
• Indian health service – freestanding facility
• Tribal 638 freestanding facility
• Homeless shelter

For more information about E/M services and outreach, see the Department of Health and Human Services Evaluation and Services online guide at [cms.gov](http://cms.gov).

**Medication-assisted treatment**

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

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

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

To find a medical MAT provider in Michigan:

1. Go to [UHCprovider.com](http://UHCprovider.com)
2. Select “Find Dr.” or “Find a Care Provider” from the menu on the home page
3. Select the care provider information.
4. Click on “Medical Directory”
5. Click on “Medicaid Plans”
6. Click on applicable state
7. Select applicable plan
8. Refine the search by selecting “Medication Assisted Treatment”

For more SAMHSA waiver information:

Physicians – [samhsa.gov](http://samhsa.gov)
Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

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

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

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 three 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 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.

If you have questions about MAT, please call Provider Services at 800-903-5253, enter your Tax Identification Number (TIN) then say ‘Representative’, and ‘Representative’ a second time, then ‘Something Else’ to speak to a representative.
<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision TAT</th>
<th>Practitioner notification of approval</th>
<th>Written practitioner/member notification of denial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent Pre-service</td>
<td>Within five working days of receipt of medical record information required but no longer 14 calendar days of receipt</td>
<td>Within 24 hours of the decision</td>
<td>Within two business days of the decision</td>
</tr>
<tr>
<td>Urgent/Expedited Pre-service</td>
<td>Within three days of request receipt</td>
<td>Within three days of the request</td>
<td>Within three days of the request</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>Within 24 hours or next business day following</td>
<td>Notified within 24 hours of determination</td>
<td>Notified within 24 hours of determination and member notification within two business days</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>Within 30 calendar days of receiving all pertinent clinical information</td>
<td>Within 24 hours of determination</td>
<td>Within 24 hours of determination and member notification within two business days</td>
</tr>
</tbody>
</table>

**Concurrent review guidelines**

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

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

**Concurrent review details**

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

Your cooperation is required with all UnitedHealthcare Community Plan requests for information, documents or discussions related to concurrent review and discharge planning including: primary and secondary diagnosis, clinical information, care plan, admission order, member status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information by access to Electronic Medical Records (EMR).

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

UnitedHealthcare Community Plan uses InterQual (we previously used MCG 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 and ambulatory facilities.
Determination of medical necessity

Medically necessary services or supplies are those necessary to:

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

Determination process

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

Evidence-based clinical guidelines

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

Pain management

UnitedHealthcare Community Plan of Michigan uses the “Michigan Guidelines for the Use of Controlled Substances for the Treatment of Pain” guidelines and conducts medical record review to monitor compliance. These guidelines address the medical management of pain and effective and appropriate pain relief. View these guidelines on the Michigan Department of Health & Human Services website at michigan.gov or contact your provider advocate to obtain a hard copy.

Medical and drug policies and coverage determination guidelines

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

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 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 Provider Portal on UHCprovider.com, contacting UnitedHealthcare Community Plan’s 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.
• Non-covered services.
• Services provided to members not enrolled on the date(s) of service.

**Second opinion benefit**

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the 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. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward his or her report to the member’s PCP and treating care provider, if different. The member may help the PCP select the care provider.
• If an in-network provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact UnitedHealthcare Community Plan at 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/Mlcommunityplan > 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**: one business day.
- **Inpatient Admissions; After Ambulatory Surgery**: one business day.
- **Non-Emergency Admissions and/or Outpatient Services (except maternity)**: at least 14 business days beforehand; if the admission is scheduled fewer than five business days in advance, use the scheduled admission time.

Utilization management guidelines

Call 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 a fee-for-service basis. We also pay in-network hospitals and other types of care providers in the UnitedHealthcare Community Plan network on a fee-for-service basis. The plan’s UM staff works with care providers to help ensure members receive the most appropriate care in the place best suited for the needed services. Our staff encourages appropriate use and discourages underuse. The UM staff does not receive incentives for UM decisions.

UM appeals

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

See Appeals in Chapter 12 for more details.

Vision services

UnitedHealthcare Community Plan uses MARCH® Vision Care for vision services. Members may self-refer to participating MARCH Vision Care optometrists for covered vision services. Find the MARCH Vision Care Provider Directory online at marchvisioncare.com.

- 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.

Optometry care providers must verify member eligibility and benefit coverage by contacting MARCH Vision Care at 800-903-5253 or online at marchvisioncare.com.
Chapter 5: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)/Prevention

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
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</thead>
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<tr>
<td>EPSDT</td>
<td>brightfutures.aap.org</td>
<td>517-484-3013</td>
</tr>
<tr>
<td>Vaccines for Children</td>
<td>michigan.gov/vfc</td>
<td>517-335-8159</td>
</tr>
</tbody>
</table>

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 to age 21, including pregnant women. EPSDT screening includes immunizations, hearing, vision, speech screening and nutritional assessments; dental screening; and growth and development tracking.

