# 2025 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

**Nebraska**

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United Healthcare Community Plan

# Welcome

Welcome to the UnitedHealthcare Community Plan® care provider manual. This up-to-date reference PDF manual allows you and your staff to find important information, such as how to process a claim and submit prior authorization requests. It features important phone numbers and websites in the **How to Contact Us** section.

## Click to access different care provider manuals

- **Administrative guide** – **UHCprovider.com/guides**
  - Under UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans), click on View Guide. Some states may also have Medicare Advantage information in their Community Plan manual.
- **A different Community Plan care provider manual** – **UHCprovider.com/guides**
  - Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on **Your State**

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

Questions about the information or material in this manual or policies, please call **Provider Services** at **1-866-331-2243**.

# Important information about the use of this care provider manual

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

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

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

This care provider manual will be amended as policies change.

## Participation Agreement

Terms and definitions as used in this care provider manual:

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

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

# Table of contents

# Chapter 1: Introduction

## Key contacts

| Topic | Link | Phone number |
|---|---|---|
| Provider Services | **UHCprovider.com**<br>Live chat available at **UHCprovider.com/contactus** | **1-866-331-2243** |
| Training | **UHCprovider.com/training** | |
| UnitedHealthcare Provider Portal | **UHCprovider.com**, then Sign In using your One Healthcare ID or go to **UHCprovider.com/portal**<br>New users: **UHCprovider.com/access** | |
| CommunityCare Provider Portal training | **UnitedHealthcare CommunityCare Provider Portal user guide** | |
| One Healthcare ID support (formally known as Optum support) | Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat** | **1-855-819-5909** |
| Resource library | **UHCprovider.com/resourcelibrary** | |

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

- Children, from birth through 18 years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act
- Pregnant members, eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act
- Children eligible for the Children's Health Insurance Program (CHIP)
- Blind and disabled children and adults who are not eligible for Medicare
- Medicaid eligible families
- Members eligible for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Every Woman Matters)
- Medicaid beneficiaries 65 years or older and not members of the blind/disabled population or members of the Section 1931 adult population
- Medicaid beneficiaries participating in a Waiver program. This includes adults with intellectual disabilities or related conditions; children with intellectual disabilities and their families, aged persons and adults and children with disabilities; members receiving targeted case management through the Department of Health and Human Services (DHHS) Division of Developmental Disabilities; Traumatic Brain Injury (TBI) Waiver participants; and any other group covered by the state's 1915(c) waiver of the Social Security Act.
- Retroactively eligible Medicaid beneficiaries, when mandatory enrollment for managed care has been determined
- Members eligible during presumptive eligibility

DHSS will determine enrollment eligibility.

# How to join our network

Learn how to join the UnitedHealthcare Community Plan care provider network at **UHCprovider.com/join**. Guidance on our credentialing process, and how to sign up for self-service and other helpful information can be found here: **uhcprovider.com/en/health-plans-by-state/nebraska-health-plans/ne-comm-plan-home.html.**

### Already in network and need to make a change?

To change an address or phone number, add or remove physicians from your TIN, or make other changes, go to My Practice Profile at **UHCprovider.com/attestation**.

# Approach to health care

### Care Model

The Care Model program seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community to improve care coordination and elevate outcomes.

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

These interventions address members' specific needs, resulting in better quality of life, improved access to health care and reduced expenses.

Care Model provides a care management/coordination team that helps increase member engagement, offers resources to fill gaps in care and develops personalized health goals using evidence-based clinical guidelines.

This approach is essential to improving the health and well-being of the individuals, families and communities UnitedHealthcare Community Plan serves.

Care Model provides:

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

The Care Model program goals are to:

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

# Compliance

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates National Provider Identifier (NPI) usage in all standard transactions (claims, eligibility, remittance advice, claims status request/response and authorization request/response) for all care providers who handle business electronically.

# Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. The goal of the program is to break down linguistic and cultural barriers to build trust and improve health outcomes. You must support our Cultural Competency Program. For more information, go to **UHCprovider.com/resourcelibrary** > Health Equity Resources > **Cultural Competency**.

- **Cultural competency training and education**

  Free continuing medical education (CME) and non-CME courses are available on our **Cultural Competency page** as well as other important resources.

  Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process**.

UnitedHealthcare Community Plan provides the following:

- **Language interpretation line**
  - We provide oral interpreter services Monday–Friday from 8 a.m.–8 p.m. ET
  - To arrange for interpreter services, please call **1-877-842-3210** TTY **711**
- **I Speak language assistance card**

  This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare members.
- **Materials for limited English-speaking members**

  We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

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

# Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual® for medical care determinations.

# Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster.

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

This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents. This includes appeals prior authorization requests and decisions. Using electronic transactions is fast and efficient – and supports a paperless work environment. Use Application Programming Interface (API), electronic data interchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

## Application programming interface

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

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

## Electronic data interchange

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

The benefit of using EDI is it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging in to different payer websites to manually request information.

This is why EDI is usually care providers' and UnitedHealthcare Community Plan's first choice for electronic transactions.

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

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

**Getting started**

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

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

## Point of Care Assist

When made available by UnitedHealthcare Community Plan, you will do business with us electronically.

Point of Care Assist® integrates members' UnitedHealthcare health data within the Electronic Medical Record (EMR) to provide real-time insights into their care needs, aligned to their specific member benefits and costs. This makes it easier for you to see potential gaps in care, select labs, estimate care costs and check prior authorization requirements, including benefit eligibility and coverage details. This helps you to better serve your patients and achieve better results for your practice. For more information, go to **UHCprovider.com/poca**.

## UHCprovider.com

This **public website** is available 24/7 and does not require registration to access. You'll find valuable resources, including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.

## UnitedHealthcare Provider Portal

Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal**. You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information — all at no cost without calling.

See **UnitedHealthcare Provider Portal** for access and to create ID or sign in using a One Healthcare ID.

- If you already have a One Healthcare ID, simply go to the **UnitedHealthcare Provider Portal** to access
- If you need to set up an account on the portal, follow **these steps** to register

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

- **Eligibility and benefits**
  View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.
- **Claims**
  Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims**.
- **Prior authorization and notification**
  Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/priorauth**.
- **Specialty pharmacy transactions**
  Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to **UHCprovider.com/pharmacy** for more information.
- **My Practice Profile**
  View and update the provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.

- **Document Library**
  Access reports and claim letters for viewing, printing, or download. The Document Library Roster provides member contact information in a PDF, which can only be pulled at the individual practitioner level. For more information, go to **UHCprovider.com/documentlibrary**.

See **UnitedHealthcare Provider Portal** to learn more about the available self-paced user guides for various tools/tasks.

### Direct Connect

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

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

All users will access Direct Connect using the **UnitedHealthcare Provider Portal**. On-site and online training are available.

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

## Privileges

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

## Provider Services

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

They can answer your questions about Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more. Provider Services works closely with all departments in UnitedHealthcare Community Plan.

# How to contact us

*We no longer use fax numbers.

| Topic | Contact | Information |
|---|---|---|
| Behavioral, mental health and substance abuse | Optum®<br>**providerexpress.com**<br>**1-800-888-2998**<br>Prior authorization requests: **1-866-331-2243**<br>Claims/customer service eligibility and benefit information: **1-866-331-2243**<br>Update provider practice information, and ask about guidelines, policies and the national network manual: **1-877-614-0484**<br>Appeals and grievances: **1-866-556-8166** | Request support for connecting members to behavioral health services. Request prior authorization, ask about claims, clarify eligibility and benefit information, submit appeals and grievances, update care provider practice information, review guidelines and policies and view the national network manual. |
| Benefits | **UHCprovider.com/benefits**<br>**1-866-331-2243** | Confirm a member's benefits and/or prior authorization. |
| Care Model (care management/disease management) | For Nebraska care providers who would like to request case management for a member's use, please send an email to **ne_cm@uhc.com** | Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing. |
| Chiropractor care | **myoptumhealthphysicalhealth.com**<br>**1-800-873-4575** | Some covered services are provided in certain situations. For specific benefits information, please see **Chapter 3** of this manual. |
| Claims | **UHCprovider.com/claims**<br>**1-866-331-2243**<br>Mailing address:<br>**UnitedHealthcare Community Plan**<br>P.O. Box 31365<br>Salt Lake City, UT 84131<br>For FedEx (use for large packages/more than 500 pages):<br>**UnitedHealthcare Community Plan**<br>709 Grant Avenue, North Lobby<br>Lake Katrine, NY 12249 | Verify a claim status or get information about proper completion or submission of claims. |

| Topic | Contact | Information |
|---|---|---|
| Claim overpayments | Sign in to **UHCprovider.com/claims** to access the UnitedHealthcare Provider Portal.<br>**1-866-331-2243**<br>Mailing address:<br>**UnitedHealthcare Community Plan**<br>Attn: Recovery Services<br>P.O. Box 740804<br>Atlanta, GA 30374-0800 | Ask about claim overpayments.<br>See the **Overpayment** section for requirements before sending your request. |
| Dental services | Access the provider portal at **uhcdentalproviders.com** | Calls for details about dental eligibility, benefits, authorizations and claims or other key information. |
| Electronic data intake (EDI) issues | **EDI Transaction Support Form**<br>**UHCprovider.com/edi**<br>**ac_edi_ops@uhc.com**<br>**1-800-210-8315** | Contact EDI Support for issues. |
| Eligibility | **UHCprovider.com/eligibility**<br>Provider Services: **1-866-331-2243** or Nebraska Medicaid Eligibility System: 1-800-642-6092 | Confirm member eligibility. |
| Enterprise Voice Portal | Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal** | The Enterprise Voice Portal provides self-service functionality. Or call to speak with a contact center agent. |
| Fraud, waste and abuse (payment integrity) | Payment Integrity Information: **UHCprovider.com/necommunityplan** > Integrity of Claims, Reports, and Representations to the Government<br>Reporting: **uhc.com/fraud**<br>**1-844-359-7736** or **1-877-401-9430** | Learn about our payment integrity policies.<br>Report suspected FWA by a care provider or member by phone or online. |
| Laboratory services | **UHCprovider.com** > Our Network > **Preferred Lab Network**<br>Labcorp 1-800-833-3984<br>Quest Diagnostics 1-866-697-8378 | Labcorp and/or Quest Diagnostics are network laboratories. |
| Medicaid (Department of Social Services) | medicaid.gov<br>1-877-255-3092 (toll free)<br>1-402-471-9128 (Lincoln area) | Contact Medicaid directly. |

| Topic | Contact | Information |
|---|---|---|
| Medical claim, reconsideration and appeal | Most care providers in your state must submit reconsideration requests electronically.<br>For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide.**<br>For those care providers exempted from this requirement, requests may be submitted at one of the following addresses:<br>Reconsiderations mailing address:<br>**UnitedHealthcare Community Plan**<br>P.O. Box 5240<br>Kingston, NY 12402-5240<br>Appeals mailing address:<br>**UnitedHealthcare Community Plan Grievances and Appeals**<br>P.O. Box 31364<br>Salt Lake City, UT 84131-0364 | Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with. |
| Member Services | **myuhc.com®**<br>**1-800-641-1902**/TTY **711** | Helps assist members with issues or concerns. Available 7 a.m.–7 p.m. CT, Monday-Friday. |
| Multilingual/ Telecommunication Device for the Deaf (TDD) services | **1-800-641-1902**<br>TTY **711** | Available 8 a.m.–5 p.m. CT, Monday-Friday, except state-designated holidays. |
| National Plan and Provider Enumeration System (NPPES) | nppes.cms.hhs.gov<br>1-800-465-3203 | Apply for a National Provider Identifier (NPI). |
| Network management | **1-800-284-0626** | Ask about contracting and care provider services. |
| Network management support | Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**. | Self-service functionality for medical network care providers to update or check credentialing information. |
| NurseLine | **1-877-303-2422** | Available 24 hours a day, 7 days a week |
| Obstetrics/pregnancy and baby care | Healthy First Steps®<br>Pregnancy Notification Form at **UHCprovider.com**, then Sign In for the UnitedHealthcare Provider Portal.<br>**1-800-599-5985**<br>**uhchealthyfirststeps.com** | For pregnant members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form.<br>Refer members to **uhchealthyfirststeps.com** to sign up for Healthy First Steps Rewards. |

