2022
Care Provider Manual
Physician, Health Care Professional, Facility and Ancillary
North Carolina
Welcome

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

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.

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(s) as “Agreement.” You must comply with the conditions in this Agreement.

Terms and definitions as used in this manual:

- “Member” or “customer” refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement.
- “You,” “your” or “provider” refers to any health care provider subject to this manual, including physicians, health care professionals, facilities and ancillary providers; except when indicated and all items are applicable to all types of health care providers subject to this guide.

Easily find information in this manual using the following steps:

1. Select CTRL+F.
2. Type in the key word.
3. Press Enter.
• Community Plan refers to UnitedHealthcare’s Medicaid plan
• “Your Agreement,” “Provider Agreement” or “Agreement” refers to your Participation Agreement with us.
• “Us,” “we” or “our” refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this guide.
• Any reference to “ID card” includes both a physical or digital card.
# Table of Contents

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 1: Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Chapter 2: Care Provider Standards &amp; Policies</td>
<td>17</td>
</tr>
<tr>
<td>Chapter 3: Care Provider Office Procedures and Member Benefits</td>
<td>31</td>
</tr>
<tr>
<td>Chapter 4: Medical Management</td>
<td>39</td>
</tr>
<tr>
<td>Chapter 5: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)/Prevention</td>
<td>57</td>
</tr>
<tr>
<td>Chapter 6: Value-Added Services</td>
<td>61</td>
</tr>
<tr>
<td>Chapter 7: Mental Health and Substance Use</td>
<td>63</td>
</tr>
<tr>
<td>Chapter 8: Member Rights and Responsibilities</td>
<td>67</td>
</tr>
<tr>
<td>Chapter 9: Medical Records</td>
<td>69</td>
</tr>
<tr>
<td>Chapter 10: Quality Management (QM) Program and Compliance Information</td>
<td>73</td>
</tr>
<tr>
<td>Chapter 11: Billing and Submission</td>
<td>79</td>
</tr>
<tr>
<td>Chapter 12: Claim Reconsiderations, Appeals and Grievances</td>
<td>87</td>
</tr>
<tr>
<td>Chapter 13: Care Provider Communications and Outreach</td>
<td>98</td>
</tr>
<tr>
<td>Glossary</td>
<td>100</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>UHCprovider.com</td>
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<tr>
<td>Training</td>
<td>UHCprovider.com/training</td>
<td></td>
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<tr>
<td>Provider Portal</td>
<td>UHCprovider.com, then Sign In using your One Healthcare ID or go to Provider Portal Self Service: UHCprovider.com/en/resource-library/link-provider-self-service.html</td>
<td>800-638-3302</td>
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<td></td>
<td>New users: UHCprovider.com &gt; New User and User Access</td>
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<tr>
<td>Provider Portal Training</td>
<td>UHCprovider.com/training</td>
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<td></td>
<td>or go to Provider Portal Self Service</td>
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<tr>
<td>Provider Portal Support</td>
<td>email: <a href="mailto:ProviderTechSupport@uhc.com">ProviderTechSupport@uhc.com</a></td>
<td>855-819-5909</td>
</tr>
<tr>
<td>Resource Library</td>
<td>UHCprovider.com &gt; Menu &gt; Resource Library</td>
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</tbody>
</table>

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

This manual applies to services provided under your Agreement(s) with UnitedHealthcare Community Plan and Optum. For care providers delivering behavioral health services and/or SUD services, this manual does not replace the Optum National Network Manual. Behavioral health and SUD services are described in detail in Chapter 7 of this manual, however the Optum National Network Manual provides the full scope of information needed for behavioral health and SUD care providers. This manual will direct you to the Optum National Network Manual as required.

UnitedHealthcare Community Plan supports the North Carolina state goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits to eligible North Carolinians. The North Carolina Division of Health Benefits (NC DHHS) will determine enrollment eligibility through their enrollment broker MAXIMUS.

How to join our network

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

Already in network and need to make a change?

To change an address, phone number, add or remove physicians from your TIN, or other changes, go to My Practice Profile.

If you have questions about the information in this manual or about our policies, go to UHCprovider.com or call Provider Services at 800-638-3302.
### Approach to health care

#### Care Model

The Care Model program helps empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community to improve care coordination and raise outcomes. Targeting UnitedHealthcare Community Plan members with chronic complex conditions, the program addresses their needs holistically by referral to care management delivered either by medical home or internal care management team.

The program provides care management to members with complex medical, behavioral, social, pharmacy and specialty needs. The Care Model approach provides a local care management 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.

The Care Model program provides:

- Market-specific local care management involving medical, behavioral and social care.
- An extended care team including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist.
- Engage members, connecting them to needed resources, care and services.
- Personal and multidisciplinary care plans.
- 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.

Care Model goals are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates.
- Improve access to needed services, such as behavioral health (BH) and community resources.
- 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 members to manage their complex illness or problem and care transitions.
- Improve coordination of care through dedicated staff resources and to meet unique needs.
- Engage community and care provider networks to help ensure access to affordable care and the appropriate use of services.

To refer your patient who is a UnitedHealthcare Community Plan member to the Care Model program, call Member Services at 800-349-1855, TTY 711. You may also call Provider Services at 800-638-3302.

### Compliance

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

### Cultural resources

You must support UnitedHealthcare Community Plan’s and the state of North Carolina’s efforts to promote culturally competent care delivery to all members. This includes members with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds. Render services regardless of gender, sexual orientation or gender identity.

You must also provide interpreter services in the member’s primary language and for the hearing impaired for all appointments and emergency services. In addition, you must provide information about care options and alternatives as well as complaints and appeals. Deliver this information in a manner appropriate to the member’s condition and ability to understand.

You must provide physical access, reasonable accommodations, and related equipment for members.
with physical or mental disabilities. This includes the following interpretation and translation services:

- You must provide qualified sign language interpreters if closed captioning is not the appropriate aid.
- You must help ensure your staff can appropriately communicate with members who have hearing loss.
- You will report to UnitedHealthcare Community Plan, in a format and frequency we determine, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.

To help you meet these requirements, we have developed a Cultural Competency Program with the following 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, they can call the phone number on their ID card.
  - If you need to call a professional interpreter during regular business hours, call Provider Services at 800-638-3302. After business hours, call our Language Lines Solutions team at 877-261-6608.
  - Enter the client payer ID 219219 (do not hit #). Press 1 for Spanish and 2 for all other languages.
- **Care provider resources**: Go to [UHCprovider.com](http://UHCprovider.com/en/resource-library/patient-health-safety/cultural-competency.html) for online trainings that help you effectively deliver care that meet members’ social, cultural, and linguistic needs. These tools are available to help serve all members, including Tribal populations.
- **Materials for limited English speaking members**: We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members. For more information, go to [uhc.com/legal/nondiscrimination-and-language-assistance-notices](http://uhc.com/legal/nondiscrimination-and-language-assistance-notices).

**Evidence-based clinical review criteria and guidelines**

UnitedHealthcare Community Plan uses InterQual (we previously used MCG Guidelines) for medical care determinations.

**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.
- **SMART** Patient allows users to track important numbers such as blood pressure, record appointments, and record doctors’ orders. It also helps them view educational videos.
- **DocGPS** provides mobile users the ability to search UnitedHealthcare Community Plan’s provider network and obtain travel directions to a care provider’s location. The app provides users with the ability to call a care provider by tapping on the search result.

**Online resources**

[UHCprovider.com](http://UHCprovider.com) is your home for care provider information with access to Electronic Data Interchange (EDI), Provider Portal online services, medical policies, news bulletins. It also includes great resources to support administrative tasks such as eligibility, claims, claims status and prior authorizations and notifications, go to [Self Service Tools and Eligibility](http://UHCprovider.com/en/resource-library/link-provider-self-service.html) or go to the Provider Portal Self Service page at [UHCprovider.com](http://UHCprovider.com).

**Electronic Data Interchange (EDI)**

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

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

- Send and receive information faster
- Identify submission errors immediately and avoid processing delays
- Exchange information with multiple payers
- Reduce paper, postal costs and mail time
- Cut administrative expenses

EDI transactions available to care providers are:
- Claims (837),
- Eligibility and benefits (270/271),
- Claims status (276/277),
- Referrals and authorizations (278),
- Hospital admission notifications (278N), and
- Electronic remittance advice (ERA/835).

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

Getting Started

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

Read our Clearinghouse Options page for more information.

Provider Portal - secure care provider website

Provider Portal provides a secure online portal to support your administrative tasks including eligibility, claims and prior authorization and notifications. To sign in to the Provider Portal, go to UHCprovider.com and click the Sign In button in the upper right corner. For more information about all online services, go to Self Service Tools and Eligibility or go to the Provider Portal Self Service page at UHCprovider.com/en/resource-library/link-provider-self-service.html.

For Provider Portal training, go to Provider Portal User Guide.
To access the Provider Portal, the secure care provider website, go to [UHCprovider.com](http://UHCprovider.com) and either sign in or create a user ID. You will receive your user ID and password within 48 hours.

The secure care provider website lets you:

- Verify member eligibility including secondary coverage.
- Review benefits and coverage limits.
- Check prior authorization status.
- Access remittance advice and review recoveries.
- Review your preventive health measure report.
- Access the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) toolset.
- Search for CPT codes. Type the CPT code in the header search box titled “what can I help you find?” on [UHCprovider.com](http://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](http://UHCprovider.com) provider portal. You can now use certain direct URLs, which helps you find and remember specific webpages easily and quickly. You can access our most used and popular web pages on [UHCprovider.com](http://UHCprovider.com) by typing in that page’s direct URL identified by a forward slash in the web address, e.g. [UHCprovider.com/claims](http://UHCprovider.com/claims). When you see that forward slash in our web links, you can copy the direct URL into your web page address bar to quickly access that page.

You will conduct business with us electronically. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use both EDI and UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically. **To access the Provider Portal, go to [UHCprovider.com](http://UHCprovider.com), then click Sign In.**

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

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

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

*For more instructions, visit [UHCprovider.com/Training](http://UHCprovider.com/Training) or [Self Service Tools](http://UHCprovider.com) for online self-service training and information.*

**Direct Connect**

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

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

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

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

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

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

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

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

Provider Ombudsman Program
Contact the NC DHHS Ombudsman Program to assist you with submitting a complaint about UnitedHealthcare Community Plan.

Call the Medicaid Managed Care Provider Ombudsman Program at 866-304-7062 or send an email to the Medicaid Managed Care Provider Ombudsman email address Medicaid.ProviderOmbudsman@dhhs.nc.gov.
Members have a separate ombudsman program.
### How to contact us