For complete details about diagnoses codes as well as full and partial screening, examination, and immunization requirements, go to the EPSDT schedule. 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 ihp.msu.edu/index.php/quality-improvement/epsdt.

If you think your infant or toddler may have a developmental delay, contact Early On at 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 (Use the Lead Risk Assessment form.)
- Personal-social and language skills
- Fine motor/gross motor skills
- Hearing
- Vision
- Dental

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

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

Addressing a child’s developmental delays – Early On
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.
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 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.

UnitedHealthcare Community Plan provides three convenient methods for obtaining specimens in the provider office, to help ensure greater member compliance. These are:

- **MedTox filter paper kits:** we offer these kits at no charge to our care providers. This method uses two drops of fingerstick blood to obtain a blood lead screen. Once collected, send the samples to the MedTox laboratory in prepaid envelopes through U.S. mail. MedTox faxes results to care provider offices and reports results electronically to MDHHS within 48 hours (usually) of MedTox laboratory sample receipt. Find more information about provided supplies at [MedTox.com](http://MedTox.com) or call MedTox at 877-725-7241.

- **The Michigan Department of Community Health filter paper kit:** Call MDHHS at 517-335-9867 to obtain free filter paper blood lead collection kits or other lead collection supplies. The MDHHS Bureau of Laboratories accepts micro tube samples and also offers the option to obtain and submit filter paper blood lead samples of Medicaid-eligible children for state lab processing. Find more information on lead testing, filter paper and the proper sample collection technique on the MDHHS website at [michigan.gov](http://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](http://michigan.gov).

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**Vaccines for Children program (VFC)**

The Vaccines for Children 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.

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

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

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

**Michigan Childhood Immunization Registry (MCIR)**

You are required by law to report to MCIR each immunization provided to a child born after Dec. 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 6: Value-Added Services

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
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</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>UHCprovider.com/Mlcommunityplan</td>
<td>800-903-5253</td>
</tr>
<tr>
<td>Healthy First Steps</td>
<td>uhchealthyfirststeps.com</td>
<td>800-599-5985</td>
</tr>
</tbody>
</table>

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

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call Provider Services at 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 with up to 18 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 provider ID & password.
3. Click “Tools & Resources.”
4. Click “Plan Summaries” or “Fee Schedules.”

For more information on chiropractic care, go to myoptumhealthphysicalhealth.com.

**Chronic condition management**

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

Members at highest risk with conditions such as asthma, CHF, diabetes, COPD and CAD receive more intense health coaching. Resources and tools are available to support members and caregivers with conditions common to children with special health care needs and help them manage their illness.

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

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

**Healthy First Steps Rewards**

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

Members self-enroll on a smartphone or computer. They can go to uhhealthyfirststeps.com and click on “Register” or call 800-599-5985.

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

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

How You Can Help
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 at Healthy First Steps Rewards.

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

- **Health4Me** enables users to review health benefits, access claims information and locate in-network providers.
- **Social Media** provides assistance on Facebook, Twitter: @UHCPregnantCare (In Spanish: @UHCEmbarazada) by delivering health and wellness information relating to pregnancy, child birth and general health information applicable to pregnant women.

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 percent for a Medicaid population. It also has an 88 percent member satisfaction. Quit For Life is for members 18 years and older.

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

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

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

A current hemoglobin or hematocrit is required:

- Hemoglobin or hematocrit within 90 days of enrollment
- Hemoglobin or hematocrit within 90 days of each succeeding six-month certification except for a child whose blood value was within normal limits at the previous certification. For these children, the lab tests are required every 12 months
- For infants younger than 9 months of age, height/length and weight dated within 60 days of enrollment and with each six-month recertification

Contact Information: signupwic.com
Chapter 7: Mental Health and Substance Use

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health/Provider Express</td>
<td>providerexpress.com</td>
<td>800-888-2998</td>
</tr>
<tr>
<td>Provider Services</td>
<td>UHCprovider.com/MIcommunityplan</td>
<td>800-903-5253</td>
</tr>
</tbody>
</table>

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

OptumHealth Behavioral Solutions (OBH) provides UnitedHealthcare Community Plan members with unlimited outpatient mental health visits for members with mild to moderate mental health diagnoses. The remainder of the mental health and substance use disorder benefit is carved out to the state of Michigan.

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

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

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

How to join our behavioral health 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 substance abuse treatment.