| Topic | Contact | Information |
|---|---|---|
| Oncology prior authorization | **UHCprovider.com/oncology**<br>**1-888-397-8129**<br>Monday–Friday, 7 a.m.–7 p.m. CT | For current list of CPT codes that require prior authorization for oncology. |
| One Healthcare ID support center | Chat with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat.**<br>**1-855-819-5909** | Contact if you have issues with your ID. Available 7 a.m.–9 p.m. CT, Monday-Friday; 6 a.m.–6 p.m. CT, Saturday; and 9 a.m.–6 p.m. CT, Sunday. |
| Pharmacy services | **professionals.optumrx.com**<br>**1-877-305-8952**<br>Pharmacy Benefit Manager Help Desk: **1-877-231-0131**<br>Pharmacy Assistance Line: **1-877-231-0131** (contact for durable medical equipment [DME] received at a pharmacy) | Optum Rx® oversees and manages our network pharmacies.<br>Use the UnitedHealthcare Provider Portal to access the PreCheck MyScript tool. |
| Prior authorization/ notification for pharmacy | **UHCprovider.com/pharmacy**<br>**1-800-310-6826** | Request authorization for medications as required.<br>Use the UnitedHealthcare Provider Portal to access the **PreCheck MyScript®** tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives. |
| Prior authorization requests/ advanced and admission notification | To notify us or request a medical prior authorization:<br>**EDI –** Transactions 278 and 278N<br>**Online – UHCprovider.com/priorauth**<br>**Phone –** Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications" or call **1-866-331-2243** | Use the Prior Authorization and Notification Tool online to:<br>• Determine if notification or prior authorization is required.<br>• Complete the notification or prior authorization process.<br>• Upload medical notes or attachments.<br>• Check request status<br>Information and advance notification/prior authorization lists:<br>**UHCprovider.com/necommunityplan** > Prior Authorization and Notification |

| Topic | Contact | Information |
|---|---|---|
| Provider advocate | Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page.<br>To locate your provider advocate and contact information, please use **UHCprovider.com/necommunityplan** > Contact Us > Nebraska Provider Advocates Contact Sheet | Contact your Nebraska provider advocate when assistance is needed to answer a question or resolve a claims payment-related issue. |
| Provider Services | **UHCprovider.com/necommunityplan**<br>**1-866-331-2243** | Available 7 a.m.–6 p.m. CT, Monday-Friday. |
| Referrals | **UHCprovider.com/referrals**<br>Provider Services **1-866-331-2243** | Submit new referral requests and check the status of referral submissions. |
| Reimbursement policy | **UHCprovider.com/necommunityplan** > **Policies and Protocols** | Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates. |
| Technical support | **UHCprovider.com/contactus**<br>**1-866-209-9320** for Optum support | Call if you have issues logging in to the UnitedHealthcare Provider Portal, you cannot submit a form, etc. |
| Tobacco Free Quit Now | 1-800-784-8669 | Ask about services for quitting tobacco/smoking. |
| Transportation (nonemergency medical) | Modivcare<br>modivcare.com<br>1-866-394-3984 | To arrange non-emergent transportation, please contact Modivcare at least 3 business days in advance. |
| Utilization management | Provider Services<br>**1-866-331-2243** | UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines.<br>For UM policies and protocols, go to **UHCprovider.com/protocols.**<br>Request a copy of our UM guidelines or information about the program. |
| Vaccines for Children program | 1-800-798-1696 | You must participate in the Vaccines for Children (VFC) program administered by the Department of Health and Human Services (DHHS) and must use the free vaccine when administering vaccine to qualified eligible children. Providers must enroll as VFC providers with DHHS to bill for the administration of the vaccine. |

| Topic | Contact | Information |
|---|---|---|
| Vision services | marchvisioncare.com<br>1-844-636-2724 | Prior authorization is not required for routine eye exams. Authorizations must be obtained from MARCH® Vision. |
| Website for Nebraska Community Plan | **UHCprovider.com/necommunityplan** | Access your state-specific Community Plan information on this website. |

# Chapter 2: Care provider standards and policies

## Key contacts

| Topic | Link | Phone number |
|---|---|---|
| Provider services | **UHCprovider.com** | **1-866-331-2243** |
| General care provider assistance | Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal** | |
| Eligibility | **UHCprovider.com/eligibility** | |
| Referrals | **UHCprovider.com/referrals** | |
| Provider directory | **UHCprovider.com/findprovider** | |

## General care provider responsibilities

### Nondiscrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them based on:

- Age
- Sex
- Race
- Physical
- Mental handicap
- National origin
- Religion
- Type of illness or condition

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

### Mainstreaming of members

To help ensure mainstreaming of Nebraska Medicaid members, UnitedHealthcare Community Plan will take affirmative action to provide covered services to members without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual orientation, genetic information or physical, or will take reasonable steps to help ensure subcontractors do the same. Prohibited practices include, but are not limited to the following, in accordance with 42 CFR 438.6(f):

- Denying or not providing a member a covered service or access to an available facility
- Providing a member a medically necessary covered service that is different, or is provided in a different manner or time from that provided to other members, other patients or the public at large, except where medically necessary
- Subjecting a member to segregation or separate treatment related to the receipt of a covered service, or restricting a member's enjoyment of an advantage or privilege enjoyed by others receiving a covered service
- Assigning times or places for the provision of services on the basis of race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, income status, Medicaid membership or physical or mental health of the participants to be served

### Communication between care providers and members

The UnitedHealthcare Community Plan Agreement is not intended to interfere with your relationship with members as patients or with

UnitedHealthcare Community Plan's ability to administer its quality improvement, utilization management or credentialing programs. Instead, we require communication between PCPs and other participating care providers. This helps ensure UnitedHealthcare Community Plan members receive both quality and cost-effective health services.

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

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

## Provide official notice

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

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

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

## Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This may include providing service(s) for a reasonable time at our in-network rate. **Provider Services** at **1-866-331-2243** 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 provider.

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

## Administrative terminations for inactivity

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

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

## Changing an existing TIN or adding a care provider

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

## Updating your practice or facility information

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

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

## After-hours care

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

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

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support and benefit from the primary care case management system.

The coverage will include availability of 24 hours a day, 7 days a week. During non-office hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services. Recorded messages are not acceptable.

## Participate in quality initiatives

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

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

## Provide access to your records

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

## Performance data

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

## Comply with protocols

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

## Office hours

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

## Protect confidentiality of member data

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

UnitedHealthcare Community Plan uses member information for treatment, operations and payment.

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

### Follow medical record standards

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

### Inform members of advance directives

The federal Patient Self-Determination Act (PSDA) gives patients the legal right to make choices about their medical care before incapacitating illness or injury through an advance directive. Under the federal act, you must provide written information to members on state laws about advance treatment directives, members' rights to accept or refuse treatment, and your own policies regarding advance directives, including any limitation regarding the implementation of advance directives as a matter of conscience. To comply with this requirement, we inform members of state laws on advance directives through Member handbooks and other communications. You can locate more advanced directives information at: caringinfo.org.

### Your Agreement

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

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

If we have a concern about your Agreement, we'll send you a letter containing the details.

If we can't resolve the complaint through informal discussions, you may file an arbitration proceeding as described in your Agreement. Your Agreement describes where arbitration proceedings are held.

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

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

## Appointment standards (Nebraska DHHS access and availability standards)

Comply with the following appointment availability standards:

### Primary care

PCPs should arrange appointments for:

- After-hours care phone number – 24 hours, 7 days a week
- Emergency care – Immediately or referred to an emergency facility
- Urgent care appointment – within 24 hours
- Routine care appointment – within 4 weeks
- Non-urgent "sick" care – within 48 hours, or sooner if clinically indicated
- Preventive care – within 4 weeks
- Physical exam – within 180 calendar days
- EPSDT appointments – within 6 weeks
- New member appointment – within 30 calendar days
- In-office waiting for appointments – not to exceed 45 minutes. This includes time spent in the waiting room and examining room for members with appointments, unless the care provider is unavailable or delayed because of an emergency. Notify the member immediately if a care provider is delayed. Offer the member a new appointment if a wait of more than 90 minutes is anticipated.
- Family planning services – within 7 calendar days
- Laboratory and X-ray services – within 48 hours (or as clinically indicated) for urgent care and within 3 weeks for routine appointments

- Behavioral health:
  - Emergency appointments – must be referred within 1 hour (generally) and within 2 hours in designated rural areas
  - Other specialty care – within 30 calendar days of referral or as clinically indicated

### Specialty care

Specialists should arrange appointments for:

- Routine appointment type: within 30 calendar days of request/referral or as clinically indicated

### Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- First trimester – within 14 calendar days of request
- Second trimester – within 7 calendar days of request
- Third trimester – within 3 calendar days of request
- High-risk – within 3 calendar days of identification of high-risk

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

# Provider Directory

You are required to tell us, within 5 business days, if you can no longer accept new patients to prevent any Provider Directory inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional help finding a care provider.

We are required to contact all participating care providers annually and independent physicians every 6 months. We require you to confirm your information is accurate or provide us with applicable changes.

We allow you up to 45 business days to contact us. If you don't, we notify you that if you continue to be nonresponsive, we will remove you from our directory after 10 business days.

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

In addition to outreach for annual or bi-annual attestations, we reach out if we receive a report of incorrect care provider information.

We are required to confirm your information. To help ensure we have your most current information:

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

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

### Care provider attestation

Confirm your data every quarter through the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-866-331-2243**. If you have received the upgraded My Practice Profile and have editing rights, access the **UnitedHealthcare Provider Portal** for My Practice Profile to make many of the updates required in this section.

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

# Prior authorization request

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

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

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

- Verify eligibility using the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-866-331-2243**. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.

- Get prior authorization from the UnitedHealthcare Provider Portal:
  1. To access the Prior Authorization app, go to **UHCprovider.com**, then Sign In.
  2. Select the **Prior Authorization and Notification app.**
  3. View notification requirements.

Identify and bill other insurance carriers when appropriate.

# Timeliness standards for notifying members of test results

After receiving results, notify members within:

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

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

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

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

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

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

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

* N.P.s may enroll with the state as solo care providers, but P.A.s cannot. P.A.s must be part of a group practice.

For services provided by an N.P. or P.A., submit the claim under the N.P. or P.A. and not the supervising care provider. Services for durable medical equipment (DME), home health and physical, occupational or speech therapies, all require an M.D. or D.O. be the ordering care provider type. Nebraska DHHS states P.A.s and N.P.s cannot be the ordering care provider for these types of services.

Members may change their assigned PCP by contacting **Member Services** at **1-800-641-1902** any time during the month. Customer Service is available 7 a.m.–7 p.m. CT, or 6 a.m.–6 p.m. MT, Monday–Friday.

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

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

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support and benefit from the primary care case management system. The coverage will include availability of 24 hours a day, 7 days a week. During non-office hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services. Recorded messages are not acceptable.

### Members with special health care needs

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

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing
- Submit all accurately coded claims or encounters timely
- Provide all well baby/well-child services
- Coordinate each UnitedHealthcare Community Plan member's overall course of care
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a 1 M.D. practice and at least 30 hours per week for a 2 or more M.D. practice
- Be available to members by telephone any time
- Tell members about appropriate use of emergency services
- Discuss available treatment options with members

When a special health care needs member is determined to need a specialized course of treatment, the member may directly access a specialist as appropriate for the member's condition and need. No referral is required to access specialist services.

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

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

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

- Offer office visits on a timely basis, based on the standards outlined in the Timeliness Standards for Appointment Scheduling section of this manual
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to Provider Services, UnitedHealthcare Community Plan Clinical, or Pharmacy Department as appropriate. Coordinate referrals to appropriate community programs and services such as the Women, Infants and Children Program (WIC) services program.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare
- Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS® or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
- Comply with the Nebraska DHHS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in **Chapter 2** of this manual.
- Medical residents in primary care practice: PCPs may use medical residents in primary care in all settings supervised by fully credentialed UnitedHealthcare Community Plan primary care providers. We will not assign members to medical residents.