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

<table>
<thead>
<tr>
<th>Topic</th>
<th>Contact</th>
<th>Information</th>
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</table>
| Behavioral, Mental Health & Substance Abuse (United Behavioral Health operating under the brand Optum) | Optum [providerexpress.com](https://providerexpress.com)  
800-888-2998 (toll-free)  
877-614-0484 | Eligibility, claims, benefits, authorization, and appeals.  
Refer members for behavioral health services.  
A PCP referral is not required. |
| Benefits                                                   | [UHCprovider.com/benefits](https://UHCprovider.com/benefits)  
800-638-3302 | Confirm a member’s benefits and/or prior authorization.                       |
| Cardiology Prior Authorization (eviCore healthcare)        | For prior authorization or a current list of CPT codes that require prior authorization, visit [UHCprovider.com/cardiology](https://UHCprovider.com/cardiology)  
866-889-8054 | Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information. |
| Care Management Referrals                                  | Provider Services 800-638-3302 | Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing and long-term services and supports. |
| Chiropractor Care                                          | [myoptumhealthphysicalhealth.com](https://myoptumhealthphysicalhealth.com)  
800-873-4575 | 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 Provider Portal at [UHCprovider.com/claims](https://UHCprovider.com/claims)  
800-638-3302 | Verify a claim status or get information about proper completion or submission of claims. |
<table>
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<tr>
<th>Topic</th>
<th>Contact</th>
<th>Information</th>
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| Claim Overpayments                   | See the Overpayment section for requirements before sending your request.  
Sign in to UHCprovider.com/claims to access the Provider Portal, then select the UnitedHealthcare Online app  
800-638-3302  
Mailing address: UnitedHealthcare Community Plan  
ATTN: Recovery Services  
P.O. Box 101760  
Atlanta, GA 30392 | 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 eligibility information, go to UHCprovider.com then Sign In to the Provider Portal or go to UHCprovider.com/eligibility.  
800-638-3302 | Confirm member eligibility.                                                 |
| Enterprise Voice Portal              | 877-842-3210 | The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent. |
| Fraud, Waste and Abuse (Payment Integrity) | Payment Integrity Information: UHCprovider.com/NCcommunityplan > Integrity of Claims, Reports, and Representations to the Government  
Reporting: uhc.com/fraud  
800-455-4521 or 877-401-9430 | Learn about our payment integrity policies.  
Report suspected FWA by a care provider or member by phone or online. |
| Laboratory Services                  | UHCprovider.com > Find Dr > Preferred Lab Network  
LabCorp 800-833-3984  
Quest Diagnostics 866-697-8378 questdiagnostics.com | LabCorp and Quest Diagnostics are nationally contracted lab providers. |
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<thead>
<tr>
<th>Topic</th>
<th>Contact</th>
<th>Information</th>
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<tbody>
<tr>
<td>Medicaid/Health Choice</td>
<td>Medicaid.gov 888-245-0179</td>
<td>Contact Medicaid directly.</td>
</tr>
<tr>
<td>Medical Claims, Reconsiderations, and Appeals</td>
<td>Sign in to the Provider Portal at UHCprovider.com or go to UHCprovider.com/claims for more information. 800-638-3302 Claims and reconsiderations mailing address: UnitedHealthcare Community Plan P.O. Box 5280 Kingston, NY 12402-5240 Appeals mailing address: UnitedHealthcare Community Plan Attn: Grievances and Appeals Unit P.O. Box 31364 Salt Lake City, UT 84131-0364</td>
<td>Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don’t agree with.</td>
</tr>
<tr>
<td>Member Services</td>
<td>myuhc.com 800-349-1855</td>
<td>Assist members with issues or concerns. Available 7 a.m. – 6 p.m. Eastern Time, Monday through Saturday, and all state holidays. Emergency services are available at any time.</td>
</tr>
<tr>
<td>Multilingual/Telecommunication Device for the Deaf (TDD) Services</td>
<td>Member Services 800-349-1855 Language Interpretation Line 877-261-6608 TDD 711</td>
<td>Available 7 a.m. – 6 p.m. Eastern Time, Monday through Friday.</td>
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<tr>
<td>National Plan and Provider Enumeration System (NPPES)</td>
<td>nppes.cms.hhs.gov 800-465-3203</td>
<td>Apply for a National Provider Identifier (NPI).</td>
</tr>
<tr>
<td>Network Management</td>
<td><a href="mailto:CarolinasPRTeam@uhc.com">CarolinasPRTeam@uhc.com</a> 800-638-3302</td>
<td>This is your provider relations team. Ask about contracting and care provider services.</td>
</tr>
<tr>
<td>Network Management Resource Team (NMRT)</td>
<td><a href="mailto:Networkhelp@uhc.com">Networkhelp@uhc.com</a> 877-842-3210</td>
<td>Self-service functionality to update or check credentialing information.</td>
</tr>
<tr>
<td>NurseLine</td>
<td>855-202-0992</td>
<td>Available 24 hours a day, seven days a week.</td>
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<td>Topic</td>
<td>Contact</td>
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<td>Obstetrics/Pregnancy and Baby Care</td>
<td>Healthy First Steps</td>
<td>For pregnant members, complete the Pregnancy Risk Form found at UHCprovider.com or on the North Carolina Medicaid website at medicaid.ncdhhs.gov/media/8475/open. Fax forms to the local health department (LHD) of member’s residence.</td>
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<td></td>
<td>Pregnancy Risk Form at UHCprovider.com &gt; Provider Portal</td>
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<td>Healthy First Steps Rewards</td>
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<td>UHChealthyfirststeps.com</td>
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<td>One Healthcare ID Support Center</td>
<td>email: <a href="mailto:ProviderTechSupport@uhc.com">ProviderTechSupport@uhc.com</a> 855-819-5909</td>
<td>Contact if you have issues with your ID. Available 7 a.m. – 9 p.m. Central Time, Monday through Friday; 6 a.m. – 6 p.m. Central Time, Saturday; and 9 a.m. – 6 p.m. Central Time, Sunday.</td>
</tr>
<tr>
<td>Pharmacy Service Line</td>
<td>UHCprovider.com 855-258-1593 (OptumRx)</td>
<td>Ask about point of sale claims, pharmacy prior authorizations, clinical coverage criteria and other general questions. Resolve claims payment and adjudication issues.</td>
</tr>
<tr>
<td>PreCheck MyScript</td>
<td>UHCprovider.com 866-842-3278, option 3</td>
<td>Use the Provider Portal to access the PreCheck MyScript tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives.</td>
</tr>
<tr>
<td>Prior Authorization/Notification for Pharmacy</td>
<td>UHCprovider.com &gt; Prior Authorization and Notification &gt; Clinical Pharmacy and Specialty Drugs OptumRx Prior Authorization Department P.O. Box 25183 Santa Ana, CA 92799 855-258-1593</td>
<td>Request prior authorization for certain drugs prescribed to North Carolina Medicaid and Health Choice members.</td>
</tr>
</tbody>
</table>
| Prior Authorization Requests and Advance Admission Notification | To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N Online Tool: UHCprovider.com/paan Phone: Call Care Coordination at the number on the member’s ID card (self-service available after hours) and select “Care Notifications.” Or call 800-638-3302. | Use the Prior Authorization and Notification Tool online to:  
  • Determine if notification or prior authorization is required.  
  • Complete the notification or prior authorization process.  
  • Upload medical notes or attachments.  
  • Check request status  
Information and advance notification/prior authorization lists: UHCprovider.com/NCcommunityplan > Prior Authorization and Notification |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Contact</th>
<th>Information</th>
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<tbody>
<tr>
<td>Provider Services</td>
<td><a href="https://UHCprovider.com/NCcommunityplan">UHCprovider.com/NCcommunityplan</a> 800-638-3302</td>
<td>Available 8 a.m. – 6 p.m. Eastern Time, Monday through Saturday.</td>
</tr>
<tr>
<td>Radiology Prior Authorization (eviCore healthcare)</td>
<td><a href="https://UHCprovider.com/radiology">UHCprovider.com/radiology</a> 866-889-8054</td>
<td>Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.</td>
</tr>
<tr>
<td>Referrals</td>
<td>UHCprovider.com &gt; Menu &gt; <a href="https://UHCprovider.com/NCcommunityplan">Referrals</a> or use Referrals on the Provider Portal. Click Sign in at the top right corner of <a href="https://UHCprovider.com">UHCprovider.com</a>, then click Referrals. Provider Services 800-638-3302</td>
<td>Submit new referral requests and check the status of referral submissions. UnitedHealthcare Community Plan of North Carolina does not require referrals.</td>
</tr>
<tr>
<td>Technical Support</td>
<td>email: <a href="mailto:ProviderTechSupport@uhc.com">ProviderTechSupport@uhc.com</a> website: <a href="https://UHCprovider.com/en/contact-us/technical-assistance.html">UHCprovider.com/en/contact-us/technical-assistance.html</a> 866-209-9320 for Optum support or 866-842-3278, Option 1 for web support</td>
<td>Call if you have issues logging in to the Provider Portal, you cannot submit a form, etc.</td>
</tr>
<tr>
<td>Third-Party Liability</td>
<td>Provider Services 800-638-3302</td>
<td>Submit information about other member coverage not available on the Provider Portal.</td>
</tr>
<tr>
<td>Tobacco Free Quit Line</td>
<td>800-784-8669</td>
<td>Ask about services for quitting tobacco/smoking.</td>
</tr>
<tr>
<td>Transportation</td>
<td>ModivCare Provider Support 855-397-3606 Member Services 800-349-1855</td>
<td>To arrange non-emergent transportation, please contact ModivCare at least two business days in advance. Urgent transportation requests, such as facility discharges or appointments for new conditions, can be scheduled same day. Members may call Member Services.</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>Provider Services 800-638-3302</td>
<td>UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. For UM Program, Policies and Protocols, go to: UHCprovider.com &gt; select <a href="https://UHCprovider.com/NCcommunityplan">Policies and Protocols</a>. Request a copy of our UM guidelines or information about the program.</td>
</tr>
<tr>
<td>Topic</td>
<td>Contact</td>
<td>Information</td>
</tr>
<tr>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| Vaccines for Children (VFC) program | [immunize.nc.gov](https://immunize.nc.gov)  
American Academy of Pediatrics/ Bright Futures [aap.org](https://aap.org)  
NC Immunization Branch: 919-707-5598 or 877-873-6247 | You are strongly encouraged to participate in the Vaccines for Children (VFC) program. The VFC program is a federally funded program that provides vaccines at no cost to children, 19 years and younger, who might not otherwise be vaccinated because of an inability to pay. Because VFC vaccines are federally purchased, enrolled care providers cannot bill for the cost of the vaccine. However, care providers can bill for vaccine administration fees. VFC care providers must maintain adequate stock of all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), as appropriate for their specific patient population. Vaccines provided for children enrolled in NC Health Choice are not covered by the VFC program. However, UnitedHealthcare Community Plan will reimburse the care provider for both the vaccine and administration for privately purchased vaccines administered to North Carolina Health Choice members. You must report all immunizations administered to the North Carolina Immunization Registry (NCIR) at [immunize.nc.gov](https://immunize.nc.gov). To request access, contact the NC Immunization Branch at 877-873-6247. |
| Vision Services | [marchvisioncare.com](https://marchvisioncare.com)  
844-736-2724 | Available 8 a.m. – 5 p.m. Eastern Time, Monday through Friday. |
| Website for North Carolina Community Plan | [UHCprovider.com/NCcommunityplan](https://UHCprovider.com/NCcommunityplan) | Access your state-specific Community Plan information on this website. |
Chapter 2: Care Provider Standards & Policies

General care provider responsibilities

You must comply with the terms and conditions set forth in your provider Agreement.

Non-discrimination

You can’t refuse an enrollment/assignment or disenroll a member or discriminate against them based on age, sex, race, physical or mental handicap, national origin, religion, type of illness or condition. You may only direct the member to another care provider if that 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 affect your relationship with members as patients or with its ability to administer quality improvement, utilization management (UM) or credentialing programs. Instead, we require communication between PCPs and other participating care providers. This helps ensure UnitedHealthcare Community Plan members receive both quality and cost-effective health services.

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

1. Educate members, and/or their representatives 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. Work with the plan care manager in developing a 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 happen:

1. Bankruptcy or insolvency.
2. Indictment, arrest, felony conviction or any criminal charge related to your practice or profession.
3. Suspension, exclusion, debarment or other sanction from a state or federally funded health care program.
4. Loss or suspension of your license to practice.
5. Departure from your practice for any reason.
6. Closure of practice.
You may use the care provider demographic information update form for demographic changes or to update NPI information for care providers in your office. This form is located at 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 services for a reasonable time at our in-network rate. Provider Services is available to help you and our members with the transition.

Arrange substitute coverage

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

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.

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 address listed on the bottom of the form.

- Download the W-9 form at irs.gov > Forms & Instructions > Form W-9.
- Download the Care Provider Demographic Information Update Form at UHCprovider.com > Menu > Find a Care Provider > My Practice Profile Tool > Care Provider Paper Demographic Information Update Form.
- To update your care provider information online, go to UHCprovider.com > Menu > Find a Care Provider > My Practice Profile Tool > Go To 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. Send this information to the address listed on the bottom of the demographic change request form.

Updating your practice or facility information

You can update your practice information through the Provider 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 emailing it to the appropriate address listed on the bottom of the form.
- Calling our Enterprise Voice Portal at 877-842-3210.

After-hours care

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

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

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

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

## 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. Keep these records for six years or longer if required by applicable statutes or regulations.

## Performance data

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

## Comply with protocols

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

You may view protocols at UHCprovider.com.

## Office hours

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

## Protect confidentiality of member data

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

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

## Follow medical record standards

Please reference Chapter 9 for Medical Record Standards.

## Inform members of advance directives

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

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

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

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

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. Locate the Member Handbook at UHCCommunityPlan.com.

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

Network adequacy standards

Our network has hospitals, physicians, advanced practice nurses, substance use disorder and behavioral health treatment providers. It also has emergent and non-emergent transportation services, safety net hospitals, and all other care provider types necessary to support capacity to make all services available.

To help ensure that members have timely access to covered health care services, UnitedHealthcare Community Plan ensures its network meets the following time and distance standards. They are measured from the member’s residence for adult and pediatric providers separately through geo-access mapping at least annually, at a minimum, as shown in the following table.
Here, “urban” is a non-rural county with around 250 or more people per square mile. This includes 20 counties the North Carolina Rural Economic Development Center notes are “regional cities or suburban counties” or “urban counties.” “Rural” is a county with less than 250 people per square mile. More information is available at ncleg.net.

<table>
<thead>
<tr>
<th>Reference Number</th>
<th>Service Type</th>
<th>Urban Standard</th>
<th>Rural Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Primary Care</td>
<td>≥ 2 providers within 30 minutes or 10 miles for at least 95% of members</td>
<td>≥ 2 providers within 30 minutes or 30 miles for at least 95% of members</td>
</tr>
<tr>
<td>2</td>
<td>Specialty Care</td>
<td>≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members</td>
<td>≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members</td>
</tr>
<tr>
<td>3</td>
<td>Hospitals</td>
<td>≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of members</td>
<td>≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of members</td>
</tr>
<tr>
<td>4</td>
<td>Pharmacies</td>
<td>≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of members</td>
<td>≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of members</td>
</tr>
<tr>
<td>5</td>
<td>Obstetrics</td>
<td>≥ 2 providers within 30 minutes or 10 miles for at least 95% of members</td>
<td>≥ 2 providers within 30 minutes or 30 miles for at least 95% of members</td>
</tr>
<tr>
<td>6</td>
<td>Occupational, Physical, or Speech Therapists</td>
<td>≥ 2 providers within 30 minutes or 10 miles for at least 95% of members</td>
<td>≥ 2 providers within 30 minutes or 30 miles for at least 95% of members</td>
</tr>
</tbody>
</table>
| 7                | Outpatient Behavioral Health Services      | • ≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of members  
• Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard | • ≥ 2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of members  
• Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard |
| 8                | Location-Based Services (Behavioral Health) | ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members | ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members |
| 9                | Crisis Services (Behavioral Health)        | ≥ 1 provider of each crisis service within each PHP region                    |                                                                                |
| 10               | Inpatient Behavioral Health Services       | ≥ 1 provider of each inpatient BH service within each PHP region               |                                                                                |
| 11               | Partial Hospitalization (Behavioral Health) | ≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members | ≥ 1 provider of specialized services partial hospitalization within 60 minutes or 60 miles for at least 95% of members |
### Prepaid Health Plan (PHP) Time and Distance Standards

<table>
<thead>
<tr>
<th>Reference Number</th>
<th>Service Type</th>
<th>Urban Standard</th>
<th>Rural Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>All State Plan LTSS (except nursing facilities)</td>
<td>PHP must have at least 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.</td>
<td>PHP must have at least 2 providers accepting new patients available to deliver each State Plan LTSS in every county; providers are not required to live in the same county in which they provide services.</td>
</tr>
<tr>
<td>13</td>
<td>Nursing Facilities</td>
<td>PHP must have at least 1 nursing facility accepting new patients in every county.</td>
<td>PHP must have at least 1 nursing facility accepting new patients in every county.</td>
</tr>
</tbody>
</table>

### Definition of Service Category for Behavioral Health Time and Distance Standards

<table>
<thead>
<tr>
<th>Reference Number</th>
<th>Service Type</th>
<th>Definition</th>
</tr>
</thead>
</table>
| 1                | Outpatient Behavioral Health Services | - Outpatient behavioral health services provided by direct-enrolled providers (adults and children)  
- Office-based opioid treatment (OBOT)  
- Research-based BH treatment for Autism Spectrum Disorder (ASD) |
| 2                | Location-Based Services (Behavioral Health) | - Outpatient opioid treatment program (OTP) (adult) |
| 3                | Crisis Services (Behavioral Health) | - Professional treatment services in a facility-based crisis program (adult)  
- Facility-based crisis services for children and adolescents  
- Ambulatory detoxification  
- Non-hospital medical detoxification (adult)  
- Ambulatory withdrawal management with extended on-site monitoring  
- Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult) |
<table>
<thead>
<tr>
<th>Reference Number</th>
<th>Service Type</th>
<th>Definition</th>
</tr>
</thead>
</table>
| 4                | Inpatient Behavioral Health Services| **Inpatient Hospital - Adult**  
• Acute care hospitals with adult inpatient psychiatric beds  
• Other hospitals with adult inpatient psychiatric beds  
• Acute care hospitals with adult inpatient substance use beds  
• Other hospitals with adult inpatient substance use beds  
**Inpatient Hospital - Adolescent/Children**  
• Acute care hospitals with adolescent inpatient psychiatric beds  
• Other hospitals with adolescent inpatient psychiatric beds  
• Acute care hospitals with adolescent inpatient substance use beds  
• Other hospitals with adolescent inpatient substance use beds  
• Acute care hospitals with child inpatient psychiatric beds  
• Other hospitals with child inpatient psychiatric beds |
| 5                | Partial Hospitalization (Behavioral Health) | • Partial hospitalization (adults and children) |
# Appointment standards (North Carolina DHHS Access and Availability Standards)

Comply with the following appointment availability standards:

<table>
<thead>
<tr>
<th>Reference Number</th>
<th>Visit Type</th>
<th>Description</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Preventive Care Services: adult, members 21 years and older</td>
<td>Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td>1a</td>
<td>Specialty Preventive Care Service: pediatric, members 20 years and younger</td>
<td></td>
<td>Within 14 calendar days for members younger than 6 months old Within 30 calendar days for members 6 months and older.</td>
</tr>
<tr>
<td>2</td>
<td>Urgent Care Services</td>
<td>Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>3</td>
<td>Routine/Check-up without Symptoms</td>
<td>Non-symptomatic visits for routine health check-up</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td>4</td>
<td>After-Hours Access – Emergent and Urgent</td>
<td>Care requested after normal business office hours</td>
<td>Immediately (24 hours a day, 365 days a year)</td>
</tr>
<tr>
<td>5</td>
<td>Initial Appointment – First or Second Trimester</td>
<td>Care provided to a member while they are pregnant to help keep member and future baby healthy, such as checkups and prenatal testing</td>
<td>Within 14 calendar days</td>
</tr>
<tr>
<td>5a</td>
<td>Initial Appointment – High-Risk Pregnancy or Third Trimester</td>
<td></td>
<td>Within 5 calendar days</td>
</tr>
<tr>
<td>6</td>
<td>Urgent Care Services</td>
<td>Care provided for a non emergent illness or injury with acute symptoms that require immediate care; examples include sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache</td>
<td>Within 24 hours</td>
</tr>
</tbody>
</table>
# Appointment Wait Time Standards

<table>
<thead>
<tr>
<th>Reference Number</th>
<th>Visit Type</th>
<th>Description</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Routine/Check-up without Symptoms</td>
<td>Non-symptomatic visits for health check</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td>8</td>
<td>After-Hours Access – Emergent and Urgent Instructions</td>
<td>Care requested after normal business office hours</td>
<td>Immediately (available 24 hours a day, 365 days a year)</td>
</tr>
</tbody>
</table>

**Behavioral Health Care**

<table>
<thead>
<tr>
<th>Reference Number</th>
<th>Visit Type</th>
<th>Description</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Mobile Crisis Management Services</td>
<td></td>
<td>Within 2 hours</td>
</tr>
<tr>
<td>10</td>
<td>Behavioral Health Urgent Care (BHUC)</td>
<td></td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>11</td>
<td>Urgent Care Services for SUDs</td>
<td></td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>12</td>
<td>Routine Services for Mental Health</td>
<td></td>
<td>Within 14 calendar days</td>
</tr>
<tr>
<td>13</td>
<td>Routine Services for SUDs</td>
<td></td>
<td>Within 14 calendar days</td>
</tr>
<tr>
<td>14</td>
<td>Emergency Services for Mental Health</td>
<td></td>
<td>Immediately (available 24 hours a day, 365 days a year)</td>
</tr>
<tr>
<td>15</td>
<td>Emergency Services for SUDs</td>
<td></td>
<td>Immediately (24 hours a day, 365 days a year)</td>
</tr>
</tbody>
</table>
Care provider directory

You must 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 error. Ask the potential new patient to contact UnitedHealthcare Community Plan for help finding a care provider.

