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2019 Physician, Health Care Professional, Facility and Ancillary Care Provider Manual

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UnitedHealthcare®
Community Plan

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 tools 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”.

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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 eighteen (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 (CHIP).
- Categorically Needy — Blind and Disabled Children and Adults who are not eligible for Medicare.
- Medicaid Expansion 19–64 years old who are not eligible for another type of Medicaid and who has an income of less than 138% of the federal poverty level.
- Medicaid eligible families.

DHSS will determine enrollment eligibility, and verify which individuals must enroll, those that may voluntarily enroll and those excluded from enrollment.

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 imaging authorization requirements.

Our Approach to Health Care

WHOLE PERSON CARE MODEL

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

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

- Market-specific care management encompassing medical, behavioral and social care.
- Extended care team including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist.
- Field-based interventions engage members, connecting them to needed resources, care and services.
- Individualized and multidisciplinary care plan.
- Assistance with appointments with PCP and coordinating appointments. The CHA refers members to an RN, BHA or other specialists as required for complex needs.

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

The goals of the WPC program are to:

- Lower avoidable admissions and unnecessary 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 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.

Care Provider Resources

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

Referring Your Patient

To refer your patient who is a UnitedHealthcare Community Plan member to WPC, call Member Services at **800-587-5187**, TTY 711. You may also call Provider Services at **800-903-5253**.

SECURE CARE PROVIDER WEBSITE

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

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

The secure care provider website lets you:

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

URL identified by a forward slash in the web address, e.g. **UHCprovider.com/claims**. When you see that forward slash in our web links, you can copy the direct URL into your web page address bar to quickly access that page.

PROVIDER SERVICES

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

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

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

NETWORK MANAGEMENT DEPARTMENT

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

If you need to speak with a network contract manager about credentialing status or contracting, call our **Network Management Phone Team**.

CULTURAL COMPETENCY RESOURCES

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

UnitedHealthcare Community Plan 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.
- **Cultural member materials:** 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.

CARE PROVIDER 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.

DIRECT CONNECT

Direct Connect is a free online portal that lets you securely communicate with payers to address errant claims. This portal has the ability to 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 Link. On-site and online training is available.

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

COMPLIANCE

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

EVIDENCE-BASED CLINICAL REVIEW CRITERIA AND GUIDELINES

UnitedHealthcare Community Plan uses MCG Care Guidelines (formally Milliman Care 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 chemotheraphy. You can call **800-903-5253** to request a copy of the guidelines.

How to Contact Us

Topic	Contact	Information
Benefits	**UHCprovider.com/benefits** 800-903-5253	Confirm a member's benefits and/or prior authorization.
Chiropractor Care	**myoptumhealthphysicalhealth.com**	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.
Claims	Use the Link Provider Portal at **UHCprovider.com/claims** 800-903-5253 Mailing address: **UnitedHealthcare Community Plan** Attn: Claims P.O. Box 30991 Salt Lake City, UT 84130-0991 **OptumHealth Behavioral Solutions** P.O. Box 30760 Salt Lake City, UT 84130-0760	Verify a claim status or get information about proper completion or submission of claims.
Behavioral Claim Disputes	Use the Link Provider Portal at **UHCprovider.com/claims** 800-903-5253 Mailing address: **UnitedHealthcare Community Plan** Attn: Claims P.O. Box 30991 Salt Lake City, UT 84130-0991 **OptumHealth Behavioral Solutions** P.O. Box 30760 Salt Lake City, UT 84130-0760	Ask about behavioral claim disputes.

Topic	Contact	Information
Claim Overpayments	See the Overpayment section for requirements before sending your request. Sign in to **UHCprovider.com/claims** to access Link, 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	Ask about claim overpayments.
Electronic Data Intake Claim Issues	**ac_edi_ops@uhc.com** 800-210-8315	Ask about claims issues or questions.
Electronic Data Intake Log-on Issues	800-842-1109	Information is also available at **UHCprovider.com/edi**.
Eligibility	To access the app, sign in to **UHCprovider.com/eligibility** to access Link, then select the UnitedHealthcare Online app 800-903-5253	Confirm member eligibility.
Fraud and Abuse	800-903-5253 Office of Inspector General: 855-643-7283 **michigan.gov/fraud** Mailing address: **UnitedHealthcare Community Plan** Compliance Officer 26957 Northwestern Highway, Suite 400 Southfield, MI 48033 or **Office of Inspector General** P.O. Box 30062 Lansing, MI 48909	Notify us of suspected fraud or abuse by a care provider or member.
Lab Services	800-445-4979	Joint Venture Hospital Laboratories (JVHL) is the preferred lab provider.