For questions about member lists, practice guidelines, medical records, government quality reporting, HEDIS®, etc., call **Provider Services** at **1-866-331-2243.**

# Primary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-866-331-2243**
- Check the member's ID card at the time of service. Verify member with photo identification. Plan participating specialists when needed.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth.**
- Refer patients to UnitedHealthcare Community Plan care providers
- Identify and bill other insurance carriers when appropriate
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form

# Rural health clinic, federally qualified health clinic and primary care clinic

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

- **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 P.A., N.P., social worker and/or another care provider
  - 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 primary care clinic that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

# Specialist responsibilities

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

- Contact the PCP to coordinate the care/services
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer
- Verify the eligibility of the member before providing covered specialty care services
- Provide only those covered specialty care services, unless otherwise authorized
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at 1 UnitedHealthcare Community Plan participating hospital at a minimum
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws
- Comply with the Nebraska DHHS Access and Availability standards for scheduling routine visits. Appointment standards are covered in **Chapter 2** of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, 7 days a week. Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

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

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

# Specialist checklist

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

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-866-331-2243**, or calling Nebraska Medicaid Eligibility System at **1-800-642-6092**. Failure to verify member enrollment may result in claim denial.
- Check the member's ID card each time the member has services. Verify against photo ID if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth** to locate and view the current prior authorization information and notification requirements.
- Identify and bill other insurance carriers when appropriate.

# Ancillary care provider responsibilities

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

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

# Ancillary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-866-331-2243**
- Check the member's ID card at the time of service. Verify member with photo identification.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth.**
- Identify and bill other insurance carriers when appropriate

# Chapter 3: Care provider office procedures and member benefits

## Key contacts

| Topic | Link | Phone number |
|---|---|---|
| Member benefits | **UHCCommunityPlan.com/ne** | **1-800-641-1902** |
| Member handbook | **UHCCommunityPlan.com/ne** > Plan Details > Member Resources > View Available Resources | |
| Provider Services | **UHCprovider.com** | **1-866-331-2243** |
| Prior authorization | **UHCprovider.com/priorauth** | |
| D-SNP | **UHCprovider.com/ne** > Medicare > Dual Complete Special Needs Plan | |

## Assignment to primary care provider panel roster

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

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

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

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

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

## Choosing a primary care provider

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

Depending on the member's age, medical condition and location, the choice of PCP may cover a variety of practice areas, such as:

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

If the member changes the initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare Community Plan to change the PCP at any other time, the change will be effective on the request date.

# Medically necessary service

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

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

# Member assignment

## Assignment to UnitedHealthcare Community Plan

Nebraska DHHS MLTC assigns eligible members to UnitedHealthcare Community Plan daily. We manage the member's care on the date the member is enrolled until the member is disenrolled from UnitedHealthcare Community Plan. Nebraska DHHS MLTC 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, responsibilities and member ID card through UnitedHealthcare Community Plan.

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

## Immediate enrollment changes

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

Get eligibility information by calling **Provider Services** at **1-866-331-2243,** the NMES line at **1**-800-642-6092 (toll free) or 1-402-471-9580 (Lincoln area), or by visiting the Nebraska DHHS eligibility page at dhhs.ne.gov > DHHS Divisions > Medicaid and Long-Term Care > Client Eligibility Verification.

## Newborn enrollment changes

Encourage your members to notify ACCESSNebraska when they know they are expecting. ACCESSNebraska notifies managed care organizations (MCOs) daily of an unborn when Nebraska Medicaid learns a woman associated with the MCO is expecting. The MCO or you may use the online change report through the ACCESSNebraska website to report the baby's birth.

With that information, ACCESSNebraska verifies the birth through the mother. The MCO and/or the care provider's information is taken as a lead. To help speed up the process, the mother should notify ACCESSNebraska when the baby is born.

Members may call ACCESSNebraska at 1-855-632-7633 (toll free), 1-402-473-7000 (Lincoln area) or 1-402-595-1178 (Omaha area).

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.

## Primary care provider selection

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

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

### 599 Children's Health Insurance Program enrollment

Unborn children of pregnant women otherwise ineligible for Medicaid may be covered under 599 Children's Health Insurance Program (CHIP). The 599 CHIP category covers a limited set of services: prenatal care and pregnancy-related services solely for the health of the unborn child. It does not cover postpartum care and medical issues separate to the pregnant woman's health and unrelated to the pregnancy.

# Member eligibility

UnitedHealthcare Community Plan serves members enrolled with Nebraska DHHS Medicaid and Long-Term Care (MLTC), Nebraska's Medicaid program. The Nebraska DHHS MLTC determines program eligibility. An individual who becomes eligible for the Nebraska DHHS MLTC program either chooses or is assigned to one of the Nebraska DHHS MLTC-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 call **1-844-359-7736.**

UnitedHealthcare Community Plan ID cards will reflect the member's Group ID number. If a member does not bring their card, call **Provider Services** at **1-866-331-2243**. You may view a copy of the member's ID card image online at **UHCprovider.com/eligibility** while verifying member eligibility. Also document the call in the member's chart.

### Member identification numbers

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

### Sample health member ID card

# Primary care provider - initiated transfers

A PCP may transfer a UnitedHealthcare Community Plan member due to member non-compliance, member's condition or illness is better treated by another PCP, member-care provider relationship is not mutually acceptable, travel distance limitations, fraud or forgery, or unauthorized use/abuse of services by the member. The PCP must provide care for the member until a transfer is complete.

1. To transfer the member, submit the specific event(s) documentation to UnitedHealthcare Community Plan by mail. Documentation includes DHHS form MS-24, the date(s) 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.

   Mailing address:
   **UnitedHealthcare Community Plan**
   Attn: Operations Department
   2717 N. 118th St., Suite 300
   Omaha, NE 68164
2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to case management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have 5 business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them.

# Verifying member enrollment

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

- UnitedHealthcare Provider Portal: access the UnitedHealthcare Provider Portal through **UHCprovider.com/eligibility**
- **Provider Services** at **1-866-331-2243** is available from 7 a.m.–6 p.m. CT, Monday-Friday
- Nebraska Medicaid Eligibility System (NMES) at 1-800-642-6092

# UnitedHealthcare Dual Complete

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

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

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

For Nebraska-specific D-SNP information, go to **UHCprovider.com/content/provider/en/health-plans-by-state/nebraska-health-plans/ne-medicare-plans/ne-dual-complete-snp-plans.html.**

# Benefit information

**The following member benefits should not be considered exhaustive.** Specific services to be delivered to Community Plan members are described in detail on the Nebraska DHHS MLTC website.

Go to **UHCcommunityplan.com/ne** or **UHCprovider.com/eligibility** for more information.

| Benefit | Services included | Limitations |
|---|---|---|
| Ambulance services | Emergent ground transportation<br>Non-emergent ground transportation – transportation should be made by the member's care provider directly with the ambulance service. | Covered if medically necessary<br>Prior authorization not required if participating care provider. Non-participating care provider requires a prior authorization. |
| | Emergent air ambulance<br>Non-emergent air ambulance transportation – transportation should be made by the member's care provider directly with the air ambulance service. | Covered if medically necessary<br>Prior authorization required for participating and non-participating care providers |
| | For more ambulance service information, please refer to **Chapter 4** of this manual. | |
| Bariatric surgery | Inpatient and outpatient bariatric surgery and specific obesity-related service. | Covered<br>Potential prior authorization required |
| Behavioral health – inpatient and residential | • Psychiatric services<br>• Substance use treatment<br>For more behavioral health coverage information, please refer to **Chapter 7** of this manual. | Some services may require prior authorization |
| Behavioral health – outpatient | • Admission evaluations and assessments<br>• Outpatient therapy services, including individual, group and family therapy<br>• Medication management<br>For more behavioral health coverage information, please refer to **Chapter 7** of this manual. | Some services may require prior authorization |

| Benefit | Services included | Limitations |
|---|---|---|
| Chiropractic services | Covered services are only for the treatment of spinal subluxations for which treatment provides a direct therapeutic benefit and has the following limitations:<br>• Chiropractic treatment is limited to treatments deemed medically necessary for all members<br>• No more than 1 treatment per member per day is covered<br>Covered services include:<br>• Certain spinal X-rays<br>• Manual manipulation of the spine<br>• Certain evaluation and management services<br>• Traction<br>• Electric stimulation<br>• Ultrasound<br>• Certain therapeutic procedures, activities and techniques designed and implemented to improve, develop or maintain function of the treated area | Covered |
| Circumcision | Outpatient service: no age limits. Inpatient service. | Covered<br>Prior authorization required |
| Cosmetic and/or reconstructive surgery | Cosmetic and reconstructive procedures are covered when medically necessary in certain situations to correct the following:<br>• Limitations in movement of a body part caused by trauma or congenital conditions<br>• Disfiguring or painful scars in areas which are visible<br>• Congenital birth anomalies<br>• Post-mastectomy breast reconstruction<br>• Other procedures determined to be restorative or necessary to correct a medical condition<br>Prior authorization may be needed except for the following conditions:<br>• Cleft lip and cleft palate<br>• Post-mastectomy breast reconstruction<br>• Congenital hemangiomas of the face<br>• Nevus removals | Potentially covered<br>Prior authorization required |

| Benefit | Services included | Limitations |
|---|---|---|
| Dental services | UnitedHealthcare offers comprehensive dental coverage with our in-network providers. This includes routine checkups, fluoride treatments, X-rays and cleanings to help keep teeth and gums strong and healthy. In general, the following types of services are covered for children age 20 and younger, adults age 21 and older, an individual who is blind or disabled according to the Social Security Administration criteria. | Covered |
| | **Dental home**<br>A dental home is a primary care dentist (PCD) that will be assigned to each member. The idea of a dental home is to foster a relationship between the PCD and patient to provide better dental care and outcomes by promoting inclusive dental care in a comprehensive, continuously accessible, coordinated and family-centered manner.<br>Members are encouraged to select their own primary care dentist PCD to serve as their dental home, but one will be assigned if not chosen. The PCD can be a general dentist or pediatric dentist from UnitedHealthcare care provider network. Members will be encouraged to visit their PCD every 6 months to receive regular dental care that prevents problems with teeth and gums.<br>Members may change their PCD any time by contacting UnitedHealthcare Community Plan's Member Services. | |
| | Our plan offers coverage for fillings.<br>With prior authorization, our plan offers coverage for:<br>• Extractions<br>• Limited oral evaluations<br>• Partial dentures<br>• Full dentures<br>• Oral surgery<br>• Orthodontics (under 20) may be covered if medical necessity is documented by the care provider | Covered |
| | Cosmetic dental procedures are not covered as a core benefit and/or service. | Not covered |
| | Dental anesthesia:<br>Nebraska Medicaid will cover physician anesthesiologists and certified registered nurse anesthetists (CRNA) in for general anesthesia in the dental office effective August 1, 2025 to increase access to dental care. This is in addition to dental anesthesiologists providing the service. | Covered |

| Benefit | Services included | Limitations |
|---|---|---|
| Dialysis service | Services covered only when provided by a certified end-stage renal disease facility (recipient may become Medicare eligible after 3 months facility treatment or 1 month home dialysis). Services covered as an outpatient only and include:<br>• Maintenance hemodialysis<br>• Peritoneal dialysis<br>• Kidney transplant services<br>• Physical therapy<br>Laboratory services are covered with the following restrictions:<br>• Bone survey performed annually<br>• Nerve conduction velocity test once every 3 months<br>• EKG performed once every 3 months<br>• Hepatitis associated antigen test performed once a month<br>• Bone mineral density every 6 months<br>• Chest X-ray every 6 months | Covered |
| | • Take home supplies (ace bandages, splints, etc.)<br>• Home dialysis (except CAPD)<br>• IV fluids (unless justified by diagnosis)<br>• Office or hospital visits by supervising M.D. on same day as a dialysis treatment<br>• Office visit for sole purpose of dialysis maintenance when M.D. billed for monthly maintenance fees<br>• Hospital admissions and hospital daily care for sole purpose of dialysis | Not covered |
| Diabetic supplies | All diabetic supplies, including but not limited to: alcohol swabs, continuous glucose monitor, syringes, test strips and lancets.<br>Diabetic supplies can be provided from a participating pharmacy. Certain diabetes testing supplies may be preferred. See our Drug Formulary on **UHCprovider.com/necommunityplan** for drugs covered under the Pharmacy Program tab.<br>Glucometers: Member must obtain an order/prescription from their care provider. The member will obtain the glucometer from a network DME provider/supplier or a UnitedHealthcare Community Plan contracted DME pharmacy.<br>Optum Rx for providers and pharmacies: **1-877-231-0131**. | Covered<br>Prior authorization required on all DME codes with a retail purchase or cumulative rental cost of more than $750 per line item. Prior authorization is required for continuous glucose monitors. Outpatient only. |