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

If we do not hear from you within 30 business days, we have 15 more business days to contact you. If we are unsuccessful, we notify you that if do not respond, we will remove you from our care provider directory after 10 business days.

If we receive notification the provider directory information is wrong, you may be subject to corrective action.

In addition to outreach for annual or bi-annual attestations, we must reach out 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 changes to:

For Delegated providers, email your changes to Pacific_DelProv@uhc.com or delprov@uhc.com.
For Non-delegated providers, visit UHCprovider.com for the Provider Demographic Change Submission Form and further instructions.

Prior authorization request

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

We may provide coverage if the service or medication is deemed medically necessary or meets specific requirements provided in the benefit plan.

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

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

Identify and bill other insurance carriers when appropriate.

If you have questions, please call UnitedHealthcare Web Support at 866-842-3278, option 3, 7 a.m. – 9 p.m. Eastern Time, Monday through Friday.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

- Urgent: 24 hours
- Non-urgent: 10 business days
Requirements for PCP and specialists serving in PCP role

Specialists include internal medicine, pediatrics, or obstetrician/gynecology

PCPs are an important partner in care delivery, and NC DHHS members may seek services from any participating care provider. The NC DHHS program requires members be assigned to PCPs. They may choose their own network PCP. If they do not, we will auto-assign them a PCP. 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.”

When a member is enrolled in an Advanced Medical Home (AMH) Tier 3, the AMH practice will perform care management functions. These activities help support the UnitedHealthcare Community Plan system by improving health care delivery in access, coordination, continuity and prevention. As such, the PCP manages initial and basic care to adult members and pediatric members, makes recommendations for specialty and ancillary care, and coordinates all primary care services. For more information about AMH and Tier 3, go to medicaid.ncdhhs.gov/transformation/advanced-medical-home.

The following care provider types may serve as PCPs:
- Family medicine
- General practice
- Internal medicine
- Nurse practitioner (NP)
- Obstetrics & gynecology
- Pediatrics
- Physician assistant (PA)
- Advanced practice midwife
- Psychiatry and neurology

Find information about classification at nctracks.nc.gov.

For information about becoming certified as an advanced medical home, go to files.nc.gov.

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

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

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

Consult with other appropriate health care professionals to develop individualized treatment plans for 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. This includes completing and submitting the North Carolina Pregnancy Risk Screening Form on UHCprovider.com.
- Coordinate each member’s overall course of care.
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a one MD practice and at least 30 hours per week for a two or more MD practice. Regardless on the number of MDs in a practice, if it has attested to a tier 3 status, it must have at least 30 open office hours to see patients.
- Be available to members by phone 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

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

- Offer office visits on a timely basis, based on the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide.
- Conduct a baseline exam during the member’s first appointment.
- Treat members’ general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to Provider Services, UnitedHealthcare Community Plan Clinical, or Pharmacy Department as appropriate.
- Admit members to the hospital when necessary. Coordinate their medical and behavioral care while they are hospitalized.
- Respect members’ advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and based on our 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 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 North Carolina 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, federally qualified health center or primary care clinic

Members may choose a care provider who meets the PCP requirements and performs PCP-type services within a RHC or FQHC 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 in rural, underserved areas.
- **Federally Qualified Health Center**: An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a care provider, PA, NP and/or social worker.
  - Mental health services.
  - Immunizations (shots).
  - Home nurse visits.
- **Primary Care Clinic**: A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a PCC that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.
Chapter 2: Care Provider Standards & Policies

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.

- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist’s care.
- Note all findings and recommendations in the member’s medical record. Share this information in writing with the PCP.
- Maintain staff privileges at 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 North Carolina DHHS Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. 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.

Personal care services provider responsibilities

In addition to other requirements for all care providers, Personal Care Service Providers must comply with the requirements outlined in Section 7 of the PCS Clinical Coverage policy. To request an assessment for Personal Care Services, call Provider Services at 800-638-3302. For the most current PCS requirements visit the NCDHHS website at medicaid.ncdhhs.gov > Providers.

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 specialists 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

- Verify the member's enrollment before rendering services. Sign in to the Provider Portal at UHCprovider.com or contact Provider Services.
- Check the member's ID card at the time of service. Verify against photo ID if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/paan.
- Identify and bill other insurance carriers when appropriate.
Chapter 3: Care Provider Office Procedures and Member Benefits

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Benefits</td>
<td>UHCcommunityplan.com</td>
<td>800-349-1855</td>
</tr>
<tr>
<td>Member Handbook</td>
<td>UHCcommunityplan.com/NC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Go to Plan Details, then Member Resources, View Available Resource</td>
<td></td>
</tr>
<tr>
<td>Provider Services</td>
<td>UHCprovider.com</td>
<td>800-638-3302</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>UHCprovider.com/pan</td>
<td>800-638-3302</td>
</tr>
<tr>
<td>DSNP</td>
<td>UHCprovider.com &gt; Health Plans by State &gt; North Carolina &gt; Medicare &gt; <a href="https://uhcprovider.com/pan">Dual Complete Special Needs Plans</a></td>
<td>800-638-3302</td>
</tr>
</tbody>
</table>

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

Member benefits

Benefit information is listed in the following chart. Click UHCprovider.com > Menu > Health Plans by State > North Carolina > Community Plan/Medicaid > Member Information to view member benefit coverage information, or UHCprovider.com > Eligibility and Benefits for more information. Members may visit UHCCommunityPlan.com/NC.

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Coverage</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicaid</td>
<td>Health Choice</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Outpatient Hospital Services</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>EPSDT Services</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>EPSDT Services</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Nursing Facility Services</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Benefit Type</td>
<td>Coverage</td>
<td>Comments</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------</td>
<td>----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Health Choice</td>
<td>Vaccines for CHIP are not covered through the VFC program. We cover both the vaccine and the administration.</td>
</tr>
<tr>
<td>Abortion Coverage</td>
<td>Yes</td>
<td>Covered with physician certification of life endangering conditions or the result of incest or rape</td>
</tr>
<tr>
<td>RHC/FQHC Services</td>
<td>Yes</td>
<td>Core service: physician services, physician assistants, nurse practitioners, nurse midwives, clinical psychologists and clinical social workers</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>Yes</td>
<td>Medical and psychiatric services</td>
</tr>
<tr>
<td>Lab and X-Ray Services</td>
<td>Yes</td>
<td>Some services require authorization through EviCore</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>Yes</td>
<td>Preventing pregnancy or arranging care for pregnant members</td>
</tr>
<tr>
<td>Freestanding Birthing Centers</td>
<td>Yes</td>
<td>Allowed only for vaginal deliveries</td>
</tr>
<tr>
<td>Non-Emergent Transportation Services</td>
<td>Yes</td>
<td>Covered through ModivCare</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>Yes</td>
<td>Ground and air transport</td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>Yes</td>
<td>Counseling and pharmacotherapy covered for pregnant women only</td>
</tr>
<tr>
<td>Prescription Drug Coverage</td>
<td>Yes</td>
<td>State PDL is followed – Diabetic testing and supplies are required to be covered through the pharmacy program.</td>
</tr>
<tr>
<td>Physical therapy/ Occupational therapy/ Speech therapy</td>
<td>Yes</td>
<td>Physical or other therapy to help members maintain their health.</td>
</tr>
<tr>
<td>Adult Immunization Services</td>
<td>Yes</td>
<td>Only vaccines approved by the Advisory Committee on Immunization Practices</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>Yes</td>
<td>Excluded from services are amputation of the entire foot, administration of anesthetic other than a local and the surgical correction of clubfoot for an infant 2 years of age or younger</td>
</tr>
<tr>
<td>Vision Services</td>
<td>Yes</td>
<td>Services covered through March Vision, includes routine eye exam, the determination of refractive errors, refraction only, prescribing corrective lenses (eyeglasses and medically necessary contact lenses), and dispensing approved visual aids. Providers who supply eye exams and eyeglasses in their office must also supply Medicaid and NC Health Choice eye exams and FFS eyeglasses to members.</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Yes</td>
<td>Limited to manual manipulation only</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Yes</td>
<td>Personal care services, skilled nursing visits or home health aides are not reimbursable during the same hours of the day as a PDN.</td>
</tr>
<tr>
<td>Benefit Type</td>
<td>Medicaid</td>
<td>Health Choice</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>----------</td>
<td>---------------</td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hospice Services</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Prosthetics, orthotics and supplies</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Individuals 18 or older in an institution for mental disease</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Inpatient Psychiatric Services</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Transplant and related services</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Dietary Evaluation and Counseling</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Auditory Implant Parts</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Obstetrics and Gynecology</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dental Services</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

*Exception are codes D0145 and D1206 submitted by physicians for the Fluoride Varnish Program*
Assignment to PCP panel roster

Once a member either chooses or is assigned an Advanced Medical Home (AMH)/PCP, view the panel rosters electronically on the Provider Portal:

1. Go to UHCprovider.com.
2. Select “Sign In” on the top right. The portal requires a unique user name and password combination to gain access.
3. Access Documents & Reporting.


Click on the available report you want to view.

Auto-assigning an AMH/PCP

When a member doesn’t choose an AMH/PCP during enrollment with us, we auto-assign them within 24 hours of the effective date. We base these assignments on the following items in this order:

1. Prior AMH/PCP.
2. Member claims history.
3. Family member’s AMH/PCP assignment.
4. Family member’s claims history.
5. Geographic proximity.
6. Special medical needs.
7. Language/cultural preference.

- Coordinating and interpreting any consultation findings with an emphasis on continuity of medical care.
- Arranging for services with qualified licensed or certified care providers.
- Coordinating the member’s overall medical care, such as periodic immunizations and diagnosis and treatment of any illness or injury.

Cause also includes:

- The member disagreeing with the treatment plan.
- The member and care provider cannot communicate due to a language barrier.
- The care provider cannot reasonably accommodate the member’s special needs.
- The care provider’s practice changes, such as:
  - The care provider moves to a location that isn’t convenient for the member.
  - There is a significant change in the hours the care provider is available, and the member can’t reasonably make appointments during the new hours.
  - The care provider no longer has hospital access.
- The member and care provider agree that a change is in the member’s best interest.
- The care provider leaves the network.

Members may change their assigned PCP twice per year without cause. They can make the request once within the first 30 days from receipt of notification of their AMH assignment. Then they can request a change again in the next year. To do so, they must call Member Services. The change is effective on the first day of the following month.

Changing a PCP

Members may change their assigned PCP with cause at any time. The Department defines cause as the care provider not appropriately doing the following:

- Providing primary care services.
- Arranging inpatient care, consultations with specialists, or laboratory or radiological services when reasonably necessary.
- Arranging for consultation appointments.
## Deductibles/copayments

Members are charged copayments as follows.

### North Carolina Cost Sharing

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Service</th>
<th>Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Medicaid beneficiaries</td>
<td>Physicians</td>
<td>$3/visit</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Outpatient services</td>
<td>$3/visit</td>
</tr>
<tr>
<td></td>
<td>Podiatrists</td>
<td>$3/visit</td>
</tr>
<tr>
<td></td>
<td>Generic and Brand Prescriptions</td>
<td>$3/script</td>
</tr>
<tr>
<td></td>
<td>Chiropractic</td>
<td>$2/visit</td>
</tr>
<tr>
<td></td>
<td>Optical Services/ Supplies</td>
<td>$2/visit</td>
</tr>
<tr>
<td></td>
<td>Optometrists</td>
<td>$3/visit</td>
</tr>
<tr>
<td></td>
<td>Non-emergency ER visit</td>
<td>$3/visit</td>
</tr>
</tbody>
</table>

### North Carolina Health Choice (NCHC)

<table>
<thead>
<tr>
<th>NCHC beneficiaries with family income &lt; 159% federal poverty level (FPL)</th>
<th>Office visits</th>
<th>Generic Prescription</th>
<th>Brand prescription (when no generic available)</th>
<th>Brand prescription (when generic available)</th>
<th>Over-the-counter medications</th>
<th>Non-emergency ER visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0/visit</td>
<td>$1/script</td>
<td>$1/script</td>
<td>$3/script</td>
<td>$1/script</td>
<td>$10/visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NCHC beneficiaries with family income &gt; 159% and &lt; 211% FPL</th>
<th>Office visit</th>
<th>Generic prescription copay</th>
<th>Brand prescription (when no generic available)</th>
<th>Brand prescription (when generic available)</th>
<th>Over-the-counter medications</th>
<th>Non-emergency ER visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$5/visit</td>
<td>$1/script</td>
<td>$1/script</td>
<td>$10/script</td>
<td>$1/script</td>
<td>$25/visit</td>
</tr>
</tbody>
</table>

### Medicaid cost-sharing exclusions

Medicaid cost-sharing does not apply to certain member populations:
- Children younger than 21 years.
- Pregnant women.
- Individuals receiving hospice care.
- Federally recognized American Indians/Alaska Natives.
- BCCCP beneficiaries.
- Foster children.
- Members whose medical cost assistance for services furnished in an institution (other than personal needs) is reduced based on income.

### Health Choice cost-sharing exclusions

North Carolina Health Choice cost-sharing does not apply to members of federally recognized American Indian tribes/Alaska Natives.

### 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

North Carolina 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.
Chapter 3: Care Provider Office Procedures and Member Benefits

Community Plan. North Carolina 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 packet that includes a copy of the UnitedHealthcare Community Plan Member Handbook. The handbook explains the member’s health care rights and responsibilities through UnitedHealthcare Community Plan.

Download a copy of the Member Handbook online at UHCcommunityplan.com/MI. Go to Plan Details, then Member Resources, View Available Resource.

Immediate enrollment changes

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

Get eligibility information by calling Provider Services.

Unborn enrollment changes

Encourage your members to notify the North Carolina DHHS when they know they are expecting. DHHS notifies us daily of an unborn when North Carolina Medicaid learns a member is expecting. UnitedHealthcare Community Plan or you may use the online change report through the North Carolina website to report the baby’s birth. With that information, DHHS verifies the birth through the mother. UnitedHealthcare Community Plan’s 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 the Medicaid Contact Center at 888-245-0179.