Topic	Contact	Information
Medical Claim Disputes	Sign in to **UHCprovider.com/claims** to access Link, then select the UnitedHealthcare Online app 800-903-5253 Reconsiderations and appeals mailing address: **UnitedHealthcare Community Plan** Grievances and Appeals P.O. Box 30991 Salt Lake City, UT 84131-0991	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	800-903-5253	Assist members with issues or concerns. Available 8:30 a.m. – 5:30 p.m. Eastern Time, Monday through Friday.
Mental Health & Substance Abuse (OptumHealth Behavioral Solutions)	OptumHealth Behavioral Solutions 800-903-5253	Refer members for behavioral health services. (A PCP referral is not required.)
Michigan ENROLLS	**Medicaid.gov** MIEnrolls: 888-367-6557 or 800-975-7630	The Michigan Department of Health & Human Services (MDHHS) contracts with Michigan ENROLLS, an enrollment services contractor, to educate Medicaid enrollees about managed care and how to enroll, disenroll and change enrollment for these beneficiaries.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	800-368-1019 or 800-537-7697 TDD 711	Available 8 a.m. – 5 p.m. Eastern Time, Monday through Friday, except state-designated holidays.
National Credentialing Center (VETTS line)	877-842-3210	Self-service functionality to update or check credentialing information.
National Plan and Provider Enumeration System (NPPES)	**nppes.cms.hhs.gov** 800-465-3203	Apply for a National Provider Identifier (NPI).
Network Management Phone Team	800-903-5253	Ask about contracting and care provider services.

Topic	Contact	Information
Obstetrics and Baby Care	Healthy First Steps 800-599-5985 Fax: 877-353-6913 Pregnancy Notification Form **Prenatal risk assessment form** **UHCBabyBlocks.com**	Links for pregnant moms and newborn babies. Refer high-risk OB members. Fax initial prenatal visit form.
Optum Support Center	**LinkSupport@optum.com** 855-819-5909	Available 7 a.m. – 9 p.m. Eastern Time, Monday through Friday; 6 a.m. – 6 p.m. Eastern Time, Saturday; and 9 a.m. – 6 p.m. Eastern Time, Sunday.
Pharmacy Services	**professionals.optumrx.com** 877-305-8952 (OptumRx)	OptumRx oversees and manages our network pharmacies.
Prior Authorization/ Notification for Pharmacy	**UHCprovider.com/priorauth** 800-310-6826 Fax: 855-225-9847	Request authorization for medications as required.
Prior Authorization/ Notification of Health Services	**UHCCommunityPlan.com** 800-903-5253 Fax: 855-225-9847	Request authorization/notify of the procedures and services outline in the prior authorization/ notification requirements section of this manual. Complete and current list of prior authorizations.
Provider Services	**UHCprovider.com/MIcommunityplan** 800-903-5253	Available 7 a.m. – 5 p.m. Eastern Time, Monday through Friday.
Tobacco Free Quit Line	800-784-8669	Ask about services for quitting tobacco/ smoking.
Transportation	LogistiCare 877-892-3995	Call LogistiCare to schedule transportation or for transportation assistance. To arrange non-urgent transportation, please call three days in advance.
Utilization Management	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.

Topic	Contact	Information
Vaccines for Children (VFC) program	517-335-8159	Care providers must participate in the VFC Program administered by the Department of Health and Senior Services (DHSS) and must use the free vaccine when administering vaccine to qualified eligible children. Providers must enroll as VFC providers with DHSS to bill for the administration of the vaccine.
Vision Services	**marchvisioncare.com** 800-903-5253	Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from MARCH® Vision Care.
Whole Person Care Person-Centered Care Model (Care Management/ Disease Management)	800-903-5253	Refer high-risk members (e.g., asthma, diabetes, obesity).
Website for Michigan Community Plan	**UHCprovider.com/MIcommunityplan**	Access your state specific community plan information on this website.

Chapter 2: Care Provider Standards & Policies

General Care Provider Responsibilities

NON-DISCRIMINATION

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

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 on form for demographic changes or update NPI information for care providers in your office. This form is located at **UHCprovider.com** > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form.

TRANSITION MEMBER CARE FOLLOWING TERMINATION OF YOUR PARTICIPATION

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This may include providing service(s) for a reasonable time at 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
26957 Northwestern Highway, Suite 400
Southfield, MI 48033

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 Link > My Practice Profile Tool.

Otherwise, complete detailed information about the change, the effective date of the change and a W-9 on your office letterhead. Email this information to the email address 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 Data Management application on **UHCprovider.com**. Go to **UHCprovider.com** > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form. Or submit your change by:

- Completing the Provider Demographic Change Form and faxing it to the appropriate number listed on the bottom of the form.
- Calling our Enterprise Voice Portal.

AFTER-HOURS CARE

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

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

PARTICIPATE IN QUALITY INITIATIVES

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

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

PROVIDE ACCESS TO YOUR RECORDS

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. 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 post-payment evaluations of their claims paid by the health plan.

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

 You may view protocols at **UHCprovider.com**.

OFFICE HOURS

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

PROTECT CONFIDENTIALITY OF MEMBER DATA

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

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

FOLLOW MEDICAL RECORD STANDARDS

Please reference Chapter 9 for Medical Record Standards.

INFORM MEMBERS OF ADVANCE DIRECTIVES

The federal Patient Self-determination Act (PSDA) gives 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 law about advance treatment directives, about members' right to accept or refuse treatment, and about 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.

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 Disputes, 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 appointment type: 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

You must confirm your provider data every quarter. You may do this through LINK or by calling Provider Services. If you have received the upgraded My Practice Profile and have editing rights, access Link's My Practice Profile App to make many of the updates required in this section.

Prior Authorization Request

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

Coverage may only be provided if the service or medication is deemed medically necessary, or meets specific requirements provided in the benefit plan. Services requiring prior authorization must have a certification number from UnitedHealthcare Community Plan before services are rendered. You must call or fax 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 Link at **UHCprovider.com/eligibility** or by calling Provider Services. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- Get prior authorization from Link:
    1. To access the Prior Authorization app, go to **UHCprovider.com**, then click **Link**.
    2. Select the **Prior Authorization and Notification app** on Link.
    3. View notification requirements.