| Benefit | Services included | Limitations |
|---|---|---|
| Diagnostic tests | **Radiology**<br>• CT; X-ray<br>• MRI (magnetic resonance imaging)<br>• MRA (magnetic resonance angiogram)<br>• PET Scan (positron emission tomography)<br>• Nuclear Medicine SPECT MPI (Myocardial perfusion imaging)<br>• Select Nuclear Medicine Studies<br>• Nuclear Cardiology | Covered<br>Diagnostic tests must always be medically necessary.<br>UnitedHealthcare Clinical Request Line for care providers: **1-866-889-8054** |
| | **Laboratory**<br>Lab visits: Labcorp 1-800-833-3984<br>You need to have a CLIA # on file or claims will deny. | |
| Durable medical equipment (DME) and medical supplies | Equipment and supplies for medical purpose. May include, but are not limited to, oxygen tanks and concentrators; ventilators; wheelchairs; crutches and canes; orthotic devices; prosthetic devices; pacemakers; and medical supplies.<br>Member must obtain an order/prescription from their care provider. The member will obtain the DME from a network DME provider/supplier or a UnitedHealthcare Community Plan contracted DME pharmacy. | Covered<br>An M.D. or D.O. must be the ordering care provider type. Per NE DHHS MLTC, P.A.s and N.P.s cannot order these services.<br>Prior authorization is required on all DME codes with a retail purchase or cumulative rental cost of more than $750 per line item. Outpatient only. |

| Benefit | Services included | Limitations |
|---|---|---|
| Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) | EPSDT service is Medicaid's comprehensive preventive child health service for individuals younger than 21 years of age.<br>Annual physicals for children ages 0–20 must meet EPSDT criteria comprehensive screenings and interim screenings include:<br>• Physical exam<br>• Comprehensive health history<br>• Vision screen<br>• Health and developmental history<br>• Hearing screenings<br>• Measurements<br>• Blood pressure<br>• Vital signs<br>• Nutritional counseling<br>• Laboratory procedures<br>• Health education/anticipatory guidance<br>• Immunizations<br>• Lead screenings<br>• Environmental investigation<br>• Dental screening | Covered<br>UnitedHealthcare does not require prior authorization or referral for EPSDT screening services. |
| Emergency, post-stabilization and urgent care | For a medical emergency or urgent care. Post-stabilization is care after an emergency. Member can get these services 24 hours a day, 7 days a week at any emergency room. | Covered anywhere in the USA |
| Family planning | Family planning services are preventive health, medical, counseling and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health.<br>**For more family planning information, please refer to Chapter 4 of this manual.** | Covered |
| Femoroacetabular impingement syndrome (FAI) | All planned elective hip arthroscopy for CPT codes 29914, 29915 and 29916. | Prior authorization required |

| Benefit | Services included | Limitations |
|---|---|---|
| Hearing services | Audiological testing to establish a need for a hearing aid to include:<br>• Hearing evaluation (bone conduction and air conduction tests)<br>• Speech audiometry<br>• Hearing aid selection<br>Treatment may include:<br>• Auditory training; speech training<br>• Aural rehabilitation (including hearing aid and cochlear implant orientation and fitting adjustments)<br>• Augmentative communication | Covered |
| | Adults – As part of the adult health screening services, audiometry sweeps are covered for once every 4 years for members more than 21 years of age. | Covered |
| | Hearing aids, necessary accessories are covered services with medical evaluation and items covered include:<br>• Hearing aids<br>• Initial care kit<br>• Batteries – limit of 32 batteries per month<br>• Repairs<br>• Cords<br>• Garments, harness and other accessories; custom ear molds<br>• Rental fees<br>• Loaner hearing aid fees<br>• Dispensing fees<br>• Hearing evaluation (including audiogram) and necessity, preferably determined by otologist<br>• ITE aids limited to children 12 years of age or older with documented medical necessity (not covered for cosmetic reasons) | Prior authorization required for ALL DME codes with a retail purchase or cumulative rental cost of more than $750 per line item. |
| Home health services | All services in the home:<br>• Home health agencies<br>• Private duty nursing<br>• PT/OT/ST<br>• Skilled nursing<br>• Social worker<br>• Home infusion<br>• Care provider home visit | Covered<br>Prior authorization required<br>An M.D. or D.O. must be ordering physician type. Per NE DHHS MLTC, P.A.s and N.P.s cannot be the ordering physician type for these services. |

| Benefit | Services included | Limitations |
|---|---|---|
| Hospice | In-home hospice and short-stay inpatient hospice.<br>MLTC provides 2 90-day benefit periods during a client's lifetime. If additional benefit periods are needed, Medicaid provides 3 60-day benefit periods. Hospice services beyond these benefit periods will be approved as an exception under the prior authorization provisions. The benefit periods may be used consecutively or at intervals. | Covered under Managed Medicaid<br>Prior authorization required |
| | Residential Inpatient Hospice Services.<br>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. | Covered under NE DHHS Medicaid and Long-Term Care |
| | **For more hospice information, please refer to Chapter 4 of this manual.** | |
| Hospital – inpatient | Inpatient hospital care. Includes medical, surgical, post-stabilization, acute and rehabilitative services. | Covered<br>Prior authorization required |
| Hospital – outpatient | Outpatient professional/medical services professional component (in/outpatient) of surgical services, including:<br>• Surgeons and assistant surgeons for surgical procedures, including appropriate follow-up care<br>• Administration of anesthesia by care provider (other than surgeon) or CRNA<br>• Second surgical opinions<br>• Same-day surgery performed in a hospital without an overnight stay<br>• Invasive diagnostic procedures such as endoscopic examinations<br>Electroconvulsive therapy (ECT) requires a prior authorization. | Covered |
| | Out-of-network: Not covered except in situations where members require urgent or emergent medical care. In urgent or emergent medical situations, coverage limited up to the point of medical stabilization | Prior authorization required for non-emergent/non-urgent hospital services |

| Benefit | Services included | Limitations |
|---|---|---|
| Immunizations | Immunizations are covered for adults.<br>Covered for children, birth through 18 years of age, through the Vaccine for Children program (VFC). Care provider must file claims using the appropriate CPT and modifier. UnitedHealthcare Community Plan only covers the administration of the VFC program.<br>Immunizations should be given in conjunction with EPSDT/well-child visits or when other appropriate opportunities occur in accordance with Advisory Committee on Immunization Practices guidelines. Care providers must report required immunization data to the Nebraska State Immunization Information System. | Covered |
| Injectable medications | Rendered on an outpatient basis. Please visit **UHCprovider.com/necommunityplan** to view the current notification requirements for Nebraska for the list of injectable medications requiring a prior authorization. To locate, select the Prior Authorization and Notification tab. Care providers must include applicable NDC numbers and quantity on claim submissions. | Covered<br>Prior authorization required |
| Joint replacement | Outpatient and inpatient joint and total hip and knee replacement procedures. | Covered<br>Prior authorization required |
| Mid-level practitioners services | Includes physician assistants (P.A.s), advanced practice registered nurse (APRN), family practice nurse practitioner (FPNP), pediatric nurse practitioner (PDNP), nurse anesthetists (CRNA) and nurse midwives. | Covered |
| Neuropsych testing | No prior authorization required if in-network. | Covered |

| Benefit | Services included | Limitations |
|---|---|---|
| Newborn services | Facility and care provider services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. | Covered |
| | Non-routine newborn care, i.e., care for sick newborns (for example, unusual jaundice, prematurity, sepsis, respiratory distress) is covered. | Prior authorization required |
| | Out-of-network: not covered except in situations where members require urgent or emergent medical care. In urgent or emergent medical situations, coverage limited up to the point of medical stabilization.<br>Outreach to the mother will be conducted by UnitedHealthcare Community Plan to provide education to the pregnant mom regarding the importance of prenatal care and reminding the mother to contact ACCESSNebraska as soon as the baby is born:<br>• 1-402-595-1178 in the Omaha area<br>• 1-402-473-7000 in the Lincoln area<br>• 1-855-632-7633 outside Omaha or Lincoln | Prior authorization required for non-emergent/non-urgent hospital services |
| Nutritional counseling | Services include outpatient education. | Covered |
| Observation | 48-hour observation | Covered |
| Orthotics and prosthetics | Orthotics and prosthetics with a retail purchase or cumulative rental cost of more than $750. | Prior authorization required |
| Outpatient and care provider visits | Services at a hospital or care center when a member stays less than a day, doctor visits, other care provider visits, family planning, preventive services and clinic visits. Specialty care provider visits. Emergency room visits, including both hospital and care provider charges. | Covered |
| Out-of-network services | A recommendation to a care provider who is not contracted with UnitedHealthcare Community Plan. | All out-of-network services require prior authorization, EXCEPT emergency services, family planning and tribal services. |
| Outpatient surgery | Services include but are not limited to:<br>• Medically necessary surgeries are covered when performed in an ambulatory surgery center (ASC and hospital ASC)<br>Covered when medically necessary and not otherwise excluded. | Covered<br>Some surgeries require prior authorization |

| Benefit | Services included | Limitations |
|---|---|---|
| Pharmacy program | Drugs prescribed by a care provider. This includes education about how to take the drugs.<br>See our Drug Formulary on **UHCprovider.com/necommunityplan** for drugs covered under the Pharmacy Program tab.<br>**For more pharmacy program information, please refer to Chapter 4 of this manual.** | Covered<br>Some drugs on the state-approved formulary and preferred drug list have a copay and may require prior authorization |
| Podiatry services | Routine/Palliative foot care:<br>Palliative foot care includes the cutting or removal of corns or calluses; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory clients; and any services performed in the absence of localized illness, injury, or symptoms involving the foot.<br>Coverage of palliative foot care is limited to: 1 treatment every 90 days for non-ambulatory clients and 1 treatment every 30 days for ambulatory clients.<br>Evaluation and management services are not covered in addition to palliative foot care on the same date of service, except:<br>**1.** New member visits; or<br>**2.** Significant, separately identifiable evaluation and management services required to treat a condition above and beyond palliative foot care.<br>Covered for medically necessary services only; typically associated with severe circulatory disease, or loss of sensation of feet or member has been diagnosed with a systemic condition by a care provider that there is medical necessity for professional foot care; such as:<br>• Debridement of non-mycotic nails<br>• Diabetes mellitus<br>• Arteriosclerosis<br>• Buerger's disease<br>• Chronic thrombophlebitis<br>• Peripheral neuropathies | Covered |

| Benefit | Services included | Limitations |
|---|---|---|
| Pregnancy-related services | UnitedHealthcare Community Plan covers all OB services through the member's pregnancy. Services include pre- and post-natal care, tests, doctor visits and other services that impact pregnancy outcomes. | Covered |
| | 599 CHIP Enrollment: Unborn children of pregnant women who are otherwise ineligible for Medicaid may be covered under 599 Children's Health Insurance Program (CHIP). The 599CHIP category covers a limited set of services: prenatal care and pregnancy-related services solely for the health of the unborn child; it does not cover postpartum care and medical issues separate from the pregnant woman's health and unrelated to the pregnancy. | Covered |
| | 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. Request prior authorization if the member is inpatient longer than federal requirements allow.<br>You may bill global days if the mother has been a UnitedHealthcare Community Plan member for 3 or more consecutive months or had 7 or more prenatal visits. The initial pregnancy visit is not included in the global days and must be billed as a separate office visit | Prior authorization required |
| | Non-routine newborn care, i.e., care for sick newborns (for example, unusual jaundice, prematurity, sepsis, respiratory distress).<br>**For more maternity and newborn information, please refer to Chapter 4 of this manual.** | Prior authorization required |

| Benefit | Services included | Limitations |
|---|---|---|
| Rehabilitation therapies | Includes physical, occupational, speech, therapies, as well as cardiac, pulmonary and others.<br>Physical, occupational and speech therapy services require prior authorization.<br>The member's primary care provider (PCP) or referring specialist is required to submit prior authorization requests for evaluations and re-evaluations.<br>After a prior authorization request is approved for an evaluation or re-evaluation, the treating therapy provider can submit the prior authorization requests for subsequent treatment visits.<br>Cardiac rehab (maximum of 12 weeks or 36 sessions).<br>Must be restorative in nature and be related to an injury or acute episode.<br>Physical, occupational and speech therapy benefits limited to 60 combined visits per calendar year for members age 21 and older. Visits incurred and paid as primary under other insurance will not count toward the annual maximum visit limit under Medicaid.<br>Maintenance physical therapy is not covered.<br>Massage therapy accumulates toward the visit limit. No limit for members age 20 and younger. | Covered<br>An M.D., D.O. or N.P. must be the ordering care provider type for physical, occupational or speech therapy. Per NE DHHS MLTC, P.A.s cannot order these services. |
| Sexually transmitted diseases – screening, diagnosis and treatment | | Covered when medically necessary |
| Skilled nursing facility (SNF) | Short-term acute rehabilitation | Covered<br>Prior authorization required |
| | Long-term custodial care | Not covered |