Newborns may get UnitedHealthcare Community Plan-covered health services beginning on their date of birth. Check eligibility daily until the mother has enrolled her baby in a managed care plan.

PCP selection

Although unborn children cannot be enrolled with us until birth, ask members to select and contact a PCP for their baby prior to delivery. This helps 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 North Carolina DHHS, North Carolina’s Medicaid program. The DHHS determines program eligibility. An individual who becomes eligible for the North Carolina DHHS program either chooses or is assigned to one of the North Carolina DHHS-contracted health plans.

Member ID card

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

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

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

Each member receives a North Carolina DHHS Medicaid member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member.

Sample health member ID card

PCP-initiated transfers

A PCP may transfer a UnitedHealthcare Community Plan member if they can’t start or maintain a professional relationship or if the member is non-compliant. The PCP must provide care for the member until a transfer is complete.

- To transfer the member, call the Member Services number on the back of the member’s card, or mail with the specific events documentation. Documentation includes the dates of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider’s name.

Verifying member enrollment

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

- Provider Portal: access the Provider Portal through UHCprovider.com/eligibility
- Provider Services is available from 8 a.m. – 6 p.m. Eastern Time, Monday through Saturday.

Services not covered by UnitedHealthcare Community Plan

The following services are not included in our program:

- Any health care not given by a doctor from our list (except emergency treatment)
- Any care covered by Medicaid but not through managed care:
  - Fabrication of eyeglasses, eyeglass lenses, and ophthalmic frames

Note: Obtain Medicaid and NC Health Choice FFS eyeglasses through the traditional NC DHHS process and bill UnitedHealthcare Community Plan/March Vision for dispensing fees after you give the FFS eyeglasses to the member.
- Long-term care services in a nursing home.
- Nursing facility services.
- Intermediate care facilities for members with mental handicap.
- Home- and community-based waiver services.
- Dental services, except for emergency services. Prior authorization may be required.
- Residential inpatient hospice services.
  • Phones and TVs used when in the hospital.
  • Personal comfort items used in the hospital such as a barber.
  • Contact lenses, unless used to treat eye disease or condition that cannot be managed with eyeglasses.
  • Sunglasses and photo-gray lenses.
  • Ambulances, unless medically necessary.
  • Infertility services.

Care providers obtain Medicaid and NC Health Choice FFS eyeglasses through the traditional NCDHHS process and bill March Vision for the dispensing fees, after the FFS eyeglasses are dispensed to the member.

**UnitedHealthcare Dual Complete (DSNP)**

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

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

For information about UnitedHealthcare Dual Complete, please see Chapter 4 of the Administrative Guide for Commercial, Medicare Advantage and DSNP. For state-specific information, go to UHCprovider.com > Menu > Health Plans by State > North Carolina > Medicare > North Carolina Dual Complete Special Needs.
Chapter 4: Medical Management

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>UHCprovider.com &gt; Menu &gt; Referrals</td>
<td>800-638-3302</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>UHCprovider.com/paan</td>
<td>800-638-3302</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>professionals.optumrx.com</td>
<td>855-258-1593</td>
</tr>
<tr>
<td>Healthy First Steps</td>
<td>uhchealthfirststeps.com</td>
<td>800-599-5985</td>
</tr>
</tbody>
</table>

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

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

Ambulance services

**Air ambulance**

Air ambulance is covered only when the services are medically necessary and transportation by ground ambulance is not available. It is also only covered when:
- Great distances or other obstacles keep members from reaching the destination.
- Immediate admission is needed.
- The pickup point is inaccessible by land.

Non-emergent air ambulance requires prior authorization.

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

**Non-emergent ambulance transportation**

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

To arrange member transportation for non-emergency ambulance trips, such as when a member is discharged from the hospital, call ModivCare at 855-397-3606. Our discharge call agents will help ensure the trip meets UnitedHealthcare Community Plan guidelines. ModivCare will coordinate the trip with a contracted transportation provider.

**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.
Chapter 4: Medical Management

**Non-emergency medical transportation (NEMT)**

UnitedHealthcare Community Plan members may get non-emergent medical transportation services through ModivCare for covered services. Covered transportation includes public transportation, taxis, vans, wheelchair vans, mini-bus, mountain area transports, or other transportation systems and non-emergency ambulance transportation.

For non-urgent appointments, members must call Member Services for transportation at least two days before their appointment.

We also have a mileage reimbursement program for qualifying members. It includes enrollment forms and trip logs so that pre-approved friends or family members can drive members to appointments and be reimbursed for the mileage. We use audits and controls to avoid fraud, waste, or abuse.

Value-added non-emergent transportation services include round-trip transportation for employment-related transportation for adult Temporary Assistance for Needy Families (TANF) members. This means members may get up to three round trips or six one-way ground trips per calendar year and up to 100 miles one way for in-state job interviews, certifications and licensure, job and career training, backup transportation to jobs and other employment-related activities.

Members must call Member Services to request non-emergent transportation at least two business days in advance.

**Cardiology**

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

You must obtain prior authorization for the following cardiology procedures:

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

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

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

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

Request prior authorization online or by phone:

- Online: UHCprovider.com/cardiology; select the Go to Prior Authorization and Notification Tool
- Phone: 866-889-8054 from 7 a.m. - 7 p.m., Monday through Friday.

Make sure the medical record is available.

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

**Care coordination/health education**

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

The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle.
- Improve the quality of care, quality of life and health outcomes of members.
- Help members understand and take part in their care and stick to treatment plans, including medications and self-monitoring.
- Lower unnecessary hospital admissions and ER visits.
- Promote care coordination by working with care providers to improve member outcomes.
- Prevent disease progression and illnesses related to poorly managed diseases.
• Support member empowerment and informed decision making.
• Effectively manage their conditions, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues.

Our program makes available population-based, condition-specific health education materials, websites, mobile apps and newsletters that include recommended routine appointment frequency, necessary testing, monitoring and self-care. We send health education materials, based upon evidence-based guidelines or standards of care, to members that address topics that help members manage their condition. The case manager works with the member to identify educational opportunities and monitors the member’s progress toward managing the targeted condition.

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

Care management programs

We support the North Carolina philosophy of local care management delivered by a multidisciplinary care team for all members who need this help. Using a data-based approach, we identify members with the following needs for our programs:
• Long-term services and supports (LTSS).
• Special health care needs, including high-risk pregnant women and at-risk children.
• High unmet resource needs related to social determinants of health.
• Unusual utilization patterns.
• Complex co-morbidities.

Individual care providers and community organizations may refer members to any of the following care management programs. Members may also self-refer.

Advanced medical homes

The advanced medical home (AMH) model consists of care provider practices that offer primary care services as well as other subspecialty services. AMH practices that are ready to take on the responsibility of care management are designated as Tier 3 practices. These practices may develop their own care management capabilities in-house. Or they may decide to partner with clinically integrated networks (CIN) to share responsibility for these functions. For AMH practices not yet ready to perform care management for members independently, we are responsible for care management for the members within those practices. All care management members will receive screening, assessment, individualized care planning, follow-up and transitional care assistance.

Long-term services and supports

The LTSS model has medical and non-medical programs that help members with chronic illnesses or disabilities maintain their health and remain in the home environment. We provide local care management for the vulnerable members who use LTSS and prioritize their engagement and outreach. We conduct comprehensive needs and health risk assessments for these LTSS members to help ensure gaps in care are addressed through patient-centered care plans. Transitional care is also part of the program.

Care management for at-risk children

We work closely with LHDs that provide specialized care management services for at-risk children. We identify at-risk children and these members are referred to LHDs for further care management.

Pregnancy Management Program and Case Management for High-Risk Pregnancy

The Pregnancy Management Program (PMP) and Case Management for High-Risk Pregnancy (CMHRP) are specialized maternity programs that help members who are:
• Pregnant.
• Experiencing an uncomplicated pregnancy.
• Dealing with other medical, behavioral and social risks.

They help improve birth outcomes and lower neonatal intensive care unit (NICU) admissions by managing prenatal and post-partum care needs of pregnant members. Care management staff are board-certified in maternal and neonatal medicine.

Pregnant Medicaid beneficiaries may also be referred to
LHDs for care management when they have a high risk of a poor birth outcome. The care management model has education, support, linkages to other services. It also helps manage high-risk behavior and responds to social determinants of health that may affect birth outcomes. Women identified as having a high-risk pregnancy are assigned a pregnancy care manager to coordinate their care through the end of the post-partum period.

See the Maternity section of this chapter for more care management programs available to pregnant members.

**Durable medical equipment**

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

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

**DME may be covered when all the following criteria are met:**

1. Provides therapeutic benefit because of certain medical conditions and/or illnesses and
2. Prescribed by a licensed care provider

**DME is not covered when it:**

- Is used primarily for convenience or upgrades beyond what is necessary to meet the member’s legitimate medical needs. Examples include decorative items, unique materials (e.g., magnesium wheelchair wheels, lights, extra batteries);
- Does not provide a therapeutic benefit to a member
- Has not been prescribed by a licensed care provider
- Primarily serves as a comfort or convenience item. Trays, back packs, and wheelchair racing equipment are examples of non-covered or convenience items
- Is used in a facility expected to provide such items to the member
- Enhances the environmental setting (e.g., air conditioners, humidifiers, air filters, portable Jacuzzi pumps, or chair lifts).

For more information, visit [medicaid.ncdhhs.gov](medicaid.ncdhhs.gov).

For more information about coverage determination or medical policy, go to our provider portal at [UHCprovider.com/policies](UHCprovider.com/policies).

### Emergency/urgent care services

Emergency services do not require prior authorization. While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about appropriate ER use. A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fevers, cough, colds and sore throats.

**Covered services include:**

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

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

### Emergency room care

For an emergency, the member should seek immediate care at the closest ER. If the member needs help getting to the ER, they may call 911. No referral is needed. Members have been told to call their PCP as soon as possible after receiving emergency care. They pay no out-of-pocket cost for ER or emergency ambulance services.
Before they are treated, UnitedHealthcare Community Plan members who visit an emergency room are screened to determine whether they have a medical emergency. Prior authorization is not required for the medical screening. UnitedHealthcare Community Plan covers these services regardless of the emergency care provider’s relationship with UnitedHealthcare Community Plan.

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

**Urgent care (non-emergent)**

Urgent care services are covered.

For a list of urgent care centers, contact [Provider Services](#).

**Emergency care resulting in admissions**

Prior authorization is not required for emergency services.

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

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

UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize UM staff to support service underutilization. Care determination criteria is available upon request by contacting Provider Services.

The criteria are available in writing upon request or by calling [Provider Services](#).


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

**Facility admission notification requirements**

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

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

**Family planning**

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

- Annual gynecological examination
- Annual pap smear
- Contraceptive supplies, devices and medications for specific treatment
- Contraceptive counseling
- Laboratory services
Blood tests to determine paternity are covered only when the claim indicates tests were necessary for legal support in court.

View the DHHS Regulations for more information on Family Planning Services.

Non-covered items include:

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

Parenting/child birth education programs

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

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.

Voluntary sterilization

For more information about auditory implant external parts, see the DHHS regulations at ncdhhs.gov.

Prior approval and regulations

Some hearing devices and services may require prior approval. Visit UHCPopvider.com/priorauth to see current prior authorization requirements.

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice.

Home hospice

UnitedHealthcare Community Plan covers benefits for routine home care every day the member is at home, under hospice and not receiving continuous home care. We cover care provider hospice at the member’s home during a medical crisis. A medical crisis is when a member requires continuous nursing care to manage symptoms.
Chapter 4: Medical Management

Respite hospice

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

Inpatient hospice

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

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

Laboratory

LabCorp and Quest Diagnostics are nationally contracted lab providers. Contact LabCorp or Quest Diagnostics directly.

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

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

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

See the Billing and Submission chapter for more information.

Maternity/pregnancy/well-child care

Pregnancy notification risk screening

Notify UnitedHealthcare Community Plan immediately of a member’s confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program. This helps ensure appropriate follow-up and coordination by the LHD case manager. If you have questions regarding case management, call the county Local Public Health Office.

Healthy First Steps (HFS)-Maternal care model

The maternity program 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.
- Give 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 health care decision-making.
- Encourage appropriate pregnancy, postpartum and infant care provider visits.
Chapter 4: Medical Management

- 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 UnitedHealthcare Community Plan for care coordination.

**Pregnancy/maternity**

Bill the initial pregnancy visit as a separate office visit. You may bill global days regardless of whether the antepartum care was provided prior to a member enrolling in the UnitedHealthcare Community Plan.

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.

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

**LHDs — Care Management For High-Risk Pregnancy (CMHRP)**

LHDs provide care management to pregnant Medicaid beneficiaries identified as high risk of a poor birth outcome. The care management model involves education, support, links to other services, high risk behavior management and response to social determinants of health that may affect birth outcomes. Women identified as having a high-risk pregnancy are assigned a pregnancy care manager to coordinate their care and services through the end of the post-partum period.

**Referrals to CMHRP**

- Complete the Pregnancy Risk Screen for each Medicaid member at the first prenatal visit and fax to the LHD where the member resides. If there is not a CMHRP program in the member’s county, fax the form to 844-897-2462.
- Work with the LHD case manager on care plan/treatment plan development.
- Help ensure a post-partum visit occurs within 56 days of delivery.

**Pregnancy risk screening forms**

At the first prenatal visit, complete the North Carolina Pregnancy Risk Screening Form. Send it to the LHD where the member resides. If there is not a CMHRP program in the member’s county, fax the form to 844-897-2462.

**Continuation of care**

UnitedHealthcare Community Plan allows pregnant members to get services from their behavioral health care provider, without prior authorization, until:

- The birth of the child.
- The cessation of pregnancy.
- Loss of eligibility.
Maternity admissions

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

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

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

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

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

- Date of delivery.
- Gender.
- Birth weight.
- Gestational age.
- Baby name.

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

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

Furnish obstetrical maternity services on an outpatient basis. This can be done under a physician’s supervision through an NP, PA or licensed professional nurse. If handled through supervision, the services must be within the staff’s scope of practice or licensure as defined by state law.

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

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

Post maternity care

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

Newborn enrollment

The hospital is responsible for telling the county of all deliveries, including UnitedHealthcare Community Plan members. The hospital provides required birth data during admission.

Bright Futures Assessment

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

**Home care and all prior authorization Services**

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

**Women, Infants and Children (WIC) program**

WIC is the special supplemental nutrition program for women, infants, and children funded by the United States Department of Agriculture. County health departments, community and RHC, and community action agencies provide WIC services. Help ensure all pregnant women and children younger than 5 years of age are referred to WIC. For more information or to find the WIC Program in your county, go to nutritionnc.com/wic/index.htm.

**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.

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

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

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

**Pregnancy termination services**

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

Allowable pregnancy termination services do not require a referral from the member’s PCP. Members must use our care provider network.

**Sterilization and hysterectomy procedures**

Reimbursement for sterilization procedures are based on the member’s documented request. This policy helps ensure UnitedHealthcare Community Plan members thinking about sterilization are fully aware of the details and alternatives. It also gives them time to consider their decision. In addition, the 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 NC DHHS 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

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

Neonatal Intensive Care Unit (NICU) case management

The NICU Management program manages inpatient and post-discharge neonatal intensive care unit (NICU) cases to improve outcomes and lower costs. Our dedicated team of NICU case managers, social workers and medical directors offer both clinical care and psychological services.

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

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

NurseLine

NurseLine is available at no cost to our members 24 hours a day, seven days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the ER or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call 855-202-0992 to reach a nurse.