Identify and bill other insurance carriers when appropriate.

If you have questions, please call the UnitedHealthcare Connectivity Help Desk at **866-842-3278**, option 3, 7 a.m. – 9 p.m. Eastern Time, Monday through Friday.

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 (M.D.s), doctors of osteopathy (DOs), nurse practitioners (NPs)* and physician assistants (PAs)* from any of the following practice areas can be PCPs:

- General practice
- Internal medicine
- Family practice
- Pediatrics

Nurse practitioners may enroll with the state as solo providers, but physician assistants cannot; they must be part of a group practice.

Members may change their assigned PCP by contacting **Member Services** at any time during the month. Customer Service is available 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.

You may print a monthly Primary Care Provider Panel Roster by visiting **UHCprovider.com**.

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

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

Females have direct access (without a referral or authorization) to any OB/GYNs, 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 Prior Authorization Department, UnitedHealthcare Community Plan Clinical, or Pharmacy Department as appropriate.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether or not a member has an advance directive form.
  - Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
  - Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
  - Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
  - Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
  - Complying with the Michigan DHHS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.

Rural Health Clinic or Federally Qualified Health Center

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. RHCs can be public, nonprofit or for-profit health care facilities. They must be located in rural, underserved areas.
- **Federally Qualified Health Center:** An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a care provider, physician assistant, nurse practitioner and/or social worker.
  - Mental health services.
  - Immunizations (shots).
  - Home nurse visits.

Primary Care Provider Checklist

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

- Verify eligibility using Link at **UHCprovider.com/eligibility** or by calling Provider Services.
- Verify member identity with photo identification, if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth** to locate and view the current prior authorization information and notification requirements.
- Refer to UnitedHealthcare Community Plan participating specialists unless we authorize otherwise. It is your responsibility to obtain the specialist's consultation report and help ensure the recommendations are implemented.
- 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. Submit on a UB-04 form if assigned to a care provider within a clinic. See Chapter 11 for more information on submitting forms.

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 serving in the PCP role must be available to members by phone 24 hours a day, seven days a week. Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

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

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

Prenatal Care Responsibilities

Notify UnitedHealthcare Community Plan as soon as a member confirms pregnancy. You must notify us if a member's pregnancy is determined to be high risk. This helps ensure appropriate follow-up and coordination by the **UnitedHealthcare Healthy First Steps** coordinator.

If you have questions, call **Healthy First Steps**. To begin patient outreach, fax the prenatal assessment form.

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

Refer members to local maternal and infant support providers, and to the Women, Infants & Children (WIC) Program. Contact us for information about community-based support programs such as WIC, perinatal education classes, and others. Document educational services you provided in the member's medical record.

UnitedHealthcare Community Plan adopts Michigan Quality Improvement Consortium (MQIC) guidelines for Routine Prenatal and Postnatal Care. View the MQIC Guidelines at **mqic.com**.

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.

Ancillary Care Provider Checklist

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

- Verify the member's enrollment before rendering services. Go to Link at **UHCprovider.com** or contact **Provider Services**. Failure to verify member enrollment and assignment may result in claim denial.
- Check the member's ID card each time the member has services. Verify against photo ID if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth**.
- Identify and bill other insurance carriers, when appropriate.

Chapter 3: Care Provider Office Procedures and Member Benefits

Assignment to PCP Panel Roster

Once a member is assigned a PCP, view the panel rosters electronically on the **UHCprovider.com** application on Link. The portal requires a unique user name and password combination to gain access.

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

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

Choosing a Primary Care Provider

Each 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 the **Medicaid Inquiry line**.

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.

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

Member Eligibility

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

Member ID Card

Our members receive 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, notify UnitedHealthcare Community Plan in writing, as discussed in Chapter 12 of this manual. 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:

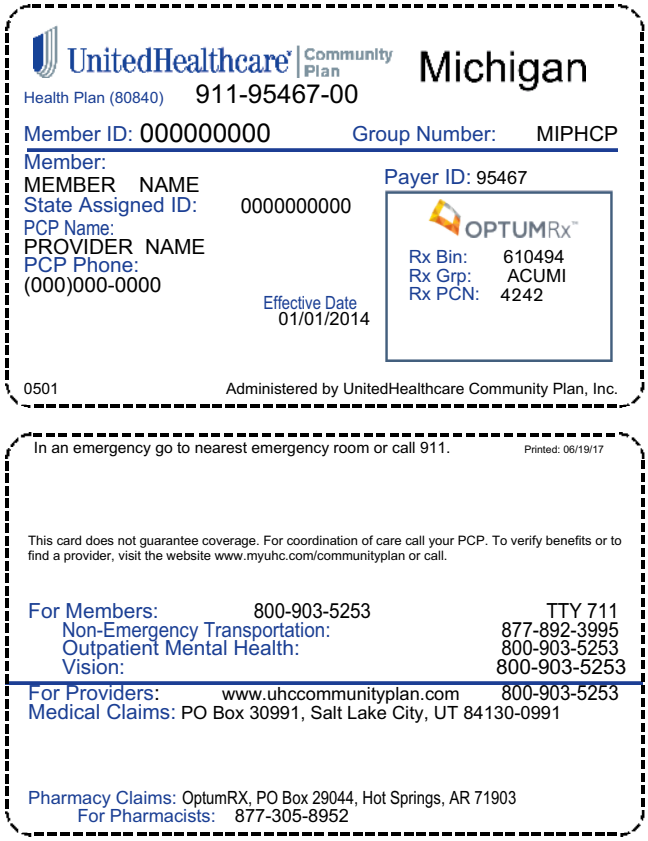
- The member displays violent or life-threatening behavior involving physical acts of violence, physical or verbal threats of violence against you or your staff, threats or violence at your location, or when the member is determined to be an excessive menace to you or your staff.
- You and/or UnitedHealthcare 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 emergency room use and other situations impeding care.