| Benefit | Services included | Limitations |
|---|---|---|
| Sleep studies | Either an outpatient hospital setting or sleep study clinic | Covered when medically necessary |
| | ATTENDED sleep studies typically performed in a sleep clinic, facility or lab | Covered |
| | UNATTENDED sleep studies performed in the patient's home | Covered |
| | Polysomnography is distinguished from sleep studies by the inclusion of sleep staging that includes a 1 to 4 lead electroencephalogram (EEG), electro-oculogram (EOG) and a submental electromyogram (EMG). For a sleep study to be reported as a polysomnography, sleep must be recorded and staged. | |
| Spinal surgery | Inpatient and outpatient spinal surgeries | Covered<br>Prior authorization required |
| Sterilization and hysterectomies | The plan covers once requirements are met. Requirements include but are not limited to:<br>**Sterilization –** The regulations require that a written consent form (MMS – 110), male or female, must be signed by the individual at least 30 days, but not more than 180 days, before any sterilization procedure is to be performed. The individual must be at least 21 years of age at the time the consent form is signed by the member. | Covered<br>All inpatient services require a prior authorization, in addition to the appropriate state consent form |
| | Reversal of voluntary sterilization | Not covered |
| | **Hysterectomies –** Services cannot be reimbursed if performed for sterilization purposes. Members undergoing hysterectomies for medical reasons other than sterilization purposes must be advised orally and in writing that sterility will result.<br>Per Nebraska Administrative Code 18-004.0, "All claims for hysterectomies (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by Form MMS-101," Informed Consent Form," (see 471-000-110) signed and dated by the member in which she states that she was informed before the surgery was performed that this surgical procedure will result in permanent sterility.<br>For additional information, visit: dhhs.ne.gov.<br>Please see **Chapter 4** of this manual for more information.<br>All inpatient services require prior authorization in addition to the appropriate state consent form. | |

| Benefit | Services included | Limitations |
|---|---|---|
| Synagis | Synagis requires prior authorization from Optum Rx.<br>Phone: **1-800-310-6826**<br>Fax: 1-866-940-7328<br>The Season Respiratory Syncytial Virus Enrollment Form needs to be completed and sent to Optum Rx. Please go to **UHCprovider.com/necommunityplan** > Pharmacy Resources tab to locate the Synagis Enrollment Form. | Covered<br>Prior authorization required |
| Telehealth and telemonitoring services | Some telehealth and telemonitoring services, including consultation, diagnosis and treatment by a physician or practitioner for members in rural areas or other places.<br>**For more telehealth and telemonitoring information, please refer to Chapter 4 of this manual.** | Covered for medically necessary services |
| Tobacco cessation | Member must be 18 years of age, must be enrolled and actively participating in the Tobacco Free Quit line to be considered participate. Members may call **1-800-784-8669** to enroll.<br>Up to 4 tobacco-cessation counseling visits with their PCP are covered per session.<br>• Coverage will include up to 2 90-day sessions during a 12-month period. No more than 4 total visits will be covered during a 90-day session and no more than 8 total visits will be covered in the 2 90-day sessions during any 12-month time period.<br>Drugs for the Tobacco Cessation program are covered under the Pharmacy Program. | Covered<br>Some limitations apply |
| Transportation (non-emergent medical) | Non-emergent transportation services for UnitedHealthcare Community Plan members are provided by Modivcare.<br>Members must make transportation arrangements at least 3 calendar days before their medical appointment. A legally responsible adult must accompany children under the age of 19. Children age 12 and under should not be transported by a public or commercial provider without adult supervision.<br>Non urgent appointments: call **1-866-394-3984.** | Covered<br>Prior authorization may be required |
| | UnitedHealthcare Community Plan is responsible for non-emergent ambulance transportation.<br>**For more non-emergency transportation information, please refer to Chapter 4 of this manual.** | Covered<br>Prior authorization required for non-participating care providers |
| Transplants | Transplant services, including donor services that are medically necessary and defined by Medicare as non-experimental. | Covered<br>Prior authorization may be required |

| Benefit | Services included | Limitations |
|---|---|---|
| Ventricular assist devices | A mechanical pump that takes over the function of the damaged ventricle of the heart and restores normal blood flow. | Covered<br>Prior authorization may be required |
| Vision services<br>MARCH® Vision Care Group Inc. | Vision exams, prescription lens and eyeglasses.<br>**Eye exams**<br>• **Recipients age 20 and younger.** Eye examinations are limited to once every 12 months. More frequent eye examinations will be covered when medically necessary and appropriate to diagnose or treat a specific eye illness, symptom, complaint or injury.<br>• **Recipients age 21 and older.** Eye examinations are limited to once every 24 months. More frequent eye examinations will be covered when medically necessary and appropriate to diagnose or treat a specific eye illness, symptom, complaint or injury.<br>**Frames**<br>• **Recipients age 20 and younger.** Eyeglass frames are limited to once every 12 months. Eyeglass frames are covered more frequently if medically necessary.<br>• **Recipients age 21 and older.** Eyeglass frames are limited to once every 24 months. Replacement of frames, which are irreparable due to breakage or loss, is allowed 1 additional time per coverage period.<br>marchvisioncare.com<br>MARCH® Vision toll free: 1-844-636-2724, 8 a.m.–5 p.m. | Covered<br>Member must use a participating MARCH® Vision provider |
| | Vision therapy/orthoptic training. Intraocular lens. | Covered |
| Weight loss surgery (bariatric surgery) | Members must meet several criteria before being approved for this procedure, for example, documentation of participation and failure in legitimate weight loss program. | Covered<br>Prior authorization may be required |

# Key contacts

| Topic | Link | Phone number |
|---|---|---|
| Referrals | **UHCprovider.com/referrals** | **1-866-331-2243** |
| Prior authorization | **UHCprovider.com/priorauth** | |
| Pharmacy | **professionals.optumrx.com** | **1-800-310-6826** |
| Dental | **uhcdentalproviders.com** | |
| Healthy First Steps | **uhchealthyfirststeps.com** | **1-800-599-5985** |

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

The following benefits should not be considered exhaustive. Specific services to be delivered to Community Plan members are described in detail on the Nebraska DHHS MLTC website. Contact the **Provider Services** at **1-866-331-2243** for questions about if a service is covered.

# Ambulance services

## Air ambulance

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

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

Non-emergent air transportation requires a prior authorization for participating and non-participating care providers.

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

## Emergency ambulance transportation

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

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

Emergency transports (in- and out-of-network) are covered if medically necessary. Prior authorization is not required for emergency transports.

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

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

## Nonemergent transportation

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

For non-urgent appointments, members must call for transportation at least 3 days before their appointment. Requests can be made online at **mymodivcare.com** or by phone at 1-833-583-5683.

Make urgent non-emergency trips, such as when a member is sent home from the hospital, through Modivcare. Schedule rides up to 30 days in advance. Prior authorization is not required for participating care providers. Non-participating care providers require a prior authorization.

Public transit will also be available if the member:

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

# Cardiology

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

You must obtain prior authorization for the following cardiology procedures:

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

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

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

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

Request prior authorization online or by phone:

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

Make sure the medical record is available.

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

# Case management

UnitedHealthcare Community Plan provides case management services to members who require service coordination due to complex medical conditions or serious psychosocial issues that impact their ability to obtain appropriate care. The UnitedHealthcare Community Plan Medical Case Management Department has assessment tools to help identify members who may be at risk for multiple hospital admissions, increased medication usage, or would benefit from a multidisciplinary approach to their medical or psychosocial needs. Programs are available to assist members with chronic conditions such as diabetes, asthma and obesity.

For Nebraska providers who would like to request Case Management for a member's use, please send an email to **ne_cm@uhc.com**.

# Chiropractic services

Covered chiropractic services are limited to:

- Certain spinal X-rays
- Manual manipulation of the spine
- Certain evaluation and management services
- Traction
- Electrical stimulation
- Ultrasound
- Certain therapeutic procedures, activities and techniques designed and implemented to improve, develop or maintain the function of the area treated

Prior authorization may be required.

# Dental

In-network dental care providers may provide routine dental services. UnitedHealthcare Community Plan covers the facility and anesthesia for medically necessary outpatient dental services. Facility services require a prior authorization. The following services are covered. However, some limitations may apply:

- Diagnostic
- Periodontics
- Preventive
- Prosthodontics (limited)
- Restorative
- Oral and maxillofacial surgery
- Endodontics
- Orthodontics (younger than age 21 only)

Refer to the Dental Provider Manual for applicable exclusions, limitations and requirements at **uhcdentalproviders.com**.

Standard ADA coding guidelines apply to all claims. To find a dental provider, go to **UHCprovider.com** > Find Dr > Dental Providers by State, Network or Location.

# Durable medical equipment

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

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

See our Coverage Determination Guidelines at **UHCprovider.com/policies** > For Community Plans > **Medical & Drug Policies and Coverage Determination Guidelines for Community Plan**.

# Emergency/urgent care services

Emergency services do not require prior authorization.

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

Covered services include:

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

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

## Emergency room care

For an emergency, the member should seek immediate care at the closest ER. If the member needs help getting to the ER, they may call 911. No referral is needed.

Members have been told to call their PCP as soon as possible after receiving emergency care. They pay no out-of-pocket cost for ER or emergency ambulance services.

Before they are treated, UnitedHealthcare Community Plan members who visit an ER 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.

After the member has received emergency care, the hospital must seek approval within 1 hour for pre-approval for more care to make sure the member remains stable. If the hospital needs to appeal the decision or if does not receive a decision within 1 hour and/or they need to speak with a peer (medical director), call **1-800-955-7615**. The treating care provider may continue with care until the health plan's medical care provider is reached, or when one of these guidelines is met:

1. A plan care provider with privileges at the treating hospital takes over the member's care.
2. A plan care provider takes over the member's care by sending them to another place of service.

3. An MCO representative and the treating care provider reach an agreement about the member's care.
4. The member is released.

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

### Urgent care (nonemergent)

Urgent care services are covered.

For a list of urgent care centers, contact **Provider Services** or view online at **UHCprovider.com/necommunityplan** > Provider Search, Referral Listings and Home and Community Based Services Providers.

## Emergency care resulting in admissions

Prior authorization is not required for emergency services.

Nurses in the Health Services Department review emergency admissions within 1 business day of notification.

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

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

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

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

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

## 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. (Pap smears as clinically indicated using evidence-based medical guidelines.)
- Contraceptive supplies, devices and medications for specific treatment
- Contraceptive counseling
- Laboratory services

Noncovered 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 Nebraska DHHS 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.

View the DHHS Regulations for more information on sterilization.

## Care coordination/ health education

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

The program goals are to:

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

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

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

For more information about Health Home, go to medicaid.gov/medicaid/long-termvservices-supports/health-homes/index.html.

# Hearing services

Monaural and binaural hearing aids are covered, including fitting, follow-up care, batteries and repair. Bilateral cochlear implants, including implants, parts, accessories, batteries, charges and repairs are covered. Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries are covered for members 20 years or younger. Prior authorization may be required.

# Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice. These services require prior authorization.

## 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.

Nebraska DHHS MLTC provides 2 90-day benefit periods during a member's lifetime. If additional benefit periods are needed, Medicaid provides 3 60-day benefit periods. Hospice services beyond these benefit periods will be approved as an exception under the prior authorization provisions. The benefit periods may be used consecutively or at intervals.

## Respite hospice

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

## Inpatient hospice

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.

# Lab services

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

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

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

See the **Billing and submission** chapter for more information.

# Maternity/pregnancy/well-child care

## Pregnancy notification risk screening

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

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

Healthy First Steps strives to:

- Increase early identification of expectant mothers and facilitate case management enrollment
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it
- Multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care
- Increase the member's understanding of pregnancy and newborn care
- Encourage pregnancy and lifestyle self-management and informed health care decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits
- Foster a care provider-member collaboration before and after delivery as well as for 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 for care coordination.

## Pregnancy/maternity

Bill the initial pregnancy visit as a separate office visit. You may bill global days if the mother has been a UnitedHealthcare Community Plan member for 3 or more consecutive months or had 7 or more prenatal visits.