Inhaled nitric oxide

Use the NRS guideline for Inhaled Nitric Oxide (iNO) therapy at UHCprovider.com > Polices and Protocols > For Community Plans > Clinical Guidelines.
Pharmacy

Pharmacy Preferred Drug List (PDL)

The North Carolina Division of Health Benefits (DHB) determines and maintains its PDL. This list applies to all UnitedHealthcare Community Plan of North Carolina members. You must prescribe Medicaid members drugs listed on the PDL. For drugs not on the PDL, North Carolina law states that the DHB may not cover a brand-name drug if an equally effective generic drug is available and is less costly unless prior authorization is followed. The same applies to UnitedHealthcare Community Plan of North Carolina members.

If a member’s condition requires a non-preferred medication, call Pharmacy Provider Services at 855-258-1593, or use the online Prior Authorization and Notification tool on the Provider Portal. Or mail your form to:

OptumRx
Prior Authorization Department
P.O. Box 25183
Santa Ana, CA 92799

We provide you PDL updates before the changes go into effect. Change summaries are posted on our website. Find the PDL and Pharmacy Prior Notification Request form at UHCprovider.com/priorauth. Contact the Provider Service Center to obtain a print PDL copy.

Pharmacy prior authorization

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

To request pharmacy prior authorization, call the Pharmacy Service Line at 855-258-1593 (OptumRX). We provide notification for prior authorization requests within 24 hours of request receipt.

Specialty pharmacy medications

The Specialty Pharmacy Management Program provides high-quality, cost-effective care for our members. This program uses a network of preferred vendors that offer clinical programs. These programs include educating and supporting members about their chronic conditions, promoting medication adherence, reducing the risk of side effects, and promoting multi-disciplinary practice and collaboration to achieve continuity of care. A specialty pharmacy medication generally has one or more of the following characteristics:

- A small percentage of the population uses it.
- It treats rare, chronic, and/or potentially life-threatening diseases.
- It’s a high-cost medication.
- It’s a biotechnology product.
- It may need frequent monitoring, intervention and ongoing clinical support.
- It’s often only sourced through select pharmacy providers or through limited channels who can meet the unique distribution and handling requirements as well as the clinical management needs.
- Members may inhale it, take it orally or by injectable.
- The member may self-administer or receive it in an outpatient setting (e.g., physician’s office, home infusion suite).

Pharmacy Claims Processing

1. Refer to the OptumRx Pharmacy Provider Manual and payer specification documents for complete claims submission requirements and guidelines, including NCPDP format.

2. You must submit a 340B pharmacy claim by submitting the Cost Basis (423-DN) field (value 08) and the Submission Clarification Code (420-DK) field (value 20). Claims may be rejected if the claim is submitted without Cost Basis value 08 (423-DN).

Quit for Life®

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

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

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

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

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

- ER
- Observation unit
- Urgent care
- Inpatient stay

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

Request prior authorization online or by phone at:

- Online: UHCprovider.com/radiology > Go to Prior Authorization and Notification Tool
- Phone: 866-889-8054 from 8 a.m. - 5 p.m. Central Time, Monday through Friday. Make sure the medical record is available. We require an authorization number for each CPT code.

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

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 to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. This includes coordinating with the Alcohol and Drug Program in the County where the member resides for treatment.

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

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

The SBIRT assessment, intervention, or treatment takes places in one of the following places of service:
• Office
• Urgent care facility
• Outpatient hospital
• ER – hospital
• FQHC
• Community mental health center
• Indian health service – freestanding facility
• Tribal 638 freestanding facility
• Homeless shelter

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

Medication-assisted treatment

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

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

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

To find a medical MAT provider in North Carolina:
1. Go to UHCprovider.com

2. Select either “Find Dr.” or “Find a Provider” from the menu on the home page
3. Select the care provider information.
4. Click on “Medical Directory”
5. Click on “Medicaid Plans”
6. Click on applicable state
7. Select applicable plan
8. Refine the search by selecting “Medication Assisted Treatment”

For more SAMHSA waiver information:
Physicians — samhsa.gov
NPs and PAs — samhsa.gov

If you have questions about MAT, please call 877-842-3210, enter your TIN then say “Representative,” and “Representative” a second time, then “Something Else” to speak to a representative.

Telehealth and telemedicine

You may use telemedicine to facilitate access to needed services in a clinically appropriate way. We cover services provided through telemedicine in an amount, duration and scope no less than what is available to beneficiaries under the Medicaid FFS program.

We consider for reimbursement telehealth services CMS recognizes. We also consider those appended with modifiers GT or GQ as well as services the AMA recognizes included in Appendix P of CPT and appended with modifier 95. We require one of these modifiers to be reported when performing a service through telehealth to indicate the type of technology used and to identify the service as telehealth.

UnitedHealthcare Community Plan reimburses for a facility fee at the originating site when the originating site is a Medicaid-enrolled provider.

For more information, such as eligible sites and practitioners, please see the UnitedHealthcare Community Plan Telehealth and Telemedicine Policy on UHCprovider.com > Policies and Protocols > For Community Plans > Reimbursement Policies > Telehealth and Telemedicine Policy.
Tuberculosis (TB) screening and treatment; Direct Observation Therapy (DOT)

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

Responsibilities

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

**Vision**

Vision services are covered by March Vision Care. Please see the Reference Guide at [marchvisioncare.com](http://marchvisioncare.com) for information such as compliance, electronic payment information, safety resources and training or call 844-736-2724.

**Medical management guidelines**

**Admission authorization and prior authorization guidelines**

All prior authorizations must have the following:
- Patient name and ID number.
- Ordering care provider or health care professional name and TIN/NPI.
- Rendering care provider or health care professional and TIN/NPI.
- ICD clinical modification (CM).

- Anticipated dates of service.
- Type of service (primary and secondary) procedure codes 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 [United Behavioral Health](https://www.unitedhealthcare.com).

If you have questions, please use the Provider Portal or go to your state’s prior auth page at UHCprovider.com/NCcommunityplan > Prior Authorization and Notification Resources.

The following table lists medical management notification requests and the amounts of time required for a decision.

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision TAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent Pre-service</td>
<td>As quickly as the member’s condition requires but no longer than 14 calendar days of request receipt</td>
</tr>
<tr>
<td>Urgent/Expedited Pre-service</td>
<td>Within 72 hours of request receipt</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>Within 24 hours or next business day following</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>Within 30 calendar days of receiving all pertinent clinical information</td>
</tr>
</tbody>
</table>

Concurrent review guidelines

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

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

**Determination of medical necessity**

Medically necessary services or supplies are those needed to:

- Prevent, diagnose, treat 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 a condition from getting worse.
- 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. No other equally effective, more conservative or substantially less costly treatment is available to the member.

Experimental treatments are not medically necessary.

**Determination process**

Benefit coverage for health services is determined by the member-specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, or Summary Plan Description, and applicable laws. You may freely talk with members about their care, 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](http://UHCprovider.com).

**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 record review.

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

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

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

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

Project ECHO

Project ECHO® increases specialty treatment access in rural and underserved geographical areas. It provides front-line clinicians with knowledge and support to manage members with complex conditions. Complex conditions include cardiology, chronic lung disease, pathology, endocrinology, hepatitis C, psychiatry and addictions. By connecting clinicians with medical center specialist teams in weekly virtual clinics or teleECHO™ clinics, rural area PCPs, nurses and other clinicians learn to provide specialty care in their own communities. We provide a stipend to North Carolina care providers who participate in Project ECHO trainings.

Reimbursement

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

- Determine if the member is eligible on the date of service by using the Provider Portal on UHCprovider.com, contacting UnitedHealthcare Community Plan’s Provider Services Department, or the North Carolina 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 dates of service.

Second opinion benefit

If a 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 NC 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 their report to the member’s PCP and treating care provider, if different. The member may help the PCP select the care provider.
• If an in-network provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should call UnitedHealthcare Community Plan at 800-638-3302.
• 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.

UnitedHealthcare Community Plan network on a FFS basis. The plan’s UM staff works with care providers to help ensure members receive the most appropriate care in the place best suited for the needed services. Our staff encourages appropriate use and discourages underuse. The UM staff does not receive incentives for UM decisions. See Appeals in Chapter 12 for more details.

Services requiring prior authorization

For a list of services that require prior authorization, the Prior Authorization and Notification section at UHCprovider.com/NCcommunityplan.

Seek prior authorization within the following time frames

• **Emergency or Urgent Facility Admission:** one business day.
• **Inpatient Admissions; After Ambulatory Surgery:** one business day.
• **Non-Emergency Admissions and/or Outpatient Services (except maternity):** at least 14 business days beforehand; if the admission is scheduled fewer than five business days in advance, use the scheduled admission time.

Utilization management guidelines

Call 800-638-3302 to discuss the guidelines and 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 FFS basis. We also pay in-network hospitals and other types of care providers in the
Chapter 5: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)/Prevention

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPSDT</td>
<td>medicaid.ncdhhs.gov</td>
<td>888-245-0179</td>
</tr>
<tr>
<td>Vaccines for Children</td>
<td>immunize.nc.gov/family/nc_immnz_program.htm</td>
<td></td>
</tr>
</tbody>
</table>

Medicaid offers children and youth younger than age 21 a comprehensive benefit for preventive health care and medical treatment. UnitedHealthcare Community Plan care providers offer or arrange for the full range of preventive and treatment services available within the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. We offer preventive (wellness) services without copays or other charges on a periodic schedule established by the state of North Carolina.

Early periodic screening services include physical exams, up-to-date health histories, developmental, behavioral and risk screens, vision, hearing and dental health screens and all vaccines recommended by the Advisory Committee on Immunization Practices. When treatment is medically necessary to correct or improve health problems, you must provide the treatment directly or arrange a referral, even when a Medicaid-covered service is not available under the state Medicaid plan.

Our pediatric primary care goal is to improve the health of Medicaid members from birth to age 21 by increasing participation in comprehensive early periodic screening (wellness) visits. When conducting early periodic screenings, you must adhere to best practice guidelines published by the American Academy of Pediatrics (AAP) in their Bright Futures publication.

For complete details about diagnoses codes as well as full and partial screening, exam, and immunization requirements, go to the EPSDT schedule.

To find more information about the periodicity schedule, go to:

- NC DHHS Wellness Visits, and Diagnostic and Treatment Services medicaid.ncdhhs.gov
- Medicaid Benefit for Children and Adolescents Younger Than Age 21 medicaid.ncdhhs.gov
- NC DHHS EPSDT State Instructions (Policy) files.nc.gov
- Health Check Early Prevention Screening Program Guide files.nc.gov
- Bright Futures Periodicity Schedule (Form) aap.org
- Coding for Pediatric Preventive Care (Bright Futures) aap.org

Development disability services and coordination with regional centers

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

**Referral** – If you think supportive services would benefit the member, refer the member to DDS for approval and assignment of a Regional Center Case Manager. That person schedules an intake assessment. The Regional Center Interdisciplinary Team then determines eligibility. While the Regional Center (RC) does not provide overall case management for their clients, they must assure access to health, developmental, social, and educational services from birth throughout the life of a member with a developmental disability.

**Continuity of Care** – The RC determines the most appropriate setting for eligible HCBS services. They work with the PCP and health plan coordinator to coordinate services. The care coordinator and PCP continue to provide and manage primary care and medically necessary services. If the member does not meet criteria for the program or placement is not available, we continue care coordination as needed to support the member’s screening, preventive, medically necessary, and therapeutic covered services.

**EPSDT criteria**

If a service is not covered under the North Carolina Medicaid state plan, it can be covered for recipients younger than age 21 if the service is listed at 1905(a) of the Social Security Act and if all EPSDT criteria are met. When a Medicaid-covered beneficiary younger than age 21 requires a medically necessary service not listed in the state plan, the beneficiary, or their legally responsible representative, should contact their health plan by calling the number on their health plan member ID card so this service can be appropriately delivered and coordinated.

The EPSDT service is covered only if it meets all the following criteria:

1. **Within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].** For example, “rehabilitative services” are a covered EPSDT service, even if the particular rehabilitative service requested is not listed in clinical policies or service definitions
2. **Medically necessary to correct or ameliorate a defect, physical or mental illness, or a health problem diagnosed by the member’s physician, therapist, or other licensed practitioner**
3. **Medical in nature**
4. **Safe and effective**
5. **Generally recognized as an accepted method of medical practice or treatment**
6. **Not experimental/investigational**

Services are covered if they are provided by a North Carolina Medicaid-enrolled care provider for the specific service type. This may include an out-of-state care provider who is willing to enroll if an in-state care provider is not available.

For any member younger than age 21, the EPSDT federal regulations are applied and medical necessity decisions are made on a case-by-case basis, depending on the member’s individual situation (physical, behavioral, psychosocial, environmental). Each service request that does not meet approval criteria will be evaluated for the EPSDT population.

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**Comprehensive well child exams**

UnitedHealthcare Community Plan requires you and other appropriate child health care providers to comply with all EPSDT services and screens based on the AAP/Bright Futures periodicity schedule. This includes:

- **Routine physical examinations.** Use as recommended and updated by the AAP Guidelines for Health Supervision III and described in Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents. This includes:
  - Screening for developmental delay at each visit through the fifth year.
  - Screening for autistic spectrum disorders.
  - Complete, unclothed physical examination.
  - All appropriate immunizations based on the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices.
  - Laboratory tests (including blood lead screening appropriate for age and risk factors) associated with well-child routine physical examinations. Health education and anticipatory guidance for both the child and caregiver.

**Comprehensive health and developmental history.** The assessment helps determine whether a child’s developmental progress falls within a
normal range of achievement based on age and cultural background. Screening for developmental assessment is done at each EPSDT visit. Refer children to the Early Intervention Program as appropriate.

- **Appropriate immunizations.** The EPSDT program requires all Medicaid child and adolescent members receive all immunizations, based on the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines. Find the ACIP guidelines at [cdc.gov](http://cdc.gov).

### Full screening

Perform a full screen. Include:

- Comprehensive health and developmental history that assesses for physical and mental health, and substance use disorders
- Comprehensive, unclothed physical examination
- Appropriate immunizations, according to the pediatric vaccines schedule established by the Advisory Committee on Immunization Practices
- Laboratory testing (including blood lead screening appropriate for age and risk factors)
- Health education and anticipatory guidance for the child and caregiver

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

For a complete listing of support and services available through the Infant-Toddler Program (ITP), go to [beearly.nc.gov](http://beearly.nc.gov).

### Preventive screenings

Preventive screenings may include anemia testing, lead toxicity, cholesterol levels, hearing, vision, and other diagnostic testing. Provide tuberculin skin testing as appropriate to age and risk.

### Early hearing detection and intervention program

As part of the state Title V Maternal and Child Health Services Program, you must complete the following hearing screenings:

- Hearing screening by 1 month of age.
- Diagnostic evaluation by 3 months of age.
- Intervention by 6 months of age.

Find more information at [ncnewbornhearing.org](http://ncnewbornhearing.org).

### Newborn screening program

State law (GS 130A-125) requires a filter paper blood spot sample be submitted to the North Carolina State Laboratory of Public Health for each infant born in North Carolina. Help ensure all newborns complete this testing.

Find more information at [slph.ncpublichealth.com](http://slph.ncpublichealth.com).

### North Carolina Childhood Lead Poisoning Prevention Program

Screen all children and pregnant women for lead exposure. The Childhood Lead Poisoning Prevention Program (CLPPP) provides a Lead and Pregnancy Risk Assessment Questionnaire. It also offers a Childhood Lead Poisoning Prevention Checklist to helps ensure compliance with required screening and testing.

Find more information at [ehs.ncpublichealth.com](http://ehs.ncpublichealth.com).