1. To transfer the member, contact UnitedHealthcare Community Plan by mail 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

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

Sample Health Member ID Card



Verifying Member Enrollment

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

- Provider Portal: access the Link portal through **UHCprovider.com/eligibility**
- **UnitedHealthcare Provider Service** is available from 7 a.m. - 5 p.m. Eastern Time, Monday through Friday.
- **Michigan Medicaid Eligibility System (MES)**

Benefit Information

To view member benefit coverage information go to **UHCCommunityPlan.com/MI** > select the applicable plan > Member Handbook.

UnitedHealthcare Dual Complete (HMO SNP)

For information regarding UnitedHealthcare Dual Complete, please see Chapter 4 of the Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for Commercial and Medicare Advantage Products. For state-specific information, go to **UHCprovider.com** > Menu > Health Plans by State.

Chapter 4: Medical Management

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

Ambulance Services

AIR AMBULANCE

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

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

EMERGENCY AMBULANCE TRANSPORTATION

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

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

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

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

NON-EMERGENT AMBULANCE TRANSPORTATION

UnitedHealthcare Community Plan members may get non-emergent transportation services through LogistiCare for covered services. Covered transportation includes sedan, taxi, wheelchair-equipped vehicle, public transit, mileage repayment and shared rides.

For non-urgent appointments, members must call for transportation at least four days before their appointment by phone at 800-903-5253.

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.

Case Management

Our Case Management Program coordinates health care services for our medically complex and high-risk members.

Case Management involves:

- Coordinating member's health care services, including home health care.
- Member and family education about the illness, maintaining wellness and preventing acute episodes.
- Reducing exacerbations resulting in emergency room visits and hospital readmissions.
- Care coordination is performed by case managers and outreach specialists.

The Case Management process is most successful in achieving desired outcomes when medically complex and high-risk members are identified early and UnitedHealthcare Community Plan case managers, in collaboration with the member's health care providers, can initiate interventions as soon as possible.

If you have a UnitedHealthcare Community Plan member who may benefit from this program, please call us at **800-903-5253**.

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:

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

Phone: 517-335-8165

Fax: 517-335-8121

After hour emergency calls only: 517-335-9030

Online:

- **Michigan.gov/mdhhs/**: for more communicable disease information, resources and reporting
- Find a county health department and contact information at **Michigan.gov/mdhhs/**

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.

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

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.

Emergency/Urgent Care Services

Emergency services do not require prior authorization.

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

Covered services include:

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

EMERGENCY ROOM CARE

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

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

URGENT CARE (NON-EMERGENT)

Urgent care services are covered.

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

Emergency Care Resulting in Admissions

Prior authorization is not required for emergency services.

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

Emergency care should be delivered without delay. Notify UnitedHealth Community Plan about admission. Call the **Prior Authorization Department** or **fax** your Prior Authorization Form by 5 p.m. the next business day. (The form is located at **UHCprovider.com/priorauth**.)

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 the Prior Authorization Department (UM Department, etc.)

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

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

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.

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, or fax your hospital review to 855-225-9847. Fax clinical admission information to 800-882-1105.

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 or fax for concurrent review, before the exhaustion of the initial or approved length of stay.
- The facility must contact us with discharge information by phone or fax 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, X-rays, Imaging Procedures

Please refer to the prior authorization list at **UHCprovider.com/MICommunityPlan** > Prior Authorization and Notification for imaging authorization requirements.

LAB SERVICES

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 Encounters chapter for more information.

Maternity/Pregnancy/ Well-Child Care

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.

For more information about global days, go to **UHCprovider.com**.

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.

Care providers should notify UnitedHealthcare Community Plan immediately of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program. You must notify UnitedHealthcare Community Plan if a member's pregnancy is determined to be high risk.

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

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

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. Emergency room labor checks do not require prior authorization. A labor check is a stay for maternity purposes of less than six hours.

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

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

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

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

- Date 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.

NEWBORN ENROLLMENT

The hospital is responsible to notify MDHHS of all deliveries, including UnitedHealthcare Community Plan members (provided the mother was admitted using her ID card).

BRIGHT FUTURES ASSESSMENT

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

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

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

HYSTERECTOMIES

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

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

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

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 situation in which prior acknowledgment was not possible. Include a description of the emergency.

Before claim submission fax the completed consent form and UnitedHealthcare Community Plan's Consent Submission Form to 855-237-1213, or mail your claim with completed consent form attached 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 fax the completed consent form and UnitedHealthcare Community Plan's Consent Submission Form to 855-237-1213, or mail your claim with completed consent form attached 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 Resource Services (NICU Case Management)

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

NRS neonatologists and NICU nurses manage NICU members through evidence-based medicine and care plan use.