Please visit Michigan.gov for county contact numbers 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 on the Eligibility and Benefits application on the Provider Portal at UHCprovider.com.
Chapter 7: Mental Health and Substance Use

Authorizations

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

Collaboration with other health care professionals

Coordination of care

When a member is receiving services from more than one professional, you must coordinate to deliver comprehensive, safe and effective care. This is especially true when the member:
- Is prescribed medication,
- Has coexisting medical/psychiatric symptoms, or
- Has been hospitalized for a medical or psychiatric condition.

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

Portal access

Website: UHCprovider.com

Access 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 800-903-5253 to verify eligibility and benefit information (available 8:30 a.m. - 5:30 p.m., Eastern Time, Monday through Friday).

Website: providerexpress.com

Update provider practice information, review guidelines and policies, and view the national Optum Network Manual. Or call Provider Services at 800-903-5253.

Claims

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

Monitoring audits

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

Addressing the opioid epidemic

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

Brief summary of framework

- Prevention:
  - Prevent OUD before they occur through pharmacy management, provider practices, and education.
- Treatment:
  - Access and reduce barriers to evidence-based and integrated treatment.
- Recovery:
  - Support case management and referral to person-centered recovery resources.
- Harm Reduction:
  - Access to Naloxone and facilitating safe use, storage, and disposal of opioids.
- Strategic community relationships and approaches:
  - Tailor solutions to local needs.
- Enhanced solutions for pregnant mom and child:
  - Prevent neonatal abstinence syndrome and supporting moms in recovery.
- Enhanced data infrastructure and analytics:
  - Identify needs early and measure progress.
Chapter 7: Mental Health and Substance Use

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. Then click “Drug Lists and Pharmacy”. Click Resource Library to find a list of tools and education.

Prescribing opioids

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

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, etc). 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 one year.

Expanding MAT access and capacity

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

To find a behavioral health MAT provider in Michigan:

1. Go to UHCprovider.com,
2. Select either Find Dr” or “Find a Care Provider" from the menu on the home page
3. Select under “Specialty Directory and Tools” the option of Optum Behavioral Health, EAP, Worklife & Mental Health Services
4. Click on “Search for a Behavioral Health Provider”
5. Enter “(city)” and “(state)” for options
6. If needed, refine the search by selecting “Medication Assisted Treatment”

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

To find medical MAT providers, see the MAT section in the Medical Management chapter.
Chapter 8: Member Rights and Responsibilities

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Services</td>
<td>UHCommunityplan.com/mi</td>
<td></td>
</tr>
<tr>
<td>Member Handbook</td>
<td>UHCommunityplan.com/mi &gt; Community Plan &gt;</td>
<td>800-903-5253</td>
</tr>
<tr>
<td></td>
<td>Member benefits</td>
<td></td>
</tr>
</tbody>
</table>

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

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

Privacy regulations

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

Access to protected health information

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

Amendment of PHI

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

Accounting of disclosures

Our members have the right to request an accounting of certain disclosures of their PHI, made by you or us, during six years prior to the request. This accounting must include disclosures by business associates. It will not include disclosures made:
- For treatment, payment and health care operations purposes
- To members or pursuant to member’s authorization
- To correctional institutions or law enforcement officials
- For which federal law does not require us to give an accounting

Right to request restrictions

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

Right to request confidential communications

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

**Member rights and responsibilities**

The following information is in the Member Handbook at the following link under the Member Information tab: [UHCcommunityplan.com/MI > select UnitedHealthcare Community Plan](#).

**Native American access to care**

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

**Member rights**

Members may:

- Request information on advance directives.
- Be treated with respect, dignity and privacy.
- Receive courtesy and prompt treatment.
- Receive cultural assistance, including having an interpreter during appointments and procedures.
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered.
- Receive information about health services and how to obtain them.
- Know the qualifications of their health care provider.
- Give their consent for treatment unless unable to do so because life or health is in immediate danger.
- Discuss any and all treatment options with you.
- Refuse treatment directly or through an advance directive.
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do.
- Receive medically necessary services covered by their benefit plan.
- Receive information about in-network care providers and practitioners, and choose a care provider from our network.
- Change care providers at any time for any reason.
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response.
- Tell us their opinions and concerns about services and care received.
- Register grievances or complaints concerning the health plan or the care provided.
- Request a fair hearing or have an external review.
- Appeal any payment or benefit decision we make.
- Review the medical records you keep and request changes and/or additions to any area they feel is needed. Expect that their medical records and communications will be treated in a confidential manner as required by law.
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, and talk with you when making decisions about their care.
- Get a second opinion with an in-network care provider. If not available in-network, the member must go through the prior authorization process for an out-of-network care provider.
- Expect health care professionals are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage.
- Make suggestions about our member rights and responsibilities policies.
- Get more information upon request, such as on how our health plan works and a care provider’s incentive plan, if they apply.
- See any in-network OB/GYN for well woman exams or obstetrical care without a referral from their PCP.
- See any in-network pediatrician without a PCP referral if they are under 18 years old.
- Ask for information about our care provider payment arrangements, and if they may affect referral use and other needed services.
- Get a copy of these rights and responsibilities or have them explained if they have questions.
Our member rights and responsibilities help uphold the quality of care and services they receive from you. The three primary member responsibilities as required by the National Committee of Quality Assurance (NCQA) are to:

- Supply information (to the extent possible) to UnitedHealthcare Community Plan and to you that is needed for you to provide care.
- Follow care to which they have agreed.

Understand their condition and take part in developing mutually agreed-upon treatment goals, to the degree possible.
Chapter 9: Medical Records

Medical record charting standards

You are required to keep complete and orderly medical records, 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 determines compliance to the following requirements:

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 80% 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 two 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 three or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record.
- Tobacco habits, alcohol use and substance abuse (12 years and older).
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one.
- History of physical examination (including subjective and objective findings).
- Unresolved problems from previous visit(s) addressed in subsequent visits; Diagnosis and treatment plans consistent with finding.
- Lab and other studies as appropriate.
- Member education, counseling and/or coordination of care with other care providers.
- Notes regarding the date of return visit or other follow-up.
- Consultations, lab, imaging and special studies initialed by PCP to indicate review.
- Consultation and abnormal studies including follow-up plans.
- 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 80% 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 10: Quality Management (QM) Program and Compliance Information

What is the Quality Improvement program?

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

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

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

Cooperation with quality-improvement activities

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

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 visits.

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

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credentialing</td>
<td>Medical: Network Management Resource Team at <a href="mailto:Networkhelp@uhc.com">Networkhelp@uhc.com</a></td>
<td>877-842-3210</td>
</tr>
<tr>
<td></td>
<td>Chiropractic: myoptumphysicalhealth.com</td>
<td></td>
</tr>
<tr>
<td>Fraud, Waste and Abuse</td>
<td>uhc.com/fraud</td>
<td>800-455-4521</td>
</tr>
<tr>
<td>(Payment Integrity)</td>
<td></td>
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</tbody>
</table>

Looking for something else?
- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.
Chapter 10: Quality Management (QM) Program and Compliance Information

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.

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

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

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

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

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable Michigan statutes and the National Committee of Quality Assurance (NCQA). The following items are required to begin the credentialing process:

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

Current board certification is not a requirement for network participation, but is a requirement for designation in the UnitedHealth Premium designation program.

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

View the Credentialing and Recredentialing Plan at UHCprovider.com > Menu > Resource Library > Join Our Network & Credentialing.

Facility criteria

UnitedHealthcare Community Plan credentials hospitals, free standing surgical centers, SNFs and home
healthcare agencies. Criteria vary based on the facility type. General criteria for contracting with a hospital and/or ancillary site is:

- Accreditation, certification or compliance with UnitedHealthcare Community Plan established standards
- In good standing with federal and state regulatory agencies
- Current state license, if applicable
- Appropriate insurance coverage
- On-site facility review, if not accredited

**Credentialing and recredentialing process**

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

**Care providers subject to credentialing and recredentialing**

UnitedHealthcare Community Plan evaluates the following practitioners:

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

Excluded from this process are practitioners who:

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

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

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

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

For chiropractic credentialing, call 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 recredits practitioners every three years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan’s guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website. Not responding to our request for recredentialing information results in administrative
Chapter 10: Quality Management (QM) Program and Compliance Information

termination of privileges as a UnitedHealthcare Community Plan care provider. You have three chances to answer the request before your participation privileges are terminated.

Performace review

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

Applicant rights and notification

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

You also have the right to receive the status of your credentialing application, please email us at networkhelp@uhc.com. Include your full name, NPI, TIN and brief description of the request. A UnitedHealthcare representative will be in touch with you within two business days from when we receive your request.

Confidentiality

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

Resolving disputes

Contract concerns

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

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

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

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

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

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

HIPAA compliance – your responsibilities

Health Insurance Portability and Accountability Act

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

Transactions and code sets

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

**Unique identifier**

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

**National Provider Identifier**

The NPI is your standard unique identifier. It is a 10-digit number with no embedded intelligence that covered entities must accept and use in standard transactions. While HIPAA only requires you to use the NPI in electronic transactions, many state agencies require it on fee-for-service (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 protected health information (PHI) the covered entity creates,
- Protect against any reasonably anticipated threats,

uses or disclosures of information not permitted or required under the Privacy Regulations, and

- Help ensure compliance with the security regulations by the covered entity’s staff.