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

For prior authorization maternity care, including out-of-plan and continuity of care, call **1-866-331-2243** or go to **UHCprovider.com/priorauth.** For more information about prior authorization requirements, go to **UHCprovider.com/necommunityplan** > **Prior Authorization and Notification.**

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

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

UnitedHealthcare Community Plan must approve all out-of-plan maternity care except in situations where members require urgent or emergent medical care. In urgent or emergent medical situations, coverage is limited up to the point of medical stabilization.

A UnitedHealthcare Community Plan 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 but may require prior authorization.

An obstetrician does not need approval from the member's care provider for prenatal care, testing or obstetrical procedures.

Obstetricians may give the pregnant member a written prescription at any UnitedHealthcare Community Plan participating radiology and imaging facility listed in the care provider directory.

## Maternity admissions

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

Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, the online Prior Authorization and Notification tool at **UHCprovider.com/priorauth**, or by calling **1-866-331-2243.**

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

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

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

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

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

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

Furnish obstetrical maternity services on an outpatient basis. This can be done under a physician's supervision through an N.P, P.A. 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 Babyscripts in **Chapter 6.**

## Newborn enrollment

The hospital is responsible for notifying UnitedHealthcare Community Plan of the birth of members within 24 hours of the birth. If the member makes a PCP selection for the newborn during the hospital stay the hospital must report the PCP selection to the UnitedHealthcare Community Plan.

## Home care and all prior authorization services

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

## Hysterectomies

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

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

Find the form on the Nebraska Department of Health and Human Services at dhhs.ne.gov.

See "Sterilization Consent Form" section on next page for more information.

Exception: Nebraska DHHS MLTC 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 Nebraska DHHS MLTC consent procedures for abortion.

Allowable pregnancy termination services do not require a referral from the member's primary care provider.

Members must use the UnitedHealthcare Community Plan care provider network.

Use the following policy and procedures to qualify for reimbursement by the Nebraska DHHS MLTC. If a pregnancy termination is needed to preserve the woman's life, you must request prior authorization from the Medicaid Division before performing the pregnancy termination. If prior authorization is approved using the Nebraska DHHS MLTC guidelines, reimbursement will be made upon documentation submission reflecting Nebraska DHHS MLTC procedure approval.

Requests must be sent in writing to:

Department of Health and
Human Services Medicaid Division
P.O. Box 95026
Lincoln, NE 68509-5026
Fax: 1-402-471-9092

## Sterilization and hysterectomy procedures

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

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

## Sterilization informed consent

A member has only given informed consent if the Nebraska Department of Health and Human Services (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

- Complete all applicable sections of the form. Complete all applicable sections of the consent form before submitting it with the billing form. The Nebraska Medical Assistance Program cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.

- Complete your statement section after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.
- The state's definition of "shortly before" is not more than 30 days before the procedure. Explain the procedure to the member within that time frame. However, do not sign and date the form until after you perform the procedure.

You may also find the form on the Nebraska DHHS website at dhhs.ne.gov.

Have 3 copies of the consent form:

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

# Neonatal intensive care unit case management

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

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

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

# Oncology

## Prior authorization

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

# Pharmacy services

## Home delivery and mail-order services

UnitedHealthcare Community Plan of Nebraska members can receive up to a 90-day supply of covered medications through our mail order program.

Members with UnitedHealthcare Dual Complete can also receive their medications through mail order.

To help members arrange mail order pharmacy services, have the member call Optum Rx at **1-877-305-8952.**

## Day supply dispensing limits

Members may receive up to a 3-month supply (90 days) of medication per prescription order or refill. You may reorder or refill a medication when 90% of the medication has been used. If you submit a claim before 75% of the medication has been used, based on the original claim submission day supply, the claim will reject with a "refill too soon" message.

## Emergency prescriptions

Provide a 72-hour emergency supply of a prescribed drug when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a PA, either because they are non-preferred drugs on the Preferred Drug List, or because they are subject to clinical edits.

Dispense 72-hour emergency supply any time a PA cannot be resolved within 24 hours for a medication on the formulary appropriate for the member's medical condition. If the prescribing care provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product packaged in a fixed and unbreakable dosage form (e.g., an albuterol inhaler) as an emergency supply.

You will receive a response by telephone or other telecommunication device within 24 hours of a PA request.

## Medication Therapy Management program

Our Medication Therapy Management (MTM) program helps assist members in understanding and providing education about their medications and ways to improve their compliance with prescribed medication regimens. The program focus is to educate members about how to effectively communicate about their preferences and needs with their prescribers to promote shared decision-making.

## PreCheck MyScript

PreCheck MyScript® is an app on the UnitedHealthcare Provider Portal. This app helps make it easy to run a pharmacy test claim and get real-time prescription coverage details for your patients who are UnitedHealthcare Community Plan members. If a medication requires prior authorization, a request can be submitted online within the app.

With PreCheck MyScript, you can:

- Check prescription coverage and price for UnitedHealthcare Community Plan members in real time
- Get information on lower-cost prescription alternatives, if available, to help save members money
- See which prescriptions currently require prior authorization, or are non-covered or non-preferred
- Request prior authorization and receive status and results

## How to access the app

Sign in to the UnitedHealthcare Provider Portal at **UHCprovider.com** and click on the Sign In button in the top-right corner.

## Preferred Drug List

UnitedHealthcare Community Plan Pharmacy Program adheres to the state-approved preferred drug list (PDL) of covered medications. This list applies to all UnitedHealthcare Community Plan of Nebraska members. Specialty drugs on the PDL are identified by an "SP" in the "Requirements and Limits" section of each page.

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

If a member requires a non-preferred medication, call the Pharmacy Prior Authorization at **1-800-310-6826**, fax a Pharmacy Prior Notification Request form to 1-866-940-7328 or use the online Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal.

We provide you PDL updates before the changes go into effect. Change summaries are posted on **UHCprovider.com**. Find the PDL and Pharmacy Prior Notification Request form at **UHCprovider.com/priorauth**.

We also provide coverage for additional drugs not found on the PDL. You may access the list of covered drugs from our website at **UHCprovider.com/necommunityplan** > **Pharmacy Resources and Physician Administered Drugs**.

## Prior authorization

Some drugs on the state-approved formulary and PDL may require 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.

Pharmacists receiving drug prescriptions requiring prior authorization should work with the prescribing care provider if the prescription can be changed to a preferred alternative medication. If a preferred alternative is not appropriate, the care provider should then contact the UnitedHealthcare Pharmacy Department at **1-800-310-6826** with questions about the prior authorization process.

The preferred drugs and those requiring prior authorization will be designated in the list of drugs at **UHCprovider.com/necommunityplan** > **Pharmacy Resources and Physician Administered Drugs**.

To request pharmacy prior authorization, call Pharmacy Prior Authorization at **1-800-310-6826.** You may also fax your authorization request to 1-866-940-7328. We provide notification for prior authorization requests within 24 hours of request receipt.

### Quantity limits

UnitedHealthcare Community Plan has medication quantity limits. The following describes the quantity limitation types:

- Prescriptions for monthly quantities greater than the indicated limit require a prior authorization request
- Quantity limits based on efficient medication dosing (also known as dose optimization)
  - The Efficient Medication Dosing Program focuses on consolidating medication dosage to the most efficient daily quantity to increase therapy adherence and also promote the efficient use of health care dollars
  - Program limits are based on FDA approval for dosing and the availability of the total daily dose in the least amount of tablets or capsules daily. Quantity limits in the prescription claims processing system will limit dispensing to consolidate dosing.
  - The Pharmacy Claims Processing System will prompt the pharmacist to request a new prescription order from the care provider

Per state regulations, certain quantity limits apply to mental health drugs. Adjustments to the Quantity Limitations program drug list will be made as needed and care providers notified accordingly. We recognize a number of patient-specific variables must be taken into account when drug therapy is prescribed; therefore, overrides will be available through the medical exception (prior authorization) process.

For more information about drug-specific quantity limits go to **UHCprovider.com/necommunityplan** > Pharmacy Resources and Physician Administered Drugs or call the UnitedHealthcare Pharmacy Department at **1-800-310-6826.**

## Restricted services

UnitedHealthcare Community Plan Restricted Services is a program to control misuse and abuse of Medical Assistance services. Our Restricted Services Program restricts Medicaid recipients to a specific care provider and/or a specific pharmacy provider; this is also known as a lock-in. We will not pay claims if a member uses another pharmacy without prior authorization. We notify members and care providers about our Restricted Services Program information.

Restrictions do not apply to emergency services. Members can change care providers with cause.

See more information about the Restricted Services Program in **Chapter 8** of this manual.

## Pharmacy contact information

### Pharmacy claims processing information

Find information about pharmacy claims processing at **UHCprovider.com/necommunityplan** > **Pharmacy Resources and Physician Administered Drugs** or at **optumrx.com**.

These websites provide pharmacy claims processing information, including:

- Payer sheets
- Paper claim submission requirements
- Compound prescriptions requirements
- Prospective drug utilization review (DUR) response requirements
- Rx BIN – 610494
- Rx GRP – ACUNE
- Rx PCN – 4444

Medicare and other insurance copays may still apply.

Pharmacy Services Call Center: 1-800-310-6826, 8 a.m.–8 p.m. CT, Monday–Friday.

Pharmacy Services fax: 1-866-940-7328.

Optum Rx Pharmacy Benefit Manager Technical Help Desk (pharmacies call): **1-877-231-0131**, 8 a.m.–8 p.m. CT, Monday–Friday.

Prior authorization request fax forms can be found at **UHCprovider.com/necommunityplan** > **Pharmacy Resources and Physician Administered Drugs**.

### Specialty pharmacy medications

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

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

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

# Telehealth and telemonitoring services

Some telehealth and telemonitoring services, including consultation, diagnosis and treatment by a care provider or practitioner for members are a covered benefit for medically necessary services. Health care providers that provide telehealth and telemonitoring services must follow all applicable state and federal regulations governing their practice and the services they provide. All telehealth communications must comply with all applicable federal and state requirements regarding privacy and security, as well as those related to efficiency, economy and quality of care.

Health care providers that provide telehealth and telemonitoring services must follow the below requirements:

- Health care practitioners providing telehealth services must follow all applicable laws
- Providers must be enrolled with Nebraska Medicaid and must be licensed (when required)
- Providers must deliver telehealth services safely and effectively
- All treatments or services must be delivered according to current Medicaid service definitions
- All treatments and services must be rendered in a clinically appropriate manner and be medically necessary or related to a treatment plan

The medical record for telehealth services must follow all applicable laws regarding documentation. The use of telehealth technology must be documented in the medical record. Providers are also required to document the reason for the delivery of treatment or services through telehealth. Providers are required to have mitigation plans in place and to provide an active and ongoing assessment of their ability to meet patients' most immediate and critical treatment needs. Claims for services provided via telehealth must include the specific telehealth modifiers and place-of-service codes outlined in the fee schedules. The location of the telehealth service is the physical location of the member. Out-of-state telehealth services are covered if the telehealth services otherwise meet not only the telehealth requirements but also the requirements for payment for services provided outside Nebraska.

The member may decline telehealth service(s) at any time without affecting their access to future care or treatment. If a member declines telehealth service(s), providers are expected to advise them of their other options and assist them in finding treatment.

Telehealth Guidance for FQHCs, RHCs, IHS and Tribal 638 facilities IHS and Tribal 638 facilities can bill the encounter rate for telehealth services if these services meet the definition of an encounter. The facility must stay in accordance with the 4 walls rule to bill for telehealth. Federally qualified health centers and rural health centers may bill the encounter rate for core services that are allowed via telehealth. For a complete list of allowable telehealth codes visit the code list on DHHS website at the below link:

https://dhhs.ne.gov/Documents/Complete%20list%20of%20Nebraska%20Medicaid%20Telehealth%20Codes.pdf

Please review our prior authorization list online at **UHCprovider.com/priorauth** to verify if prior authorization is required for the telehealth and telemonitoring services.

# Tuberculosis screening and treatment; Direct Observation Therapy

Guidelines for Tuberculosis (TB) screening and treatment; Direct Observation Therapy (DOT) screening and treatment should follow the recommendations of the American Thoracic Society (ATS) and the Centers for Disease Control and Prevention (CDC).

## Responsibilities

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

# Vision services

UnitedHealthcare Community Plan uses MARCH® Vision Care as its Medicaid vision vendor. Members may self-refer to any MARCH Vision Medicaid network provider for services. To aid members in making a provider selection, please refer them to MARCH Vision at marchvisioncare.com or they may call UnitedHealthcare Community Plan member services toll free at **1-800-641-1902.**

Please remind the member to mention they are a UnitedHealthcare Community Plan member and they have MARCH Vision coverage when making an appointment with a MARCH Vision care provider. They will also need to provide the UnitedHealthcare Community Plan ID number. For plan coverage details, members may call **1-877-542-9238**.