The NRS nurse case manager will:

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

The NRS nurse case manager's role includes:

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

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

Pharmacy Programs

PREFERRED DRUG LIST (PDL)

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**.

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
Fax: 866-940-7328

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, and fax them to UnitedHealthcare Community Plan National Intake at **855-225-9847**.

Submit prior authorization or exception requests to Pharmacy Services by completing and faxing a prior authorization form to **866-940-7328**. A prior authorization or exception request can also be called in to **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 faxes 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.

Drugs on the Preferred Drug List (PDL) that are part of this program are identified by a "SP" in the "Requirements and Limits" section of each page.

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 separate code. You may provide a brief intervention on the same day as a full screen in addition to the E/M exam. You may also perform a brief intervention on subsequent days. Brief interventions are limited to four sessions per patient, per provider per calendar year.

WHAT IS INCLUDED IN SBIRT?

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

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

Referral to treatment: Refer members whose screening indicates a severe problem or dependence 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
- Emergency room – hospital
- Federally qualified health center (FQHC)
- Community mental health center
- Indian health service – free standing facility
- Tribal 638 free standing facility
- Homeless shelter

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**.

Medical Management Guidelines

ADMISSION AUTHORIZATION AND PRIOR AUTHORIZATION GUIDELINES

All prior authorizations must have the following:

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

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

Locate the Prior Authorization Fax Request Form at **UHCprovider.com/priorauth**. If you have questions, please call **Prior Authorization Intake**.

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 call or fax request(s) to us no less than three business days before the planned service date.
- You can fax your prior authorization request to us at **855-225-9847**.

- 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.

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

Concurrent Review Guidelines

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

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

CONCURRENT REVIEW DETAILS

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

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

Your cooperation is required with all UnitedHealthcare Community Plan requests from our interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone. You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide all requested and complete clinical information and/or documents as required within four hours of receipt of our request if it is received before 1 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1 p.m. local time (but no later than 12 p.m. local time the next business day).

UnitedHealthcare Community Plan uses MCG (formally Milliman Care Guidelines), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, skilled nursing facilities, home health care 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**.

PREVENTIVE HEALTH AND CLINICAL PRACTICE GUIDELINES

UnitedHealthcare Community Plan participates in the Michigan Quality Improvement Consortium (MQIC). MQIC Preventive Health Guidelines (PHGs) and Clinical Practice Guidelines (CPGs) are reviewed every two years for changes in evidence-based national standards of care and updated as appropriate.

View the MQIC Guidelines at **mqic.com**. Care providers may obtain a paper copy of the guidelines by contacting your provider or hospital and facility advocate.

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** > Policies and Protocols > Community Plan Policies > 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 LINK 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/priorauth**.

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 **866-815-5334** to discuss the guidelines and utilization management.

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

UTILIZATION MANAGEMENT (UM) APPEALS

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

Chapter 5: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)/Prevention

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

Follow the EPSDT 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**.

To find the Healthy Child Forms, go to: **brightfutures.aap.org**.

Find details on how to fill out the Healthy Child form at: **toolkits.solutions.aap.org**.

Early On Program

The Early On Program provides early intervention services to infants and toddlers with disabilities and their families.

Referral – refer children who are identified as potentially requiring developmental intervention services to the appropriate agency for evaluation once you identified the need for services. Provide information as requested to complete the referral process. If the child has a visual impairment, hearing impairment, or severe orthopedic impairment, or any combination of these impairments, contact the Local Education Agency (LEA) for evaluation and early intervention services. After contacting the regional center or local education agency, a service coordinator will be assigned to help the child's parents through the process to determine eligibility.

Continuity of Care – support the development of the Individualized Family Service Plan (IFSP) developed by the Early Start Program through either the RC or LEA. The assigned coordinator will help the local Regional Center or local Early Start Program and you to ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the IFSP. UnitedHealthcare Community Plan provides member case management and care coordination to help ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the IFSP developed by the Early Start Program, with your participation.

Find more information and resources at **ihp.msu.edu**.

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 HCY [Healthy Children and Youth] Lead Risk Assessment form.)
- Personal-social and language skills
- Fine motor/gross motor skills
- Hearing
- Vision
- Dental

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

Interperiodic Screens

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

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

Lead Screening/Treatment

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** 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**.

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**.

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.

Contact **VFC** with questions.
Phone: 800-219-3224
Fax: 573-526-5220

State of Michigan Division of Communicable Disease and Immunizations:
517-335-8159.

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

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

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

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**.

Baby Blocks™ Program

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

BABY BLOCKS™ BENEFIT

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

How it Works

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

How You Can Help

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

Members self-enroll on a smartphone or computer. They can go to **UHCBabyBlocks.com** and click on "Sign Up Here."

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**.

Healthify

This web-based referral tool helps members gain access to food, housing, employment, energy, support groups, child care, and clothing. It is for members at risk for poor outcomes or inappropriate health care use.

Healthy First Steps

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

HFS-MATERNAL CARE MODEL

The HFS-Maternal care model strives to:

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

Tell UnitedHealthcare Community Plan when a member becomes pregnant. Faxing a Prenatal Risk Assessment form to the **Healthy First Steps program** at **877-353-6913** will initiate case management program outreach.

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.