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

Find additional information on HIPAA regulations at [cms.hhs.gov](http://cms.hhs.gov).

**Ethics and integrity**

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

**Compliance program**

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

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

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

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

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

To facilitate the reporting process of questionable incidents involving members or care providers, call our Fraud, Waste and Abuse line or go to UHC.com/fraud.

Please refer to the Fraud, Waste and Abuse section of this manual for additional details about the UnitedHealthcare Community Plan Fraud, Waste and Abuse program.

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

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

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the state of 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.

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 seven 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.

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

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

You must cooperate with the state or any of its authorized representatives, the Michigan Department of Health and Human Services, CMS, the Office of Inspector General, or any other agency prior-approved by the state, at any time during your Provider Agreement. These entities may, at all reasonable times, enter your premises. You agree to allow access to and the right to audit, monitor and examine any relevant books, documents, papers and records to otherwise evaluate (including periodic information systems testing) your performance and charges.

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

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

Office site quality

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

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

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

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.

The following table describes the QOC criteria and thresholds.

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

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
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</thead>
<tbody>
<tr>
<td>Claims</td>
<td>UHCprovider.com/claims</td>
<td>866-633-4449</td>
</tr>
<tr>
<td>National Plan and Provider Enumeration System (NPPES)</td>
<td>nppes.cms.hhs.gov</td>
<td>800-465-3203</td>
</tr>
<tr>
<td>EDI</td>
<td>UHCprovider.com/EDI</td>
<td>866-633-4449</td>
</tr>
</tbody>
</table>

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

Our claims process

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

UnitedHealthcare Community Plan follows the same claims process as UnitedHealthcare.

For a complete description of the process, go to UHCprovider.com/guides > View online version > Chapter 10 Our Claims Process.

General billing guidelines

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

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.

National Provider Identifier

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

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

Your clean claims must include your NPI and federal TIN.
Modifier codes

Use the appropriate modifier codes on your claim form. The modifier must be used based on the date of service.

Member ID Card for Billing

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

Acceptable Claim Forms

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

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

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

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

Care provider coding

UnitedHealthcare Community Plan complies with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) state standards based on claims data and chart review. Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to find an ICD-10 code. You must code to the highest level of specificity. Include at least one diagnosis code, and up to four, in order of priority (primary, secondary condition, etc.) to describe the service reason.

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 HCFA 1500 and UB-04 forms.

EDI companion documents

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

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

The companion documents are located on UHCprovider.com/edi > Go to companion guides.

Clearinghouse and status reports

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

For clearinghouse options, use our Electronic Data Exchange (EDI) at UHCprovider.com > Resource Library > Clearinghouse.

e-Business support

Call Provider Services at 800-903-5253 for help with online billing, claims, Electronic Remittance Advices (ERAs), Electronic Funds Transfers (EFTs).

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

Find more information at UHCprovider.com, Click Menu, then Resource Library to find Electronic Data Interchange menu.

Completing the CMS 1500 claim 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:

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

Capitated services

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period. We pay you whether that person seeks care.

Capitation payment arrangements apply to participating physicians and health 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, and
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 providers are performing on behalf of UnitedHealthcare Community Plan.

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

Subrogation and coordination of benefit

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

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

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

Global days

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

For reimbursement, we follow CMS guidelines and

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

Correct Coding Initiative

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

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

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

Clinical Laboratory Improvements Amendments

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

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

The Department of Health and Human Services covers medically necessary, non-experimental transplants. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation.

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 will be rejected as “unclean”, including most codes ending in 99 and others such as A4649, E1399, J3490, and J7799. Submit supporting documentation as a claim attachment if these codes must be used for delivered services.
• For surgical services using the above non-specific codes, submit operative notes to UnitedHealthcare Community Plan's Medical Director for review.
• Non-specific Durable Medical Equipment (DME) codes require a manufacturer’s invoice to determine pricing. If the invoice is not submitted we will deny the claim for required documentation.
• We will pay not otherwise classified (NOC) codes 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.

Please refer to your contract or contact your provider advocate for more information about using appropriate billing codes.

Medical necessity

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

Place of Service codes

Go to CMS.gov for Place of Service codes.

Asking about a claim

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

Provider Services

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

• Member’s ID number
• Date of service
Chapter 11: Billing and Submission

- Procedure code
- Amount billed
- Your ID number
- Claim number

Allow Provider Services 45 days to solve your concern.