### SAFE/CARE examinations

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

**Case management for at-risk children ages 0-5 years**

Medicaid offers targeted care management services for at-risk children (CMARC) birth to 5 years old. The program coordinates services between health care providers, community programs and family support programs. To help ensure these services are given seamlessly during the move to managed care, services currently provided under the CC4C program will transition into CMARC.

**Referral Criteria** — Many children currently receiving CC4C services will meet exemption criteria for managed care. To keep consistency between the FFS and managed care populations, the referral criteria will be same as today’s program. CMARC will accept referrals for children with the following needs:

- Special health care.
- Exposed to severe stress, including:
  - Extreme poverty along with ongoing family chaos.
  - Recurrent physical or emotional abuse.
  - Chronic neglect.
  - Severe and enduring maternal depression.
  - Persistent parental substance use.
  - Repeated exposure to community or family violence.
  - In NICU needing help going back to community/medical home care.

**Referral** — Refer members eligible for CMARC services to the appropriate LHD.

**Continuity of Care** — UnitedHealthcare Community Plan will coordinate the member’s health care with the LHD/CMARC and their member’s PCP. This helps determine the medical necessity of recommended diagnostic and treatment services recommended and coverage.

**Vaccines for Children program**

You are strongly encouraged to participate in the Vaccines for Children (VFC) program. The VFC program is a federally funded program that provides vaccines at no cost to children, 19 years and younger, who might not otherwise be vaccinated because of an inability to pay. The Centers for Disease Control and Prevention purchases vaccines at a discounted rate and distributes them to grantees, who in turn, distributes them to VFC enrolled public and private health care providers. The North Carolina Immunization Branch in the Division of Public Health is the state’s VFC awardee.

Because VFC vaccines are federally purchased, enrolled care providers cannot bill for the cost of the vaccine. However, you may bill for vaccine administration fees. VFC care providers must maintain adequate stock of all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), as appropriate for their specific patient population. Non-VFC enrolled care providers choosing to use private stock to vaccinate Medicaid-covered children will not be reimbursed for the cost of the vaccine. For more information visit immunize.nc.gov, or contact the NC Immunization Branch at 919-707-5598 to begin the VFC enrollment process.

Vaccines provided for children enrolled in NC Health Choice are not covered by the VFC program. However, UnitedHealthcare Community Plan will reimburse the care provider for both the vaccine and administration for privately purchased vaccines administered to North Carolina Health Choice members.

You must report all immunizations administered to the North Carolina Immunization Registry (NCIR) at immunize.nc.gov.

To request access, contact the NC Immunization Branch at 877-873-6247.
Chapter 6: Value-Added Services

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>UHCprovider.com</td>
<td>800-638-3302</td>
</tr>
<tr>
<td>Healthy First Steps Rewards</td>
<td>uchealthyfirststeps.com</td>
<td>800-599-5985</td>
</tr>
<tr>
<td>Value Add Services</td>
<td>UHCcommunityplan.com/NC View plan details</td>
<td>800-638-3302</td>
</tr>
</tbody>
</table>

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

In addition to covered benefits, UnitedHealthcare Community Plan offers additional benefits to eligible members. If you have questions or need to refer a member, call Provider Services at 800-638-3302 unless otherwise noted. The member may also check eligibility by contacting Member Services at 800-349-1855 TTY 711.

Acute home-delivered meals
Eligible members will have access to 14 prepared home-delivered meals after discharge from an acute inpatient hospital stay back into the community setting.

Alternative healing benefit
We provide a $100 annual reimbursement for alternative healing for purchases and services. This includes herbal medications and remedies, therapeutic massage, acupuncture, vitamins, and minerals. As with use for any over-the-counter medications, members should check with their care providers before use.

Assistance for asthmatics
Improve asthma control and reduce allergies caused by dust or synthetic bedding. Controlling these issues can help to lower asthma-related hospitalizations and ER visits.

Hypoallergenic bedding is limited to individuals with asthma in case management. The member’s care manager will determine eligibility for a hypoallergenic mattress cover and pillowcase.

Breast pumps
Medicaid members not participating in the WIC program may receive manual, electronic or hospital-grade breast pumps. Members must be at least 36 weeks pregnant.

Doctor Chat—virtual visits
Members will have access to UnitedHealthcare Doctor Chat, an innovative, chat-first platform supported by live video to connect with a doctor from their computer or mobile device for non-emergent care. A board-certified emergency medicine physician will assess the severity of the enrollee’s situation, provide treatment (including prescriptions) and recommend additional care. Virtual visits can improve access to care, reduce health disparities and reduce avoidable use of the ED. This program highlights our commitment to bring forward looking solutions to expand and deliver access to care.

GED exam voucher
Eligible members receive a GED exam voucher ($160 value), preparation materials and testing support.
**Healthy First Steps (HFS)™ Rewards**

Healthy First Steps (HFS) is a web-based, mobile tool that reminds and rewards pregnant women and new mothers to get prenatal, postpartum and well-child care. HFS is available to pregnant UnitedHealthcare Community Plan members or their newborns.

Members self-enroll on a smartphone or computer. They can go to [UHC healthyfirststeps.com](http://UHC healthyfirststeps.com) and click on “Register” or call 800-599-5985.

**HFS benefit**

HFS 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**

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

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

**How You Can Help**

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

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**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.

**On My Way**

This online program helps young adults who are either transitioning from foster care or from their parents'/guardians’ home to independent living. OMW teaches skills on budgeting, housing, job training and attending college.

**Youth club membership**

We provide up to $75 for membership dues to the Boys and Girls Club programs and YMCA youth club programs, for qualified members younger than age 19.

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**Healthy Weight and Your Child**

Healthy Weight and Your Child is a childhood obesity program that helps create a healthier environment and behaviors in the home. Through a group intervention model, the child and caregiver learn healthy eating and exercise habits. Healthy Weight and Your Child is for members ages 6-17. Call Provider Services for more information.
Chapter 7: Mental Health and Substance Use

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
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</thead>
<tbody>
<tr>
<td>Behavioral Health/Provider Express</td>
<td>providerexpress.com</td>
<td>800-888-2998</td>
</tr>
<tr>
<td>Provider Services</td>
<td>UHCprovider.com</td>
<td>800-638-3302</td>
</tr>
</tbody>
</table>

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

United Behavioral Health, operating under the brand Optum, administers mental health and substance use disorder (SUD) benefits for UnitedHealthcare Community Plan members. The Optum National Network Manual is the source of truth for current information for care providers who offer behavioral health and substance use disorder services.

The Optum National Network Manual is located on providerexpress.com.

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

This manual will direct you to the Optum National Network Manual for additional information, as appropriate. The Optum National Network Manual controls when there are differences between this manual and the Optum National Network Manual.

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

To request an ID number, go to the NC DHHS website at medicaid.ncdhhs.gov. Click on “Providers,” then “Provider Enrollment.”

How to join our network

To join the UnitedHealthcare Community Plan of North Carolina, care providers must be enrolled in North Carolina Medicaid program through NC Tracks and request a registration form at ncnetworkmanagement@optum.com to complete the provider loading process.

Covered services

UnitedHealthcare Community Plan offers covered behavioral health services for mental, emotional and substance use disorders. We offer care management to help members, clinicians, and PCPs using and offering behavioral health services. We provide information and tools for mental health and substance abuse diagnoses, symptoms, treatments, prevention and other resources in one place.

liveandworkwell.com, accessed through a link on myuhc.com, includes mental health and well-being information, articles on health conditions, addictions and coping, and provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.
For member resources, go to providerexpress.com. Go to the Live and Work Well (LAWW) clinician center. Locate Health Condition Centers at the Clinical Resources tab.

Provider Express has resources for behavioral and medical care providers. The Provider Express Recovery and Resiliency page includes tools to help members addressing mental health and substance use issues. The Behavioral Health Toolkit includes screening tools and other resources.

Benefits include:
- Mobile crisis management
- Medically supervised or ADATC detox crisis stabilization
- Inpatient psychiatric hospital (acute)
- Outpatient assessment and treatment:
  - Partial hospitalization
  - Ambulatory detoxification and non-hospital medical detoxification
  - Medication management
  - Outpatient therapy (individual, family, or group)
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Research Based-Behavioral Health Treatment (RB-BHT): RB-BHT services are researched-based behavioral intervention services that prevent or minimize the disabilities and behavioral challenges associated with Autism Spectrum Disorder (ASD) and promote, to the extent practicable, the adaptive functioning of a beneficiary. RB-BHT demonstrate clinical efficacy in treating ASD: prevent or minimizes the adverse effects of ASD; and promote, to the maximum extent possible, the functioning of a beneficiary.
  - Child-parent psychotherapy
  - Electroconvulsive therapy
  - Telemental health/virtual visits

The following are available in lieu of services:
- Behavioral Health Urgent Care (BHUC): An alternative to hospital ER services, this helps members with urgent behavioral health crisis needs see behavioral health professionals faster.
- Institutions for Mental Disease (IMD) for acute psychiatric care: We offer members more choices for places to receive acute mental health hospitalization, so we are covering placement in freestanding psychiatric centers.

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

Prior authorization
Members may access all routine behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as partial hospitalization or inpatient care. Help ensure prior authorizations are in place before rendering non-emergent services. Submit prior authorization requests using the Prior Authorization and Notification tool on the Provider Portal at UHCprovider.com/paan, or calling 877-614-0484.

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 complete, 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.

Talk to members about the benefits of sharing essential clinical information.
SUD recovery coaching

Our SUD (Substance Use Disorder) recovery coach works with members to develop coping skills. Skills include encouragement, safety and a sense of responsibility for their own recovery. This benefit also emphasizes support to those with a behavioral health diagnosis while working through SUD treatment and recovery. Eligible members are identified through predictive modeling and claims data, a health risk assessment (HRA) or your referral.

Addressing the opioid epidemic

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

Brief summary of framework

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

Increasing education and awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep OUD-related resources available on our provider portal to help ensure you have the information you need, when you need it. We maintain toolkits that includes screening tools, guidelines and other resources related to substance use, opioid abuse and pain management. Find these toolkits at providerexpress.com on the Medical Providers page. 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.

Portal access

Website: UHCprovider.com
Access the Provider Portal, the gateway to UnitedHealthcare Community Plan’s online services, on this site. Use the services to verify eligibility, review electronic claim submission and view claim status.

View the Prior Authorization list, find forms and access the care provider manual. Or call the Provider Services at 800-638-3302 to verify eligibility and benefit information (available 8 a.m. – 6 p.m. Eastern Time, Monday through Saturday).

Website: providerexpress.com
Update provider practice information, review guidelines and policies, and view the Optum National Network Manual. Or call United Behavioral Health Provider Services at 877-614-0484.

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.
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-Prescriber Home program

The Pharmacy-Prescriber Home program helps ensure eligible members use services appropriately. Members are identified based on N.C. Gen. Stat. § 108A-68.2 using pharmacy and medical claims data. Enrolled members must receive state-defined covered substances from one prescriber and one pharmacy within the PHP network. A covered substance is identified as an opioid or benzodiazepine, excluding benzodiazepine sedative-hypnotics.

When a member is enrolled in the program, they are sent a written notification that certain substances will be limited. If the member would like to use different care providers, they can call Member Services. After enrollment begins, the member may request a network provider change for a good cause reason as long as both the member and the health plan agree. All enrolled members will be provided care coordination.

The member does have appeal rights that are outlined in the notification letter and the Member Handbook. Provisions allow a one-time, four-day emergency supply per year for medications available at a pharmacy or written by a prescriber other than one of the member’s lock-in providers.

To refer a member to the Pharmacy-Prescriber Home program, please include member name, member ID, member demographics and an explanation for your referral.

Fax your request to 844-228-5276.
Email your request to uhpcs_pharmacy_lockin@uhc.com.
Call Provider Services at 800-638-3302.

Expanding medication assisted treatment access and capacity

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

For more information about MAT, go to providerexpress.com.

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

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

For more information, go to providerexpress.com.
Chapter 8: Member Rights and Responsibilities

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Services</td>
<td>UHCCommunityPlan.com/NC</td>
<td>800-349-1855</td>
</tr>
<tr>
<td>Member Handbook</td>
<td>UHCCommunityPlan.com/NC &gt; Community Plan &gt; Member benefits</td>
<td>800-349-1855</td>
</tr>
</tbody>
</table>

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

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

Privacy regulations

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

Access to protected health information

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

Amendment of PHI

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

Accounting of disclosures

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

Right to request restrictions

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

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

Member rights and responsibilities

The following information is in the Member Handbook at the following link under the Member Information tab: UHCCommunityPlan.com.

Native American access to care

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

Your rights

As a member of UnitedHealthcare Community Plan, you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, sexual orientation or gender identity
- Be told where, when and how to get the services you need from UnitedHealthcare Community Plan
- Be told by your PCP what health issues you may have, what can be done for you and what will likely be the result, in language you understand.
- Get a second opinion about your care
- Give your approval of any treatment
- Give your approval of any plan for your care after that plan has been fully explained to you
- Refuse care and be told what you may risk if you do
- Get a copy of your medical record and talk about it with your PCP
- Ask, if needed, that your medical record be amended or corrected
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract or with your approval
- Use the UnitedHealthcare Community Plan complaint process to settle complaints
- Use the state fair hearing (SFH) system
- Appoint someone you trust (relative, friend or lawyer) to speak for you if you are unable to speak for yourself about your care and treatment
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints

Your Responsibilities

As a member of UnitedHealthcare Community Plan, you agree to:

- Work with your PCP to protect and improve your health
- Find out how your health plan coverage works
- Listen to your PCP’s advice and ask questions
- Call or go back to your PCP if you do not get better or ask for a second opinion
- Treat health care staff with the respect
- Tell us if you have problems with any health care staff by calling Member Services at 800-349-1855
- Keep your appointments. If you must cancel, call as soon as you can
- Use the emergency department only for emergencies
- Call your PCP when you need medical care, even if it is after hours

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.
### Medical record charting standards

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

<table>
<thead>
<tr>
<th>Topic</th>
<th>Contact</th>
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<tbody>
<tr>
<td>Confidentiality of Record</td>
<td>Office policies and procedures exist for:</td>
</tr>
<tr>
<td></td>
<td>- Privacy of the member medical record.</td>
</tr>
<tr>
<td></td>
<td>- Initial and periodic training of office staff about medical record privacy.</td>
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<td></td>
<td>- Release of information.</td>
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<tr>
<td></td>
<td>- Record retention.</td>
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<tr>
<td></td>
<td>- Availability of medical record if housed in a different office location.</td>
</tr>
<tr>
<td></td>
<td>- Process for notifying United Healthcare Community Plan upon becoming aware of a patient safety issue or concern.</td>
</tr>
<tr>
<td></td>
<td>- Coordination of care between medical and behavioral care providers.</td>
</tr>
<tr>
<td>Record Organization and</td>
<td>• Have a policy that provides medical records upon request. Urgent situations require copies be provided within 48 hours.</td>
</tr>
<tr>
<td>Documentation</td>
<td>• Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing Medical records.</td>
</tr>
<tr>
<td></td>
<td>- Release only to entities as designated consistent with federal requirements.</td>
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<tr>
<td></td>
<td>- Keep in a secure area accessible only to authorized personnel.</td>
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</tbody>
</table>
## Procedural Elements

**Medical records are readable**
- Sign and date all entries.
- Member name/identification number is on each page of the record.
- Document language or cultural needs.
- Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member’s first language is something other than English.
- Procedure for monitoring and handling missed appointments is in place.
- An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives.
- Include a list of significant illnesses and active medical conditions.
- Include a list of prescribed and over-the-counter medications. Review it annually.*
- Document the presence or absence of allergies or adverse reactions.*

## History

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

<sup>*</sup>Critical element
A member or their representative is entitled to one free copy of their medical record. Additional copies may be available at member’s cost. Medical records are generally kept for a minimum of five years unless federal requirement mandate a longer time frame (i.e., immunization and TB records required for lifetime).