My HealthLine (cellphone program)

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

This Federal Lifeline program provides the cellphones. Our members who meet federal eligibility requirements receive 350 voice minutes per month and unlimited texting, plus a pre-programmed member services number that does not count against the minutes. They are also automatically enrolled in the Connect4health texting program.

Non-Emergency Transportation

Some members require non-emergency transportation (NEMT) to and from services beyond what the state agency covers. NEMT provides crucial support in helping improve our members' access to care. All members eligible for state-approved transportation services are qualified for this additional health benefit.

NEMT includes unlimited trips to and from WIC, methadone clinics, inpatient behavioral health and to the pharmacy immediately following a covered service appointment. To request and schedule rides, members call LogistiCare directly, 24 hours a day, seven days a week.

If members need assistance in scheduling rides, the service coordinators, Member Services Advocates (MSAs) and the mobility manager can assist. Services may be scheduled up to 14 days in advance. Hotel stays will be paid for trips that require an overnight stay with prior approval for eligible members.

Urgent non-emergency trips, such as when a member is discharged from the hospital, may be made through the call center after 7 p.m. Eastern Time. Urgent calls are the ONLY calls taken in person by a reservation specialist after 7 p.m. Eastern Time. Schedule rides up to 30 days in advance.

For non-urgent appointments, members must call LogistiCare at **877-892-3995**, for transportation at least four days before their appointment.

IMPORTANT TRANSPORTATION BENEFIT INFORMATION

- Transportation is for the member only, unless the member is a child or an adult needing assistance.
- Transportation from a member's residence to a pharmacy is not covered. Pharmacy stops can be made when the pharmacy is on the route between the care provider's office and the member's return destination.
- Share transportation issues or problems with your provider advocate.

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.

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.

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**.

Women, Infants and Children Supplemental Nutrition Program (WIC)

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

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

A current hemoglobin or hematocrit is required:

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

Contact Information: **signupwic.com**

Chapter 7: Mental Health and Substance Use

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

Credentialing

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 Link at **UHCprovider.com**.

Authorizations

Prior authorization is required for out-of-network care providers. Get prior authorization by going to **UHCprovider.com/priorauth**, calling **866-604-3267**, or faxing **844-881-4772**.

Collaboration with Other Health Care Professionals

COORDINATION OF CARE

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

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

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

Portal Access

Website: **UHCprovider.com**

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

View the Prior Authorization list, find forms and access the care provider manual. Or call 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 **866-815-5334**.

Appeals and Grievances

Call **800-903-5253** and a Provider Services representative will assist you with the Appeals and Grievances process. You may file an appeal with written consent from the member within 60 calendar days of the notice of action.

Send written requests to:

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

Claims

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

Monitoring Audits

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

Addressing the Opioid Epidemic

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

BRIEF SUMMARY OF FRAMEWORK

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

INCREASING EDUCATION & AWARENESS OF OPIOIDS

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep Opioid Use Disorders (OUD) related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical

practice guidelines, free substance use disorders/ OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, "The Role of the Health Care Team in Solving the Opioid Epidemic," and "The Fight Against the Prescription Opioid Abuse Epidemic." While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

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

PRESCRIBING OPIOIDS

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

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.

Chapter 8: Member Rights and Responsibilities

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 assert member rights.

ACCESS TO PROTECTED HEALTH INFORMATION

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

AMENDMENT OF PHI

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

ACCOUNTING OF DISCLOSURES

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

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

RIGHT TO REQUEST RESTRICTIONS

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

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

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

Member Rights and Responsibilities

The following information is in the Member Handbook 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.
- Give and 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.

MEMBER RESPONSIBILITIES

Members should:

- Understand their benefits so they can get the most value from them.
- Show you their Medicaid member ID card.
- Inform us of other health insurance coverage.
- Always carry their member ID card and prevent others from using their ID card.
- Understand their health problems and give you true and complete information.
- Ask questions about treatment.
- Work with you to set treatment goals.
- Follow the agreed-upon treatment plan.
- Tell you their complete health history, and about any changes in their health.
- Get to know you before they are sick.
- Keep appointments or tell you when they cannot keep them.
- Treat your staff and our staff with respect and courtesy.
- Get any approvals needed before receiving treatment.

- Use the emergency room only during a serious threat to life or health.
- Report emergency treatment to you within 48 hours. Report an emergency stay at a hospital soon after.
- Notify us of any change in address or family status.
- Make sure you are in-network.
- Follow your advice and understand what may happen if they do not follow it.
- Give you and us information that could help improve their health.
- Know the name(s) of their medication(s), what they are for and how to use them.
- Tell us if they move or change phone numbers.
- Respect the rights of other UnitedHealthcare Community Plan members, doctors and staff.

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:

SCREENING AND DOCUMENTATION TOOLS

These tools were developed to help you follow regulatory requirements and practice.

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 primary care provider 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 enhance patient safety
- Tracking member and provider satisfaction and take actions as appropriate

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

COOPERATION WITH QUALITY-IMPROVEMENT ACTIVITIES

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

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

Quality Improvement Program

UnitedHealthcare Community Plan considers all QI activities privileged and confidential, consistent with state and federal laws. We require your cooperation and compliance to:

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

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

CORRECTIVE ACTION PLANS

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

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

QUALITY OF CARE CASE REFERRAL

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

- Phone: 800-903-5253
- Fax: 248-331-4519
- In writing to:

  UnitedHealthcare Community Plan
  Quality Management Department
  26957 Northwestern Highway, Suite 400
  Southfield, MI 48033

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, skilled nursing facilities 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
- Nurse practitioners and physician assistants who practice under a credentialed UnitedHealthcare Community Plan care provider.