**UnitedHealthcare Community Plan Provider Portal**

You can view your online transactions with the Provider Portal by signing in at [UHCprovider.com](http://UHCprovider.com) with your One Healthcare ID. This portal offers you with online support anytime. If you are not already registered, you may do so on the website.

The Provider Portal lets you move quickly between applications. This helps you:
- Check member eligibility.
- Submit claims reconsiderations.
- Review coordination of benefits information.
- Use the integrated applications to complete multiple transactions at once.
- Reduce phone calls, paperwork and faxes.

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

Find Provider Portal training on [UHCprovider.com/training](http://UHCprovider.com/training) and Self Service Tool training at [cx.uhc.com/content/uhc-provider/uhconair/en/self-service.html](http://cx.uhc.com/content/uhc-provider/uhconair/en/self-service.html).

Provider Portal training course is available using the [CommunityCare Provider Portal User Guide](http://CommunityCare Provider Portal User Guide).

**Resolving claim issues**

To resolve claim issues, contact [Provider Services](#), use the Provider Portal or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan  
P.O. Box 30991  
Salt Lake City, UT 94130-0991

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

**For paper claims**

Submit a screen shot from your accounting software that shows when you submitted the claim. The screen shot must show the correct:
- Member name.
- Date of service.
- Claim date submission (within the timely filing period).

**Timely filing**

Timely filing issues may occur if members give the wrong insurance information when you treat them. This results in receiving:
- A denial/rejection letter from another carrier.
- Another carrier’s explanation of benefits.
- A letter from another insurance carrier or employer group saying that the member either has no coverage or had their coverage terminated before the date of service.

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

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

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

If a claim is rejected, and corrections are not received within 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.
• You deny a claim for late submission, unauthorized service or as not medically necessary.
• UnitedHealthcare Community Plan is reviewing a claim.

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

If you don’t know who your provider advocate is, email Michigan.PR.Team@uhc.com. A provider advocate will get back to you.

**Third-party resources**

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

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

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider contract.

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

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

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>DEFINITION</th>
<th>WHO MAY SUBMIT?</th>
<th>SUBMISSION ADDRESS</th>
<th>ONLINE FORM OR MAIL</th>
<th>CONTACT PHONE NUMBER</th>
<th>WEBSITE (Care Providers Only) for Online Submissions</th>
<th>CARE PROVIDER FILING TIME FRAME</th>
<th>UnitedHealthcare Community Plan RESPONSE TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Provider Claim Correction (Resubmission)</td>
<td>Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission.</td>
<td>Care Provider</td>
<td>UnitedHealthcare Community Plan P.O. Box 30991 Salt Lake City, UT 84130-0991</td>
<td>UHCprovider.com/claims</td>
<td>866-331-2243</td>
<td>Use the Claims Management or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.</td>
<td>Re-submit corrected claims within 12 months from service date</td>
<td>30 business days</td>
</tr>
<tr>
<td>Care Provider Claim Reconsideration (step 1 of claim dispute)</td>
<td>Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.</td>
<td>Care Provider</td>
<td>UnitedHealthcare Community Plan P.O. Box 30991 Salt Lake City, UT 84130-0991</td>
<td>UHCprovider.com/claims</td>
<td>866-815-5334</td>
<td>Use the Claims Management or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.</td>
<td>Must receive within 365 calendar days of the claim processing date</td>
<td>30 business days</td>
</tr>
</tbody>
</table>
## Appeals and Grievances Standard Definitions and Process Requirements

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>DEFINITION</th>
<th>WHO MAY SUBMIT?</th>
<th>SUBMISSION ADDRESS</th>
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<th>WEBSITE (Care Providers Only) for Online Submissions</th>
<th>CARE PROVIDER FILING TIME FRAME</th>
<th>UNITEDHEALTHCARE COMMUNITY PLAN RESPONSE TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Provider Claim Formal Appeal (step 2 of claim dispute)</td>
<td>A second review in which you did not agree with the outcome of the reconsideration.</td>
<td>Care Provider</td>
<td>UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 30991 Salt Lake City, UT 84130-0991</td>
<td>UHC provider.com/claims</td>
<td>866-331-2243</td>
<td>Use the Claims Management or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.</td>
<td>Level one appeal: within 180 calendar days of the reconsideration decision letter Level two appeal: within 60 calendar days from the level one appeal decision letter</td>
<td>30 business days</td>
</tr>
<tr>
<td>Care Provider Grievance</td>
<td>A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member</td>
<td>Care Provider</td>
<td>UnitedHealthcare Community Plan P.O. Box 30991 Salt Lake City, UT 84130-0991</td>
<td></td>
<td>505-555-1212</td>
<td>Use the Claims Management or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.</td>
<td>120 business days</td>
<td>30 business days</td>
</tr>
<tr>
<td>Member Appeal</td>
<td>A request to change an adverse benefit determination that we made.</td>
<td>* Member</td>
<td>UnitedHealthcare Community Plan P.O. Box 30991 Salt Lake City, UT 84130-0991</td>
<td>UHC provider.com/claims</td>
<td>505-555-1212</td>
<td>* AOR Consent Form on this site for member appeals</td>
<td>60 calendar business days</td>
<td>Urgent appeals - 72 hours Standard appeals - 30 days</td>
</tr>
<tr>
<td>Member Grievance</td>
<td>A member’s expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.</td>
<td>* Member</td>
<td>UnitedHealthcare Community Plan P.O. Box 30991 Salt Lake City, UT 84130-0991</td>
<td></td>
<td>505-555-1212</td>
<td>N/A</td>
<td>90 calendar days</td>
<td></td>
</tr>
</tbody>
</table>
These definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements.