Call MARCH Vision toll free at 1-844-636-2724, 8 a.m.-5 p.m., or go online to marchvisioncare.com.

# Medical management guidelines

## Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

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

For behavioral health and substance use disorder authorizations, please contact **United Behavioral Health.**

If you have questions, go to **UHCprovider.com/necommunityplan** > **Prior Authorization and Notification**.

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

| Type of request | Decision turn-around time (TAT) | Practitioner notification of approval | Written practitioner/ member notification of denial |
|---|---|---|---|
| Non-urgent pre-service | Within 5 working days of receipt of medical record information required but no longer than 7 calendar days of receipt of request<br>Note: An extension of up to 14 days may be possible at your or the member's request, or if there is justification for more information and the delay is in the member's best interest | Within 24 hours of the decision | Within 2 business days of the decision |
| Urgent/expedited pre-service | Within 72 hours of request receipt<br>Note: an extension of up to 14 days may be possible at your or the member's request, or if there is justification for more information and the delay is in the member's best interest | Within 72 hours of the request | Within 72 hours of the request |
| Concurrent review | Within 24 hours from receipt of the request. If at least 1 attempt to obtain clinical information is made and documented within the initial 24-hour TAT, the TAT is extended to 72 hours from the initial request. | Notified within 24 hours of determination | Notified within 24 hours of determination and member notification within 2 business days |
| Retrospective review | Within 30 calendar days of receiving all pertinent clinical information | Within 24 hours of determination | Within 24 hours of determination and member notification within 2 business days |

# Concurrent review guidelines

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

### Concurrent review details

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

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

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

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

# Determination of medical necessity

Medically necessary services or supplies are those necessary to:

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

# Determination process

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

# Evidence-based clinical guidelines

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

# Medical and drug policies and coverage determination guidelines

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

# Referral guidelines

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

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

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

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

# Reimbursement

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

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

UnitedHealthcare Community Plan will not reimburse:

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

# Second opinion benefit

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

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Care providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward their report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a nonparticipating care provider. The participating care provider should contact UnitedHealthcare Community Plan at **1-800-641-1902.**
- 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

# Serious reportable events and reportable adverse incidents

Consistent with the Affordable Care Act administered through the CMS, UnitedHealthcare Community Plan will implement the Provider Preventable Conditions initiative requirements, which include:

1. Reimbursement adjustment for health care acquired conditions (HCAC).
2. Present on admission (POA) indicator requirement.
3. No reimbursement for "never events."
4. Other provider preventable conditions (OPPC) as defined by any additional state regulations that expand or further define the CMS regulations.

For more information about this reimbursement policy, HCAC and POA, go to **UHCprovider.com** > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > **Reimbursement Policies for Community Plan.** Search for "Health Care Acquired Conditions and Present on Admission Policy."

# Services not covered by UnitedHealthcare Community Plan

The following services are not included in the UnitedHealthcare Community Plan program:

- Any health care not given by a care provider from our list (except emergency treatment, Native American access to care, direct access for members with special health care needs to a specialist, members requiring direct access to a women's health specialist and family planning services), including services received outside of the United States
- Any care covered by Medicaid but not through managed care:
  - Long-term care services in a nursing home
  - Intermediate care facilities for members with an intellectual/developmental disability (I/DD)
  - Home- and community-based waiver services
  - Residential inpatient hospice services
  - School-based services
  - Medicaid state plan personal assistance 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
- Sunglasses and photo-gray lenses
- Ambulances, unless medically necessary
- Infertility services

# Services requiring prior authorization

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

## Direct access services – Native Americans

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

## Seek prior authorization within the following time frames

- **Emergency or urgent facility admission** – within 24 hours, unless otherwise indicated
- **Inpatient admissions; after ambulatory surgery** – within 24 hours, unless otherwise indicated
- **Nonemergency admissions and/or outpatient services (except maternity)** – at least 14 business days beforehand; if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time

Call **1-866-331-2243** or submit requests online using the Prior Authorization and Notification Tool on the UnitedHealthcare Provider Portal at **UHCprovider.com**.

# Authorization determinations

UnitedHealthcare will make standard service authorization determinations within 7 business days of obtaining appropriate information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations must be made no later than 14 calendar days following receipt of the request for service unless an extension is requested.

An extension may be granted for an additional 7 calendar days if the member or the provider or authorized representative requests an extension and the extension is in the member's best interest. In no instance must any determination of standard service authorization be made later than 28 calendar days from receipt of the request.

# Utilization management guidelines

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

## Utilization management appeals

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

# Key contacts

| Topic | Links | Phone number |
|---|---|---|
| EPSDT | dhhs.ne.gov | 1-402-471-3121 |
| Vaccines for Children | dhhs.ne.gov | 1-800-798-1696 or 1-402-471-6423 |

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

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

Visit the Nebraska DHHS MLTC website at dhhs.ne.gov for Health Checks and Treatment Services for Conditions disclosed during Health Checks (EPSDT) criteria, please reference Chapter 33.

For complete details about diagnosis codes as well as full and partial screening, examination and immunization requirements, go to the EPSDT schedule. UnitedHealthcare Community Plan is required to and will report compliance with EPSDT standards to the state of Nebraska, based on claims data and chart review.

# Coding

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

The following are guidelines for submitting claims:

- CPT codes 99381 through 99395 must be submitted with an EP modifier. Include the appropriate referral indicator in box 24H as indicated on the CMS-1500 form.
- For electronic claims submission, include the modifier in the CRC segment in the 2300 loop of the 837 professional file
- The required EP referral indicators are:
  - AV: Patient refused referral
  - S2: Patient is currently under treatment for diagnostic or corrective health problem
  - NU: No referral given
  - ST: Referral to another provider for diagnostic or corrective treatment

Claims submitted without the correct referral indicator codes will be denied.

For more information about ICD-10 coding and social determinants of health protocol and how they apply to the members you treat, see the Specific Protocols chapter in the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) at **UHCprovider.com/guides**. You can also visit **UHCprovider.com/policies.** Under Additional Resources, choose **Protocols** > Social Determinants of Health ICD-10 Coding Protocol.

## Procedure and ICD CM codes

If a member presents for a preventive or well visit, use these codes:

- Newborn – 99431-99433, ICD10 = Z00.129 or Z00.121: Routine infant or child health check, development testing of infant or child. ICD10 = Z38.00 through Z38.2

- Child – 99381-99384, ICD10 = Z00.129 or Z00.121: Routine infant or 99391-99394 child health check, development testing of infant or child
- Adult – 99385 and ICD10 = Z00.00 or Z00.01: Routine general 99395 medical exam at health care facility; health checkup. OR ICD10 = Z00.8: Unspecified general medical exam.

If a member also addresses a medical diagnosis during the visit, use the appropriate ICD-CM code in addition to one of the above "Z" codes.

UnitedHealthcare Community Plan will assume an EPSDT exam has been performed for a given age category when one of the previously listed codes is used.

## Full screening

Perform a full screen. Include:

- Interval history
- Unclothed physical examination
- Anticipatory guidance
- Lab/immunizations (lab and administration of immunizations are reimbursed separately.)
- Lead assessment
- Personal-social and language skills
- Fine motor/gross motor skills
- Hearing
- Vision
- Dental

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

## Immunization data – required state reporting

You are required to submit immunization data to the Nebraska State Immunization Information System. The Nebraska State Immunization Information System (NESIIS) is a secure, statewide, web-based system that connects and shares immunization information among public clinics, private care provider offices, local health departments, schools, hospitals and other health care facilities that administer immunizations. For more information go to dhhs.ne.gov.

## Interperiodic screens

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

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

## Lead screening/treatment

Refer to the Department of Health Lead Program at 1-402-471-0386 if you find a child has a lead blood level over 15ug/dL. For Nebraska providers who would like to request case management for a member's use, please send an email to **ne_cm@uhc.com**.

## Vaccines for Children

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

UnitedHealthcare does not require prior authorization or referral for EPSDT screening services.

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

Contact VFC or DHHS public health at 1-800-798-1696 if you have questions or visit the Nebraska DHHS VFC page at dhhs.ne.gov.

Phone: 1-402-471-6423

Fax: 1-402-471-6426

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

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

# Chapter 6: Member programs

## Key contacts

| Topic | Link | Phone number |
|---|---|---|
| Provider services | **UHCprovider.com** | **1-866-331-2243** |
| Babyscripts | **babyscripts.com** | **1-800-599-5985** |
| Value-added services | **UHCCommunityPlan.com/ne** | **1-866-331-2243** |

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call UnitedHealthcare Provider Services at **1-866-331-2243** unless otherwise noted

## Babyscripts

Pregnant members can sign up for Babyscripts™ by visiting the Apple App Store® or Google Play™ store on their smartphone and downloading the Babyscripts myJourney app.

Babyscripts engages members in a variety of methods (app notifications, email and text messages) and provides daily education on important topics that are specific to pregnancy stages.

Members will also receive appointment reminders for recommended doctor visits and can earn up to 3 Walmart Healthy Living gift cards for completing important prenatal and postpartum visits.

Members self-enroll on a smartphone or computer. They can go to babyscripts.com or call **1-800-599-5985**.

**How you can help**

1. Identify UnitedHealthcare Community Plan members during prenatal visits.
2. Provide program information.
3. Encourage the member to enroll in Babyscripts.

## Back-to-school programming

A collaborative partnership with local schools. We work with school administrators to host on-site events designed to promote healthy habits and nutrition

## Breast pumps

We will pay the cost of a member's portable electric breast pump. A prescription is required. Call **Member Services** at **1-800-641-1902**, TTY **711** if you have questions about the program or need to find an in-network medical equipment company. The medical equipment company will need a physician prescription.

## Care Angel

Care Angel is for members who are pregnant with complex, chronic conditions and in need of population health management. Care Angel will telephonically deliver 1 onboarding call and up to 2 maternity risk trimester assessments and 2 postpartum outreach calls. Our maternity care coordinator will refer the member to engage with Care Angel. For further information, call **Member Services** at **1-800-641-1902**, TTY **711**.

## Client assistance program

A short-term, solution-focused intervention for individuals experiencing behavioral health or substance use symptoms. Also known as bridge sessions, members can meet with qualified providers up to 5 times before completion of an initial diagnostic interview.

## Dr. Health E. Hound

Our UnitedHealthcare Community Plan mascot delivers nutritional education and promotes fitness and healthy habits.

## Social service referrals

Members have support from the health plan to find community resources such as food pantries, housing support, utilities support, childcare, diabetic education, transportation and more. Our Member Services advocates and care and case management staff will use FindHelp to find and refer members to community-based social service supports.

## Healthy rewards

A reward program whereby qualifying members can get a gift card for use at a retailer for CMS-approved health items when they get preventive health services (i.e., EPSDT services or well-care visits). Members will be invited to earn a gift card for completing defined health activities as defined by the health plan

## KidsHealth

A website for children and teens to learn about health and wellness. It provides fun, interactive health information to guide parents and answer kids' questions. Clinicians approve all materials, including over 10,000 articles and more than 200 videos. All content is written to 4th through 7th grade reading levels and available in English and Spanish.

## Mobile apps

UnitedHealthcare mobile apps are available for health and wellness needs. Members can download applications on their smartphone or other mobile devices to find a nearby doctor, ER or urgent care clinic

## NurseLine

NurseLine is available at no cost to our members 24 hours a day, 7 days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the emergency room or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **1-877-543-4293** to reach a nurse

## Self Care

Self Care provides immediate access to cognitive behavioral therapy (CBT) based tools and techniques for members looking to manage stress and emotional well-being. Self Care is a self-paced digital program that uses clinically validated techniques to help members relieve symptoms and build life skills.

Self Care empowers members to engage with activities to improve their mental health from the convenience of their digital device anytime, anywhere. It offers self-paced access to evidence based mental health support such as mediation and mindfulness techniques, habit tracking, daily check-ins, weekly assessments, helping members develop resilience.

It recommends exercises and tips based on goals and mood and offers an opportunity to connect with others who have had similar experiences. Available to members age 13 and older. Members can download the Self Care app at no cost.