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

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

First-time applicants must call the **National Credentialing Center (VETTS line)** to get a CAQH number and complete the application online.

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

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

ADVANCE DIRECTIVES

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

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

Peer Review

CREDENTIALING PROCESS

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

RECREDENTIALING PROCESS

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

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

PERFORMANCE REVIEW

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

APPLICANT RIGHTS AND NOTIFICATION

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

CONFIDENTIALITY

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

Resolving Disputes

CONTRACT CONCERNS

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

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

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

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

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

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

HIPAA Compliance – Your Responsibilities

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

TRANSACTIONS AND CODE SETS

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

UNIQUE IDENTIFIER

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

NATIONAL PROVIDER IDENTIFIER (NPI)

The National Provider Identifier (NPI) is your standard unique identifier. It is a 10-digit number with no embedded intelligence that covered entities must accept

and use in standard transactions. While HIPAA only requires you to use the NPI in electronic transactions, many state agencies require it on fee-for-service claims and on encounter submissions. For this reason, UnitedHealthcare Community Plan requires the NPI on paper transactions.

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

PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

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

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

SECURITY

Covered entities must meet basic security measures:

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

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

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

Ethics & Integrity

INTRODUCTION

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

COMPLIANCE PROGRAM

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

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

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

REPORTING AND AUDITING

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

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

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

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

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

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

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. 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, the Centers for Medicare & Medicaid Services, the Office of Inspector General, or any other agency prior-approved by the state, at any time during your Provider Agreement.

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

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

DELEGATING AND SUBCONTRACTING

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

Office Site Quality

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

QOS Issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determines to pose a risk to patient safety	One complaint
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determines to pose a risk to patient safety	Two complaints in six months
Other	All other complaints concerning the office facilities	Three complaints in six months

Chapter 11: Billing and Submission

Our Claims Process

UnitedHealthcare Community Plan follows the same claims process as UnitedHealthcare.

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

National Provider Identifier

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

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

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

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

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

Fee Schedule

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

Modifier Codes

Use the appropriate **modifier codes** on your claim form. 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 nurse practitioners or physician assistants who are part of a collaborative agreement.

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.

- OptumInsight can provide you with clearinghouse connectivity or your software vendor can connect through an entity that uses OptumInsight.
- 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.

If you treat another diagnosis, use that ICD CM code as well.

For more information, contact **EDI Claims**. You can also see **enshealth.com** or contact your provider or hospital and facility advocate.

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.

Importance and Usage of EDI Acknowledgment/Status Reports

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

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

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

e-Business Support

UnitedHealthcare Community Plan offices are open 8:30 a.m. – 5:30 p.m. Eastern Time, Monday through Friday. They can help you with Electronic Remittance Advices (ERAs) and Electronic Funds Transfers (EFTs). To use ERAs, you must enroll through a clearinghouse or entity that uses OptumInsight.

Support is also available for **EDI Claims** and **EDI Log-on Issues**.

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

IMPORTANT EDI PAYER INFORMATION

- Claim Payer ID: 95467
- ERA Payer ID: UFNEP

Completing the CMS 1500 Claim Form

Companion documents for 837 transactions are on **UHCprovider.com**, Click Menu, then Resource Library to find the EDI section.

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 emergency room 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

CAPITATED CARE PROVIDERS

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 of time. We pay you whether or not 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.

Please contact your Provider Advocate for more information or questions.

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 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.

Correct Coding Initiative

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

COMPREHENSIVE AND COMPONENT CODES

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

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

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**.

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

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

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

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

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

Find Link training on **UHCprovider.com**.

Resolving Claim Issues

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

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 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

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

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

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
SITUATION	**DEFINITION**	**WHO MAY SUBMIT?**	**SUBMISSION ADDRESS**	**ONLINE FORM FOR FAX OR MAIL**	**CONTACT PHONE NUMBER/ FAX**	**WEBSITE (Care Providers Only) for Online Submissions**	**CARE PROVIDER FILING TIMEFRAME**	**UnitedHealthcare Community Plan RESPONSE TIMEFRAME**
Care Provider Claim Correction (Resubmission)	Creating a new claim. If a claim was denied, you need to submit a claim correction and enter a 7 in box 22 for a HCFA and use xx7 bill type on a UB. Resubmitting a new claim will result in a duplicate denial.	Care Provider	UnitedHealthcare Community Plan P.O. Box 30991 Salt Lake City, UT 84130-0991	**UHC provider.com/claims**	866-331-2243	Use the Claims Management or ClaimsLink application on Link. To access Link, go to **UHCprovider.com/link**.	Re-submit corrected claims within 12 months from service date	30 business days
Care Provider Claim Reconsideration (step 1 of claim dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care Provider	UnitedHealthcare Community Plan P.O. Box 30991 Salt Lake City, UT 84130-0991	**UHC provider.com/claims**	866-815-5334 Fax: 801-994-1224	Use the Claims Management or ClaimsLink application on Link. To access Link, go to **UHCprovider.com/link**.	Must receive within 365 calendar days of the claim processing date	30 business days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
SITUATION	**DEFINITION**	**WHO MAY SUBMIT?**	**SUBMISSION ADDRESS**	**ONLINE FORM FOR FAX OR MAIL**	**CONTACT PHONE NUMBER/ FAX**	**WEBSITE (Care Providers Only) for Online Submissions**	**CARE PROVIDER FILING TIMEFRAME**	**UnitedHealthcare Community Plan RESPONSE TIMEFRAME**
Care Provider Claim Formal Appeal (step 2 of claim dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care Provider	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 30991 Salt Lake City, UT 84130-0991	**UHC provider.com/claims**	866-331-2243 Fax: 801-994-1082	Use the Claims Management or ClaimsLink application on Link. To access Link, go to **UHCprovider.com/link**.	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	30 business days