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

Denial

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

An Administrative denial is when we didn’t get notification before the service, or the notification came in too late.

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

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

Other top reasons for denial include:

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

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

Eligibility expired. Most practices verify coverage beforehand to avoid issues, but sometimes that doesn’t happen. One of the most common claim denials involving verification is when a patient’s health insurance coverage has expired and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.

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

Time limit expired. This is when you don’t send the claim in time.

Claim correction

What is it?

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

When to use:

Submit a corrected claim to fix or void one that has already processed. Submit corrected claims within one year of the service date if the original claim was received within the care provider’s filing limit.

How to use:

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

Mailing address:

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

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.

**How to use:**

To resubmit the claim, follow the same submission instructions as a new claim. To mail your resubmission, provide all claim information to:

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

**Claim reconsideration**
(Step one 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. Submit claim reconsiderations within 12 months from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) as required by law (or your Participation Agreement).

• In your reconsideration request, please ask for a medical necessity review and include all relevant medical records.
• Please include any additional clinical information that may not have been reviewed with your original claim.
• Show how specific information in the medical record supports the medical necessity of the level of care performed – for example, inpatient instead of observation.

**How to use:**

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

• **Electronically:** Use the Claim Reconsideration application on the Provider Portal. Include electronic attachments. You may also check your status using the Provider Portal.
• **Phone:** Call Provider Services at 800-903-5253 or use the number on the back of the member’s ID card. The tracking number will begin with SF and be followed by 18 numbers.
• **Mail:** Submit the Claim Reconsideration Request Form to:

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

This form is available at [UHCprovider.com/claims](http://UHCprovider.com/claims).

**Tips for successful claims resolution**

To help process claim reconsiderations:

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

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

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

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

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

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

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

Overpayment

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

How to use:
If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your contract. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with 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 timeframe as listed in your contract.

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

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

<table>
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<th>Member ID</th>
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<th>Amount of Overpayment</th>
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<td>06/15/14</td>
<td>332.63</td>
<td>332.63</td>
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</table>

Appeals (step two 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 one, use the claim appeal process.

- Submit a level one appeal within 180 days from the reconsideration decision letter date. You may request a level two appeal if you are dissatisfied with a level one appeal decision denial. Appeal rights are included in appeal determination letters.
- Submit a level two appeal within 60 days from the level one appeal notice. You must include additional information or documentation that could affect the level one decision. We will not accept a letter requesting a review of the information submitted with the level one appeal.

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

- **Electronic claims:** Use the Claims Management or Claims on the Provider Portal. Click Sign in to the Provider Portal in the top right corner of UHCprovider.com, then click Claims. You may upload attachments. Include confirmation that UnitedHealthcare Community Plan or one of its affiliates received and accepted your claim.
- **Mail:** Send the appeal to:
  
  UnitedHealthcare Community Plan
  Attn: Appeals and Grievances Unit
  P.O. Box 30991
  Salt Lake City, UT 84130-0991

**Discussion with care provider reviewer**

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

Questions about your appeal or need a status update? Call Provider Services. If you filed your appeal online, you should receive a confirmation email or feedback through the secure provider portal.
Provider grievance

What is it?
Grievances are complaints related to your UnitedHealthcare Community Plan policy, procedures or payments.

When to file:
You may file a grievance about:
• Benefits and limitations.
• Eligibility and enrollment of a member or care provider.
• Member issues or UnitedHealthcare Community Plan issues.
• Availability of health services from UnitedHealthcare Community Plan to a member.
• The delivery of health services.
• The quality of service.