### Medical record review

On an ad hoc basis, we conduct a review of our members’ medical records. We expect you to achieve a passing score of 85% or better. To achieve this score, the medical records you maintain should contain an initial health assessment, including a baseline comprehensive medical history. This assessment should be completed in less than 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).
- 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 initiated by primary care provider to indicate review.
- Consultation and abnormal studies including follow-up plans.

Member hospitalization records should include, as appropriate:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- Documentation of appropriate preventive screening and services
- Documentation of behavioral health assessment (CAGE-AID, TWEAK AND PHQ-9)
Chapter 10: Quality Management (QM) Program and Compliance Information

Key contacts

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

Looking for something else?

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

What is the Quality Improvement program?

UnitedHealthcare Community Plan’s complete 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.
- Cooperating with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.
- Taking part in quality audits, such as site visits and medical record standards reviews. You must also take part in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review.
- Providing requested medical records at no cost (or as indicated in your Agreement with us). You may do so during site visits, by email or secure email.
- Completing appointment access and availability surveys.
- Allowing the plan to use your performance data.
- Offering Medicaid members the same number of office hours as commercial members (or don’t restrict office hours you offer Medicaid members).

Care provider satisfaction

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

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

Our main concern with the survey is objectivity. That’s why we engage independent market research firm Escalent to analyze and report findings.

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

**Clinical Practice Guidelines**

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. We respect our network care providers. We appreciate the collaboration to promote better health, improve health outcomes and lower overall costs to offer our members. You are encouraged to visit the following website to view the guidelines, as they are an important resource to guide clinical decision-making.

[UHCprovider.com/cpg](http://UHCprovider.com/cpg)

**Credentialing standards**

To join the UnitedHealthcare Community Plan network, you must register and enroll with the Department as a North Carolina Medicaid care provider. This includes provider disclosure, screening and enrollment requirements.

The [Provider Enrollment Online Application](#) is a user-friendly online application that gathers all the information needed to enroll you or your organization as a licensed Medicaid provider in North Carolina.

**Credentialing and recredentialing process**

You must go through the credentialing and recredentialing process before you may treat our members.

We accept care provider credentialing and verified information from NC DHHS or a designated NC DHHS vendor. We will not request more credentialing information from you without NC DHHS’s written prior approval. We are not prohibited from collecting other information from you necessary for contracting processes.

NC DHHS has established a centralized credentialing process including a standardized provider enrollment application and qualification verification process. The Department will engage a Provider Data Management/Credential Verification Organization (PDM/CVO), where the CVO is certified by the National Committee on Quality Assurance (NCQA), to facilitate the enrollment process including the collection and verification of provider education, training, experience and competency.

It is the provider’s obligation to complete reenrollment/ recredentialing before contract renewal and in accordance with the following:

1. At least every five years during the provider credentialing transition period.
2. At least every three years during the provider credentialing under full implementation period, except as otherwise permitted by the Department

In addition, we will evaluate a contracted provider’s continued eligibility for contracting by confirming the appearance of the provider on the daily Provider Enrollment File.

**Care providers subject to credentialing and recredentialing**

NC DHHS 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)

Organizational providers (e.g., hospitals, home health agencies, SNFs, ambulatory surgery centers, long-term...
services and supports providers) are also subject to applicable requirements.

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

### Health facilities

Facility providers such as hospitals, home health agencies, SNFs and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements.

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

The enrollment application is completed online by the NCTracks provider portal. To login to the provider portal you will need a NCID. Reference the “Getting Started” page of the portal for additional information.

### Peer review

#### Recredentialing process

You must complete the re-credential/re-verification process every three years to help ensure your provider information is accurate and current. As part of this process, credentials and qualifications will be evaluated to help ensure they meet the professional requirements and are in good standing.

You will receive a re-credentialing/re-verification letter, or an invitation by NCTracks secure portal inbox or email, when scheduled to begin the recredentialing process.

### 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 will need to submit a Manage Change Request (MCR) by contacting the NCTracks Call Center at 800-688-6696. If you have any questions regarding completion of the Provider Enrollment Online Application, please contact the CSRA Call Center by phone at 800-688-6696, at 855-710-1965, or email at NCTracksprovider@nctracks.com.

### Confidentiality

The credentialing/recredentialing process and the information obtained through it is confidential. All individuals with file access are responsible to assure that all credentialing/recredentialing information remains confidential, except as otherwise provided by law.

UnitedHealthcare Community Plan is prohibited from using, disclosing or sharing your credentialing information for any purpose other than use in Medicaid Managed Care without the express, written consent of you and the NC DHHS.

### Medicaid-enrolled provider

You must be enrolled with the Department as a North Carolina Medicaid care provider, consistent with applicable provider disclosure, screening and enrollment requirements.

### HIPAA compliance – your responsibilities

#### Health Insurance Portability and Accountability Act

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

**Transactions and code sets**

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

**Unique identifier**

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

**National Provider Identifier**

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

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

**Privacy of individually identifiable health information**

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

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

**Security**

Covered entities must meet basic security measures:

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

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

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

**Ethics and integrity**

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

**Compliance program**

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

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

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

**Reporting and auditing**

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

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

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

Please refer to the Fraud, Waste and Abuse section of this manual for more 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 North Carolina 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 North Carolina 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 North Carolina 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 North Carolina program standards.

You must cooperate with the state or any of its authorized representatives, the North Carolina 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 care (QOC) and services concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all primary care provider office sites to help ensure facility quality.

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

- Clean and orderly overall appearance.
- Available handicapped parking.
- Handicapped accessible facility.
- Available adequate waiting room space
- Adequate exam rooms for providing member care.
- Privacy in exam rooms.
- 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.

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

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

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

Our claims process

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

UnitedHealthcare Community Plan follows the same claims process as UnitedHealthcare.

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

Claims: From submission to payment

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

Claims reconsideration and appeals

If you think we processed your claim incorrectly, please see the Claims Reconsiderations, Appeals and Grievances chapter in this manual for next steps.

National Provider Identifier

HIPAA requires you have a unique NPI. The NPI identifies you in all standard transactions.
If you have not applied for a NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan. Call Provider Services.

Your clean claims must include your NPI and federal TIN. All NPIs or APIs (state atypical ID) submitted on a claim must be active on the North Carolina state provider credential file for the date of service and submit their taxonomy for billing, rendering or attending.

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 dates 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.

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.

Clean claims and submission requirements

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

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

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

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

Care provider coding

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

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

- All claims are set up as “commercial” through the clearinghouse.
- Our payer ID is 87726.
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don’t successfully transmit.
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for HCFA 1500 and UB-04 forms.

For more information, contact EDI Claims.

EDI companion documents

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

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

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

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

Clearinghouse and status reports

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

For clearinghouse options, use our EDI at UHCprovider.com > Menu > Resource Library > Electronic Data Interchange > Clearinghouse.

e-business support

Call Provider Services at 800-638-3302 for help with online billing, claims, Electronic Remittance Advices (ERAs) and Electronic Funds Transfers (EFTs).

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

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

Electronic Payment Solutions

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

Why Choose ACH/Direct Deposit?

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

What Does This Mean to You?

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

Completing the CMS 1500 claim Form

Companion documents for 837 transactions are on [UHCprovider.com](http://UHCprovider.com). Click Menu, then Resource Library to find the EDI section.

Visit the [National Uniform Claim Committee](http://www.nucc.org) website to learn how to complete the CMS 1500 form.

Completing the UB-04 Form

Bill all hospital inpatient, outpatient and ER services using revenue codes and the UB-04 claim form:
• Include ICD CM diagnosis codes.
• Identify other services by the CPT/HCPCS and modifiers.

Capitated services

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period. We pay you whether that person seeks care. In most instances, the capitated care provider is either a medical group or an Independent Practice Association (IPA). In a few instances, however, the capitated care provider may be an ancillary provider or hospital.

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

1. Who have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare Community Plan for such member, 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.

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

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

Form reminders

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

Subrogation and coordination of benefit

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

• **Subrogation:** We may recover benefits paid for a member’s treatment when a third party is liable for medical bills related to 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.

Hospital and clinic method of billing professional services

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

Global days

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

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

Correct Coding Initiative

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

Comprehensive and component codes

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

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

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 obstetrical services

Follow this reporting procedure when submitting obstetrical delivery claims. Otherwise, we will deny the claim:

• If billing for both delivery and prenatal care, use the date of delivery.
• Use one unit with the appropriate charge in the charge column.

Billing guidelines for transplants

UnitedHealthcare Community Plan covers medically necessary, non-experimental transplants, including the transplant evaluation and work-ups. Obtain prior authorization for the transplant evaluation, including all required referrals and evaluations, to complete the pre-transplant evaluation process once the member is identified as a possible candidate.

Ambulance claims (emergency)

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

Interest and penalty for late claims payment

We will pay interest on late payments to you at the annual percentage rate of 18% beginning on the first day after the date the claim should have been paid, as specified in the Agreement. In addition, we will pay you a penalty equal to 1 percent of the claim for each calendar day following the date the claim should have been paid, as specified in the Agreement.

We will process claims based on requirements by the North Carolina Gen. Stat. § 58-3-225:

• We will, within 18 calendar days of receiving a medical claim, notify you whether the claim is clean or pended the claim and request from you all additional information needed to timely process the claim.
• We will pay or deny a clean medical claim at lesser of 30 calendar days of claim receipt or the first scheduled care provider reimbursement cycle following adjudication.
• A medical pended claim will be paid or denied within 30 calendar days of receipt of the requested additional information.
• If the requested additional information on a medical claim is not submitted within 90 calendar days of the notice requesting the required additional information, we may deny the claim based on N.C. Gen. Stat. § 58-3-225(d).
• For purposes of actions which must be taken by us as found in the Prompt Pay Standards, if the referenced calendar day falls on a weekend or a holiday, the first business day following that day is the date the required action must be taken.
• If you submit an adjustment to a previously adjudicated claim, we adjudicate the new claim within the same time frames as the initial clean claim.

National Drug Code

Claims must include:

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

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

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

Place of Service codes

Go to CMS.gov for Place of Service codes.

Asking about a claim

You can ask about claims through UnitedHealthcare 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. Limit phone calls to five issues per call.

UnitedHealthcare Community Plan Provider Portal

You can view your online transactions with the Provider Portal by signing in at UHCprovider.com with your One Healthcare ID. This portal offers you with online support any time. If you are not already registered, you may do so on the website.

The Provider Portal lets you move quickly between applications. This helps you:

- Check member eligibility.
- Submit claims reconsiderations.
- Review coordination of benefits information.

- Use the integrated applications to complete multiple transactions at once.
- Reduce phone calls and paperwork.

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

Find training on UHCprovider.com/training. Click “Digital Solutions” to find the Provider Portal User Guide.

Resolving claim issues

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

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 5280
Kingston, NY 12402-5240

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

For paper claims

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

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

Timely filing

Timely filing issues may occur if members give the wrong insurance information. 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.
- We deny a claim for late submission, unauthorized service or as not medically necessary.
- UnitedHealthcare Community Plan is reviewing a claim

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

If you don’t know who your provider advocate is, email CarolinasPRTeam@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 report other found insurance. You must also bill and obtain an explanation of benefits (EOB) from any other insurance or health care coverage resource before billing UnitedHealthcare Community Plan, as required by contract. Refer to your Agreement for third-party claim submission deadlines. Once you bill the other carrier and receive an EOB, the claim may then be submitted to UnitedHealthcare Community Plan. Please attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or denial reason.
Chapter 12: Claim Reconsiderations, Appeals and Grievances

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

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

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

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>DEFINITION</th>
<th>WHO MAY SUBMIT?</th>
<th>SUBMISSION ADDRESS</th>
<th>ONLINE FORM FOR OR MAIL</th>
<th>CONTACT PHONE NUMBER/ WEBSITE (Care Providers Only) for Online Submissions</th>
<th>CARE PROVIDER FILING TIME FRAME</th>
<th>UnitedHealthcare Community Plan RESPONSE TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Provider Claim Resubmission</td>
<td>Creating a new claim. If a claim was denied and you resubmit the claim (as if it was a new claim), then you will normally receive a duplicate claim rejection on your resubmission</td>
<td>UnitedHealthcare Community Plan P.O. Box 5280 Kingston, NY 12402-5240</td>
<td>UHCprovider.com/claims</td>
<td>800-638-3302</td>
<td>Use the Claims Management or Claims on the Provider Portal. Click Sign in to the Provider Portal in the top right corner of UHCprovider.com, then click Claims.</td>
<td>PAR: within 90 calendar days from the date of notice (i.e., remittance advice/PRA or request for additional information)</td>
<td>NONPAR: within 90 calendar days after the date of notice.</td>
</tr>
</tbody>
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</tr>
</thead>
<tbody>
<tr>
<td>Care Provider Claim</td>
<td>Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.</td>
<td>Care Provider</td>
<td>UnitedHealthcare Community Plan P.O. Box 5280 Kingston, NY 12402-5240</td>
<td>800-638-3302</td>
<td>Use the Claims Management or Claims on the Provider Portal. Click Sign in to the Provider Portal in the top right corner of UHCprovider.com, then click Claims.</td>
<td>PAR: 180 calendar days from the date of notice (i.e., remittance advice/PRA) NONPAR: 180 calendar days from the date of notice (i.e., remittance advice/PRA).</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>Care Provider Claim Formal Appeal (step 2 of claim payment dispute)</td>
<td>A second review in which you did not agree with the outcome of the reconsideration.</td>
<td>• Care provider • Attorney with proof of representation</td>
<td>UnitedHealthcare Community Plan Grievances and Appeals Unit P.O. Box 31364 Salt Lake City, UT 84131-0364</td>
<td>800-638-3302</td>
<td>Use the Claims Management or Claims on the Provider Portal. Click Sign in to the Provider Portal in the top right corner of UHCprovider.com, then click Claims.</td>
<td>Within 30 calendar days on which the provider receives written notice of the reconsideration decision giving the right to appeal. The timeframe may be extended by an additional 30 calendar days when a provider submits evidence of a good-cause such as the voluminous nature of required evidence to support the appeal.</td>
<td>Acknowledge within 5 calendar days of receipt of the request. Resolve within 30 calendar days.</td>
</tr>
<tr>
<td>Care Provider Grievance</td>
<td>A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member</td>
<td>Care Provider</td>
<td>UnitedHealthcare Community Plan Grievances and Appeals Unit P.O. Box 31364 Salt Lake City, UT 84131-0364</td>
<td>800-638-3302</td>
<td>Use the Claims Management or Claims on the Provider Portal. Click Sign in to the Provider Portal in the top right corner of UHCprovider.com, then click Claims.</td>
<td>No time limit</td>
<td>Acknowledge within 5 calendar days of receipt of the request. Resolve within 30 calendar days.</td>
</tr>
</tbody>
</table>
### Chapter 12: Claim Reconsiderations, Appeals and Grievances

#### APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>DEFINITION</th>
<th>WHO MAY SUBMIT?</th>
<th>SUBMISSION ADDRESS</th>
<th>ONLINE FORM FOR OR MAIL</th>
<th>CONTACT PHONE NUMBER/WEBSTIE (Care Providers Only) for Online Submissions</th>
<th>CARE PROVIDER FILING TIME FRAME</th>
<th>UnitedHealthcare Community Plan RESPONSE TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Appeal</td>
<td>A request to change an adverse benefit determination that we made.</td>
<td>• Member&lt;br&gt;• Care provider or authorized representative (such as friend or family member) on behalf of a member with member’s written consent</td>
<td>UnitedHealthcare Community Plan Grievances and Appeals Unit&lt;br&gt;P.O. Box 31364&lt;br&gt;Salt Lake City, UT 84131-0364</td>
<td><a href="#">UHCprovider.com/claims</a></td>
<td>Member Services: 800-349-1855</td>
<td>60 calendar days from the date on the adverse benefit determination notice</td>
<td>Acknowledge within 5 calendar days for standard appeals. Expedited appeals resolved within 72 hours.&quot; Standard appeals resolved within 30 calendar days.&quot; &quot;May be extended by 14 calendar days.</td>
</tr>
<tr>
<td>Member Grievance</td>
<td>A member’s expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.</td>
<td>• Member&lt;br&gt;• Care provider or authorized representative (such as friend or family member) on behalf of a member with member’s written consent</td>
<td>UnitedHealthcare Community Plan Grievances and Appeals Unit&lt;br&gt;P.O. Box 31364&lt;br&gt;Salt Lake City, UT 84131</td>
<td>Member Services: 800-349-1855</td>
<td>No time limit</td>
<td>Acknowledge within 5 calendar days for standard grievances. 5 calendar days to resolve expedited grievance. 30 calendar days&quot; (all other grievances). &quot;May be extended by 14 calendar days.</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

Other top reasons for denial include:

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

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

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

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

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

Claim correction

**What is it?**

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

**When to use:**

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

**How to use:**

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

**Mailing address:**

UnitedHealthcare Community Plan  
P.O. Box 5280  
Kingston, NY 12402-5240

**Additional Information:**

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

Resubmitting a claim

**What is it?**

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

**When to use it:**

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

**Common Reasons for Rejected Claims:**

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

- Errors in member demographic data – name, age, date of birth, sex or address.
- Errors in care provider data.
- Wrong member insurance ID.
- No referring care provider ID or NPI number.
How to use:
To resubmit the claim, follow the same submission instructions as a new claim. To mail your resubmission, provide all claim information to:

UnitedHealthcare Community Plan
P.O. Box 5280
Kingston, NY 12402

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

Claim reconsideration (step one of claim payment dispute)

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

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

For administrative denials:
• In your reconsideration request, please ask for a medical necessity review and include all relevant medical records.