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

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

Denial

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

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 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 Link. To access Link, sign in to **UHCprovider.com** using your Optum ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Mailing address:

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

Additional Information:

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

Resubmitting a Claim

What is it?

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

When to use it:

Resubmit the claim if it was rejected. A rejected claim is one that has not been processed due to problems detected before claim processing. Since rejected claims have not been processed yet, there is no appeal - the claim needs to be corrected through resubmission.

Common Reasons for Rejected Claims:

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

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

How to use:

To resubmit the claim, follow the same submission instructions as a new claim. 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 to use:

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, mail or fax:

- **Electronically:** Use the Claim Reconsideration application on Link. Include electronic attachments. You may also check your status using Link.
- **Phone:** Call Provider Services at **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**.
- **Fax:** Send the Claim Reconsideration Request Form to **801-994-1224**.

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, mail or fax with the following information:

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

Additional Information:

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

Appeals (step two of dispute)

What is it?

An appeal is a second review of a reconsideration claim.

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:

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

- **Electronic claims:** Use the Claims Management or ClaimsLink application on Link. You may upload attachments. Include confirmation that UnitedHealthcare Community Plan or one of its affiliates received and accepted your claim.
- **Mail:** Send the appeal to:

  UnitedHealthcare Community Plan
  Grievances and Appeals
  P.O. Box 30991
  Salt Lake City, UT 84130-0991
- **Fax:** Send the appeal to **801-994-1082**.

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.

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.

Overpayment

What is it?

An overpayment happens when we overpay a claim you don't dispute.

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 Return Overpayment through the Adjustment Request form.

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

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

Where to send:

Mail refunds with an Overpayment Return Check or the Return Overpayment through Adjustment Request form to:

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

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

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

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

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

Sample Overpayment Report

***The information provided is sample data only for illustrative purposes.**
Please populate and return with the data relevant to your claims that have been overpaid.

Member ID	Date of Service	Original Claim #	Date of Payment	Paid Amount	Amount of Overpayment	Reason for Overpayment
11111	01/01/14	14A000000001	01/31/14	115.03	115.03	Double payment of claim
2222222	02/02/14	14A000000002	03/15/14	279.34	27.19	Contract states $50, claim paid 77.29
3333333	03/03/14	14A000000003	04/01/14	131.41	99.81	You paid 4 units, we billed only 1
44444444	04/04/14	14A000000004	05/02/14	412.26	412.26	Member has other insurance
55555555	05/05/14	14A000000005	06/15/14	332.63	332.63	Member terminated

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**.

Fraud, Waste and Abuse

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

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

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

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

UnitedHealthcare Community Plan has a legal responsibility to report incidents to the Centers for Medicare and Medicaid Services (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
26957 Northwestern Highway, Suite 400
Southfield, MI 48033
800-903-5253

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

Find the UnitedHealth Group policy on Fraud, Waste and Abuse by calling us at **800-903-5253**, the Office of Inspector General at **855-643-7283**, or going online to **michigan.gov/fraud**.

Chapter 13: Care Provider Communications & Outreach

The UnitedHealthcare Community Plan care provider education and training program is built on years of experience with you and 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
- Quality and utilization requirements
- Educational materials such as newsletters and bulletins
- Provider service updates – new tools and initiatives (UHC on Air, PreCheck MyScript, etc.)

In addition, we have created a member website that gives access to the Member Handbook, newsletters, provider search tool and other important plan information. It is **UHCCommunityPlan.com** > select Member.

Care Provider Office Visits

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

Care Provider Newsletters and Bulletins

UnitedHealthcare Community Plan produces a care provider newsletter to the entire 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

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

Find more information about the Network Bulletin, Medical Policy Update Bulletin and other communications on **UHCprovider.com/guides** > Provider Communication Chapter 17.

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)

Chapter 14: 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 as defined by A.R.S 46-451.

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

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.

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 a decision that denies a benefit or payment (either in whole or in part).

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.

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

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

Disallow Amount (Amt)
Medical charges for which the network provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member. Examples are:

- The difference between billed charges and in-network rates.
- Charges for bundled or unbundled services as detected by Correct Coding Initiative edits.

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

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

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

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 an patient enrolled with UnitedHealthcare Community Plan on the date of service. You are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan electronically reports these encounters to state Medicaid. The state audits encounter submission accuracy and timeliness on a regular basis.

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

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

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

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

Expedited Grievance
A grievance where delay in resolution could harm the member's health or life.

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

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

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 serious danger; or

- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body.

Medically Necessary
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.

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

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

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

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

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 or care provider does not agree with a Notice of Decision or 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.