How to file:
File verbally or in writing.
• **Phone:** Call Provider Services toll free at 800-903-5253
• **Mail:** Send care provider name, contact information and your grievance to:
  UnitedHealthcare Community Plan  
  Attn: Appeals and Grievances Unit  
  P.O. Box 31364  
  Salt Lake City, UT 84131-0364

You may only file a grievance on a member’s behalf with the written consent of the member. See Member Appeals and Grievances Definitions and Procedures.

Fraud, waste and abuse (FWA)

Call the toll-free 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.

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

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

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

Member appeals and grievances

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

State fair hearings

For information regarding member state fair hearings, refer the member to the UnitedHealthcare Community Plan Member Handbook at UHCCommunityPlan.com/MI.
the administration or delivery of UnitedHealthcare Community Plan benefits.

You need to:

- Ensure potential employees are not excluded from participating in federal health care programs.
  For more information or access to the publicly accessible excluded party online databases, use the following links:
  - General Services Administration (GSA) System for Award Management at SAM.gov.
- Review the exclusion lists monthly and disclose to us any exclusion or other event that makes an individual ineligible to perform work directly or indirectly on federal health care programs.
- Maintain a record of exclusion checks for 10 years. We, or CMS, may request exclusion checks documentation to verify completion.

**Standards of conduct awareness**

You must provide a copy of your own code of conduct, or the UnitedHealth Group’s (UHG’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.

**FWA and general compliance training**

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

**Distinction between and examples of FWA**

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 web sites: 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 FWA 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
  - **800-903-5253**

- **Office of Inspector General**
  - P.O. Box 30062

Lansing, MI 48909
855-643-7283
michigan.gov/fraud
Chapter 13: Care Provider Communications and Outreach

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Provider Education</td>
<td>UHCprovider.com &gt; Menu &gt; Resource Library</td>
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<td>News and Bulletins</td>
<td>UHCprovider.com &gt; News and Network Bulletin</td>
<td>800-903-5253</td>
</tr>
<tr>
<td>Provider Manuals</td>
<td>UHCprovider.com/guides</td>
<td></td>
</tr>
</tbody>
</table>

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

Connect with us on social media: 📚🎬🎬

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

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

Care provider websites

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

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

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

Care provider office visits

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

Care provider newsletters and Network Bulletins

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

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

**Network Bulletins**

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

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

**Care provider manual**

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

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)
Glossary

AABD
Assistance to the aged, blind and disabled

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

Abuse (of member)
Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault.

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

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

Adverse Benefit Determination
1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner, as defined by the state.
5. The failure of someone or a company to act within the time frames provided in the contract and within the standard resolution of grievances and appeals.
6. For a resident of a rural area, the denial of an member’s request to exercise his or her right, to obtain services outside the network.
7. The denial of a member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Disallow Amount (Amt)
Medical charges for which the network provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member. Examples are:
- The difference between billed charges and in-network rates.
- Charges for bundled or unbundled services as detected by Correct Coding Initiative edits.

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

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

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

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

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

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

Electronic Data Interchange (EDI)
The electronic exchange of information between two or more organizations.

Electronic Funds Transfer (EFT)
The electronic exchange of funds between two or more organizations.
**Electronic Medical Record (EMR)**
An electronic version of a member’s health record and the care they have received.

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

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

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

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

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

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

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

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

**FHC**
Family Health Center

**Fraud**
An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or another person. This includes any act constituting fraud under applicable federal or state law (42 CFR § 455.2).

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

Grievances may include, but are not limited to, the quality of care or services provided, and relationships such as rudeness of a provider or employee, or failure to respect the member’s rights regardless of whether remedial action is requested. Grievance includes an member’s right to dispute an extension of time proposed to make an authorization decision.

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

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

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

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

**Medicaid**
A federal health insurance program for low-income families and children, eligible pregnant women, people with disabilities, and other adults. The federal government pays for part of Medicaid and sets guidelines for the program. States pay for part of Medicaid and have choices in how they design their program. Medicaid varies by state and may have a different name in your state.
Medical Emergency
An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention you could reasonably expect one of the following to result:
- Their health would be put in danger; or
- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body.

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

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

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

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

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

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

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

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

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

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

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by Michigan DHHS.

Specialist
A care provider licensed in the state of Michigan and has completed a residency or fellowship focusing on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a care provider who has special training in a specific area of health care.

State Fair Hearing
An administrative hearing requested if the member does not agree with a Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

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

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

Timely Filing
When UnitedHealthcare Community Plan puts a time limit on submitting claims.
Title XIX
Section of Social Security Act describing the Medicaid program coverage for eligible persons.

UnitedHealthcare Community Plan
An affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

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

Waste
The overutilization of services or practices resulting in unnecessary costs. Waste also refers to useless consumption or expenditure without adequate return.