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

How to use:
If you disagree with a claim determination, submit a claim reconsideration request electronically, by phone or mail:
• **Electronically:** Use the Claim Reconsideration application on the Provider Portal. Include electronic attachments. You may also check your status using the Provider Portal.
• **Phone:** Call Provider Services at 800-638-3302 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 5280
Kingston, NY 12402

This form is available at UHCprovider.com/claims.

Tips for successful claims resolution

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

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

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

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

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

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

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

Overpayment

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

How to use:
If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within 60 days. If your payment is not received by that time, we may apply the overpayment against future claim payments based on our Agreement and applicable law. If you prefer we recoup the funds from your next payment, call Provider Services.

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

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

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

UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 101760
Atlanta, GA 30392

Instructions and forms are on UHCprovider.com/claims.

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

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

We make claim adjustments without requesting additional information from you by taking the claim data from the claim system and submitting it to the state as encounter data. Once the payment has been recovered, you see the adjustment on the EOB or Provider Remittance Advice (PRA). We submit the adjustment to the state in the encounter submission as either a replacement or void and new day, depending on the original encounter status. When additional information is needed, we 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.*

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Date of Service</th>
<th>Original Claim #</th>
<th>Date of Payment</th>
<th>Paid Amount</th>
<th>Amount of Overpayment</th>
<th>Reason for Overpayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>11111</td>
<td>01/01/14</td>
<td>14A0000000001</td>
<td>01/31/14</td>
<td>115.03</td>
<td>115.03</td>
<td>Double payment of claim</td>
</tr>
<tr>
<td>222222</td>
<td>02/02/14</td>
<td>14A0000000002</td>
<td>03/15/14</td>
<td>279.34</td>
<td>27.19</td>
<td>Contract states $50, claim paid 77.29</td>
</tr>
<tr>
<td>3333333</td>
<td>03/03/14</td>
<td>14A0000000003</td>
<td>04/01/14</td>
<td>131.41</td>
<td>99.81</td>
<td>You paid 4 units, we billed only 1</td>
</tr>
<tr>
<td>44444444</td>
<td>04/04/14</td>
<td>14A0000000004</td>
<td>05/02/14</td>
<td>412.26</td>
<td>412.26</td>
<td>Member has other insurance</td>
</tr>
<tr>
<td>555555555</td>
<td>05/05/14</td>
<td>14A0000000005</td>
<td>06/15/14</td>
<td>332.63</td>
<td>332.63</td>
<td>Member terminated</td>
</tr>
</tbody>
</table>

### Claim appeals (step two of claim payment dispute)

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

**When to use/file:**
If you do not agree with the outcome of the claim reconsideration, use the claim appeal process. Also refer to the Other Provider Appeals Situations section of this chapter.

**Timely Filing:**
You must submit an appeal within 30 calendar days from receipt of UnitedHealthcare Community Plan’s response or determination, or from the date when we should have taken action but did not do so.

**Exception:**
We may extend the time frame by an additional 30 calendar days if you submit a large amount of good cause evidence to support the 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 or by mail. In your appeal, please include any supporting information not included with your appeal request. You may have an attorney represent you.

- **Electronic claims:** Use the Claims Management application on the Provider Portal. You may upload attachments.
- **Mail:** Send the appeal to:
  
  UnitedHealthcare Community Plan  
  Attn: Appeals and Grievances Unit  
  P.O. Box 31364  
  Salt Lake City, UT 84131-0364

### Other care provider appeals situations

In some cases, when you submit a care provider appeal, we appoint a committee to review and issue a decision.
Chapter 12: Claim Reconsiderations, Appeals and Grievances

When to use:
If you are a network care provider, and you do not agree with the claim reconsideration outcome in step one, use the claim appeal process in the following cases:

- Program Integrity-related findings or activities.
- Finding of fraud, waste, or abuse by UnitedHealthcare Community Plan.
- Finding of or recovery of an overpayment by UnitedHealthcare Community Plan.
- Withhold or suspension of a payment related to fraud, waste, or abuse concerns.
- Termination of, or determination not to renew, an existing contract for LHD care management services.
- Determination to lower an AMH care provider’s tier status.
- Violation of terms between you and us.

If you are an out-of-network care provider, follow the claim appeal process when the following occurs:

- An out-of-network payment arrangement.
- Finding of waste or abuse by the UnitedHealthcare Community Plan.
- Finding of or recovery of an overpayment by UnitedHealthcare Community Plan.

We will offer you an in-person or phone hearing when you are appealing whether we have good cause to withhold or suspend payment to you. We will schedule the hearing and issue a written decision about whether we had good cause to suspend or withhold payment within 15 business days of receiving the appeal.

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

Provider grievance

What is it?
Grievances are complaints where remedial action is not requested.

When to file:
You may file a grievance about:

- Benefits and limitations.
- Eligibility and enrollment of a member or care provider.

Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses the Centers for Medicare and Medicaid Services (CMS) definitions for appeals and grievances.

Member appeals

What is it?
An appeal is a formal way to share dissatisfaction with a benefit determination.

You (with a member’s written consent) or a member may appeal when the plan:

- Lowers, suspends or ends a previously authorized service.
- Refuses, in whole or part, payment for services.
- Doesn’t provide services in a timely manner, as defined by the state or CMS.
- Doesn’t act within the time frame CMS or the state requires.
When to use:
You may act on the member’s behalf with their written consent. You may provide medical records and supporting documentation as appropriate.

Where to send:
You or the member may call or mail the information within 60 calendar days from the date of the adverse benefit determination.

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 84130-0364

Phone: Call Member Services toll-free at 800-349-1855 Monday - Saturday, 7 a.m. - 6 p.m. Eastern Time, including state holidays.

How to use:
Whenever we deny a service, we must provide the member with UnitedHealthcare Community Plan appeal rights. The member has the right to:

- Receive a copy of the rule used to make the decision.
- Ask UnitedHealthcare Community Plan Member Services for help writing the letter.
- Present evidence, and allegations of fact or law, in person and in writing.
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written documents considered for the appeal.
- Ask for an expedited appeal if waiting could seriously jeopardize the member’s life; physical or mental health; or ability to attain, maintain, or regain maximum function.
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the provider, you cannot ask for a continuation. Only the member may do so.

We resolve a standard appeal 30 calendar days from the day we receive it.

We resolve an expedited appeal as quickly as the member’s condition requires and provide written notice. We must make reasonable effort to give oral notice of resolution no later than 72 hours of receipt of the request.

We may extend the response up to 14 calendar days if the member requests that we take longer. We may also extend it if it we request more information and explain how the delay is in the member’s interest.

If submitting the appeal by mail, you must complete the Authorization of Review (AOR) form-Claim Appeal.

A copy of the form is online at UHCprovider.com.

Member grievance

What is it?
A grievance is an expression of dissatisfaction about UnitedHealthcare Community Plan and/or a care provider about any matter other than an adverse benefit determination. This includes quality of care or service concerns and aspects of interpersonal relationships, such as a care provider or employee’s rudeness.

When to use:
You may act on the member’s behalf with their written consent.

Where to send:
You or the member may call or mail the information to:

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

Phone: Call Member Services toll-free at 800-349-1855 Monday - Saturday, 7 a.m. - 6 p.m. Eastern Time, including state holidays.

We will send an answer within 30 calendar days from when you file the grievance or as quickly as the member’s health condition requires. If an extension is needed, we will send an answer no longer than 44 calendar days from when you file the grievance. If the grievance involves us denying a member’s request to expedite an appeal decision, we send an answer within five calendar days.
State fair hearings

What is it?
A state fair hearing (SFH) lets members share why they think North Carolina Medicaid services should not have been denied, reduced or terminated.

When to use:
Members have 120 calendar days from the date on UnitedHealthcare Community Plan’s adverse appeal determination letter.

How to use:
To request an SFH, call The Office of Administrative Hearings at 984-236-1850 or write to the North Carolina Office of Administrative Hearings, Hearings Division and Clerks’ office:

Mail: Office of Administrative Hearings
1711 New Hope Church Road
Raleigh, NC 27609
Phone: 984-236-1850
Fax: 984-236-1871

For Medicaid-Specific inquiries:
Office of Administrative Hearings
Medicaid Hotline
Phone: 984-236-1860

Website: oah.nc.gov > Hearings Division > Medicaid Recipient Appeals > Filing a Contested Medicaid Recipient Appeal

Email: nc_sfh@uhc.com

• The member may ask UnitedHealthcare Community Plan Member Services for help writing the letter.
• The member may have someone attend with them. This may be a family member, friend, care provider or lawyer. Written consent is required.

Processes related to reversal of our initial decision
If the SFH decides UnitedHealthcare Community Plan must approve appealed services, we pay for the services as specified in the policy and/or regulation.

Fraud, waste and abuse

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

UnitedHealthcare Community Plan’s Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to the NC DHHS and the Medicaid Investigation Division 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 NC DHHS and the Medicaid Investigation Division in the investigation or prevention of fraud, waste and abuse.

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

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

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

Exclusion checks

First-tier, downstream and related entities (FDRs) must review federal (HHS-OIG and GSA), System of Award Management (SAM), Social Security Administration Death Master File (SSADMF), National Plan and Provider Enumeration System (NPPES), the Office of Foreign Assets Control (OFAC), and state exclusion lists before hiring/contracting persons with an ownership or controlling interest in the health plan, agents and managing health plan employees, network care providers, delegated entities and subcontractors. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month.

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

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

Prepayment review

If you have been added to prepayment review and wish to be removed, call Provider Services and ask to speak with an Optum RAVE Team member. The Optum RAVE analyst will research the request, ask you for appropriate documentation, and present it to UnitedHealthcare Community Plan governance for removal. Prepayment review happens on an as-needed basis.

What you need to do for exclusion checks

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.
Chapter 13: Care Provider Communications and Outreach

Key contacts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Education</td>
<td>UHCprovider.com &gt; Menu &gt; Resource Library</td>
<td>800-638-3302</td>
</tr>
<tr>
<td>News and Bulletins</td>
<td>UHCprovider.com &gt; News and Network Bulletin</td>
<td>800-638-3302</td>
</tr>
<tr>
<td>Provider Manuals</td>
<td>UHCprovider.com/guides</td>
<td>800-638-3302</td>
</tr>
</tbody>
</table>

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

Connect with us on social media

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

- Website
- Forums/town hall meetings
- Newsletters and bulletins
- Manual
- Provider relations team support

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 (e.g., PreCheck MyScript)

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.

UnitedHealthcare Community Plan provides training to new care providers within 30 days of joining the network. We also offer periodic live and virtual training sessions.

You may also find training on various topics at UHCprovider.com > Menu > Resource Library > More Resource Topics > Training.
Care provider newsletters and Network Bulletins

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

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

Network Bulletin

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

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

Provider relations team support

Physician and hospital advocates regularly visit care providers. We also have daily availability of our provider relations team by email. We do this to create program awareness, promote compliance and assist with revenue cycle questions and issues.

Care provider manual

UnitedHealthcare Community Plan publishes this manual online based on the guidelines in its contract with North Carolina. The care provider manual includes an overview of the program, a toll-free number for Provider Services, and a list of additional care provider resources. To request a physical copy of the manual, write to your provider advocate or call Provider Services.

State website and forms

Find the following forms on the state’s website at medicaid.ncdhhs.gov/forms:

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

AABD
Assistance to the aged, blind and disabled

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

Abuse (of member)
Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S 46-451.

Adverse Benefit Determination
(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
(2) The reduction, suspension, or termination of a previously authorized service.
(3) A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a clean claim.
(4) The failure to provide services in a timely manner, as defined by the state.
(5) The failure of someone or a company to act within the time frames provided in the contract and within the standard resolution of grievances and appeals.
(6) For a resident of a rural area, the denial of a member’s request to exercise their right, to obtain services outside the network.
(7) The denial of an member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

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 an adverse benefit determination.

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

Behavioral Health Care
Assessment and treatment of mental health and/or substance use disorders (MH/SUD).

Billed Charges
Charges you bill for rendering services to a UnitedHealthcare Community Plan member.
Capitation
A prepaid, periodic payment to providers, based upon the number of assigned members made to a care provider for providing covered services for a specific period.

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

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

CHIP
Children’s Health Insurance Program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Electronic Funds Transfer (EFT)**
The electronic exchange of funds between two or more organizations.

**Electronic Medical Record (EMR)**
An electronic version of a member’s health record and the care they have received.

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

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

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

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

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

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

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

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

**FHC**
Family Health Center

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

**Grievance**
A member’s expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights regardless of whether remedial action is requested. Grievance includes a member’s right to dispute an extension of time proposed by UnitedHealthcare Community Plan to make an authorization decision.

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

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

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

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

**Medicaid**
A federal health insurance program for low-income families and children, eligible pregnant women, people with disabilities, and other adults. The federal government pays for part of Medicaid and sets
guidelines for the program. States pay for part of Medicaid and have choices in how they design their program. Medicaid varies by state and may have a different name in your state.

**Medical Emergency**
An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention you could reasonably expect one of the following to result:
- Their health would be put in danger; or
- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body.

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

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

**Mental Health and/or Substance Use Disorder (MH SUD)**
Mental health and/or substance use disorder.

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

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

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

**Primary Care Provider (PCP)**
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or 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 NC DHHS.

**Specialist**
A care provider licensed in the state of North Carolina 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 (SFH)**
A member’s request for an administrative hearing when the member does not agree with an Adverse Appeal Notice or if UnitedHealthcare Community Plan fails to decide the member’s appeal timely.

**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
Glossary

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.