## Text4Baby

A mobile information service for members throughout their pregnancy and baby's first year of life. It is important to engage members using their preferred mode of communication. Texting is a great way to maintain strong communication with the member and to educate them.

## Tobacco quit line

To quit smoking, call Nebraska Tobacco Quitline. Nebraska residents get free and confidential access to counseling and support services 24 hours a day, 7 days a week. Call 1-800-QUIT-NOW (1-800-784-8669).

## UHC Latino

**Latino | UnitedHealthcare** our award-winning Spanish-language site, provides more than 600 pages of health and wellness information and reminders on important health topics.

## WellHop

WellHop is a virtual support group for members who are pregnant. Through WellHop members who are pregnant can interact with the social support network and receive guidance from a training group and the group leader.

WellHop brings expecting parents together with similar due dates in group video conservation throughout their pregnancies and after birth.

Members participate during the 2nd and 3rd trimesters and up to 4 months postpartum.

Members can download the free app from the Apple App Store. Call **Member Services** at **1-800-641-1902**, TTY **711**.

Call us toll-free at **1-800-599-5985,** TTY **711,** 7:00 a.m.–6:00 p.m. CT. Follow us on X (FKA Twitter) @UHCPregnantCare.

## Women, Infants and Children supplemental nutrition

Women, Infants and Children supplemental nutrition (WIC) is the special nutrition program for women, infants and children enrolled in Medicaid. The WIC program provides healthy food at no cost, breastfeeding support, nutrition education and health care referrals. If the member is pregnant, talk to them about filling out a WIC application during their next visit. Members will need to submit a WIC application to their local WIC office.

# Chapter 7: Mental health and substance use

## Key contacts

| Topic | Link | Phone number |
|---|---|---|
| Behavioral health/Provider Express | **providerexpress.com** | **1-877-614-0484** |
| Provider Services | **UHCprovider.com** | **1-866-331-2243** |

United Behavioral Health, operating under Optum, provides UnitedHealthcare Community Plan members with mental health and SUD benefits. The national Optum network manual generally applies to all types of business. Some sections may apply differently based on state law.

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

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

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

To request an ID number, go to the Department of Health and Human Services website at nppes.cms.hhs.gov > go to the section titled "Apply to be a Medicaid Provider."

**Note:** Atypical care providers do not have to have an NPI number, per Nebraska Medicaid. Nebraska Medicaid defines "atypical" providers as: MHCP (Medically Handicapped Children's Program) clinics, MIPS (Medicaid in Public Schools), personal care aides, mental health personal care aides/ community treatment aides, mental health home health care aides and non-emergency transportation providers. Not applicable for SSAD, MHCP and DPFS.

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

## Covered services

UnitedHealthcare Community Plan offers covered behavioral health services for mental, emotional and substance use disorders. We offer case 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.

A number of member resources are available at **liveandworkwell.com,** which can be accessed directly or through a link on **myuhc.com.** These resources include information on behavioral health and well-being, many physical health conditions, addictions and coping. Members can take self-assessments, read articles on a variety of topics and locate community resources.

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

Benefits may include (depending on the member's age and other factors):

- Crisis stabilization services (includes treatment crisis intervention)
- Inpatient psychiatric hospital (acute and sub-acute)
- Psychiatric residential treatment facility
- Outpatient assessment and treatment:
  - Partial hospitalization

  - Social detoxification
  - Day treatment
  - Intensive outpatient
  - Medication management
  - Outpatient therapy (individual, family or group)
  - Injectable psychotropic medications
  - Substance use disorder (SUD) and opioid use disorder (OUD) treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Sex offender risk assessment
  - Community treatment aide (CTA) services (for children only)
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)
  - Child-parent psychotherapy
  - Parent child interaction therapy
  - Applied behavioral analysis
  - In-home psychiatric nursing
  - Peer support services
  - Multi-systemic therapy
  - Functional family therapy
  - Electroconvulsive therapy
  - Telehealth
- Rehabilitation services
- Day treatment/intensive outpatient
- Dual-disorder residential
- Intermediate residential (SUD)
- Short-term residential
- Community support
- Psychiatric residential rehabilitation
- Secure residential rehabilitation
- Professional resource family care
- Halfway house
- Therapeutic group home
- Therapeutic community
- Assertive community treatment (ACT) and Alternative (Alt) ACT
- Day rehabilitation
- Opioid treatment program (OTP)
- Withdrawal management

# Eligibility

Verify the UnitedHealthcare Community Plan member's Medicaid eligibility on day of service before treating them. View eligibility online using the Eligibility and Benefits tool on the **UnitedHealthcare Provider Portal** > Sign In, or the Nebraska Medicaid Eligibility System (NMES) at 1-800-642-6092.

# Authorizations

Members may access most behavioral health outpatient individual and group services without authorization.

More intensive outpatient services require authorization. Inpatient and residential services also require authorization. The UnitedHealthcare Community Plan prior authorization list is available on **UHCprovider.com/necommunityplan** > **Behavioral Health.** Ensure prior authorizations are in place before rendering non-emergent services. Initiate the authorization process by going to **providerexpress.com** or by calling **1-866-331-2243**.

# Portal access

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

# 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.

# Training resources and materials

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

- **Behavioral health toolkits**
- **Provider training materials**
- **Network provider manuals**

# Addressing the opioid epidemic

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

## Brief summary of framework

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

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

## Prescribing opioids

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

## Pharmacy Coordinated Services (lock-in) program

The Pharmacy Coordinated Services (lock-in) program helps ensure that members selected for program enrollment will use services appropriately. The program limits members to filling prescriptions at 1 pharmacy. Members with potentially inappropriate patterns of medication use are identified using pharmacy and medical claims data.

When a member is enrolled in the program, they are sent a written notification of the intent to restrict their medication use to 1 pharmacy and a suggested pharmacy. The member can call Member Services if they would like to use a different pharmacy. After this time, the member may request a network pharmacy change for a good cause reason as long as both the member and the health plan agree.

The member's appeal rights are outlined in the notification letter and the Member Handbook. The member will remain in the program until they show a pattern of using services appropriately.

Provisions allow a one-time emergency supply for medications available at a pharmacy other than the member's pharmacy.

To refer a member to the Pharmacy Coordinated Services (lock-in) program, please include member name, member ID, member demographics and an explanation for your referral.

Submit your request by:

**Email: uhpcs_pharmacy_lockin@uhc.com**

**Call Provider Services: 1-866-331-2243**

# Expanding medication assisted treatment access and capacity

Evidence-based medication-assisted treatment (MAT) 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 continually seek to expand our MAT provider network to maximize member access.

To find a behavioral health MAT care provider in Nebraska:

1. Go to **UHCprovider.com/findprovider.**
2. Select under "Specialty Directory and Tools" the option of Optum Behavioral Health, EAP, Worklife and Mental Health Services.
3. Click on "Search for a Behavioral Health Provider."
4. Enter "(city)" and "(state)" for options.
5. If needed, refine the search by selecting "Medication Assisted Treatment."

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

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

# Chapter 8: Member rights and responsibilities

## Key contacts

| Topic | Link | Phone number |
|---|---|---|
| Member Services<br>Member handbook | UHCCommunityPlan.com/ne | 1-800-641-1902 |

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 Protected Health Information

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

### Accounting of disclosures

Our members have the right to request an accounting of certain disclosures of their PHI, made by you or us, during 6 years prior to the request. This accounting must include disclosures by business associates. It will not include disclosures made:

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

### Right to request restrictions

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

### Right to request confidential communications

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

# Member rights and responsibilities

The following information is in the Member Handbook at the following link under the Member Information tab: **UHCCommunityPlan.com/ne** > Provider Information > **Member Handbook**.

## Native American access to care

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

## White Bison healing resources

White Bison recovery resources are available at whitebison.org.

## Member rights

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

- Be treated with respect, dignity, and privacy, without discrimination or retaliation
- Get information about your treatment options and alternatives, in a way that is appropriate to your condition and your ability to understand the information
- Get your treatment options, risks and benefits in a way you understand, to make an informed decision about your treatment
- Take part in choices about your healthcare, including the right to refuse treatment.
- UnitedHealthcare Community Plan cannot request disenrollment of a member for refusal of treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Request and receive a copy your medical records for free
- Request that your medical records be amended or corrected
- Obtain available and accessible health care services covered by UnitedHealthcare Community Plan
- Request disenrollment
- Change your health plan within 90 days of initial enrollment or every 12 months without cause after that
- Be free to exercise these rights without negatively affecting your treatment by UnitedHealthcare Community Plan, our providers, or the State.
- Talk to your provider and UnitedHealthcare Community Plan and know your health information will be kept confidential
- Choose and have access to your health plan and Primary Care Provider (PCP)
- Change your PCP at any time, for any reason
- Receive appropriate medical care 24 hours a day, 7 days a week
- Make a complaint about your provider or health plan and receive a timely response
- Appeal if services are denied, terminated or reduced
- Receive information on the medical services covered and not covered by UnitedHealthcare Community Plan
- Have UnitedHealthcare Community Plan materials explained or interpreted
- Have interpreters, at no cost to you, if necessary, during medical appointments and in all discussions with your PCP and/or UnitedHealthcare Community Plan
- Receive culturally competent assistance including having interpreter services during
- appointments and procedures
- Request information on Advance Directives
- Make an Advance Directive and receive assistance if needed
- Refuse treatment through an Advance Directive or withhold your consent for treatment
- You also have the right to ask for more information about:
  - Our structure and operation
  - Our physician incentive plan
  - Our service utilization policies
  - How to report alleged marketing violations to the State
  - Reports to the State about transactions between UnitedHealthcare and other parties

## Member responsibilities

As a UnitedHealthcare Community Plan member, you have a responsibility to:

- Understand your health plan and follow it to get the most benefits
- Choose a PCP within UnitedHealthcare Community Plan's network
- Show your ID card to providers and pharmacies
- Keep appointments or call your provider at least 24 hours before the scheduled appointment if it needs to be rescheduled
- Tell your provider about any medical problems
- Ask questions about your treatment so that you understand
- Follow the advice of your providers and understand possible results if you do not follow their advice
- Assist with the transfer of your medical records
- Receive services from your PCP unless referred somewhere else by your PCP
- Cooperate with all UnitedHealthcare Community Plan inquiries and surveys

## Member responsibilities required by the National Committee for Quality Assurance

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

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

# Chapter 9: Medical records

## Medical record charting standards

You are required to keep complete and orderly medical records 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:

| Topic | Contact |
|---|---|
| Confidentiality of record | Office policies and procedures exist for:<br>• Privacy of the member medical record<br>• Initial and periodic training of office staff about medical record privacy<br>• Release of information<br>• Record retention<br>• Availability of medical record if housed in a different office location<br>• Process for notifying UnitedHealthcare Community Plan upon becoming aware of a patient safety issue or concern<br>• Coordination of care between medical and behavioral care providers |
| Record organization and documentation | • Have a policy that provides medical records upon request. Urgent situations require copies be provided within 48 hours.<br>• Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing Medical records.<br>• Release only to entities as designated consistent with federal requirements<br>• Keep in a secure area accessible only to authorized personnel |
| Procedural elements | **Medical records are readable***<br>• Sign and date all entries<br>• Member name/identification number is on each page of the record<br>• Document language or cultural needs<br>• 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.<br>• Procedure for monitoring and handling missed appointments is in place<br>• An advance directive is 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.<br>• Include a list of significant illnesses and active medical conditions<br>• Include a list of prescribed and over-the-counter medications. Review it annually.*<br>• Document the presence or absence of allergies or adverse reactions* |

***Critical element**

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

***Critical element**

### Member copies

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

When a member changes care providers, copies of medical records must be forwarded to the new provider within 10 business days from receipt of the request for transfer of the medical records.

## Medical record review

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

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

Member hospitalization records should include, as appropriate:

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

# Chapter 10: Quality management program and compliance information

## Key contacts

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

## What is the Quality Improvement program?

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

The program consists of:

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

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

### Cooperation with quality-improvement activities

You must comply with all 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
- Participating in quality audits, such as site visits and medical record standards reviews, and taking part in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review
- Providing requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by secure email.
- Completing practitioner 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 UnitedHealthcare Community Plan engages independent market research firm Center for the Study of Services (CSS) to analyze and report findings.

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

# Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. You are encouraged to visit **UHCprovider.com/cpg** to view the guidelines, as they are an important resource to guide clinical decision-making.

# Credentialing standards

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

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

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

Medicaid ID and Disclosure of Ownership Form are enrollment requirements. The MCO must notify the Medicaid Agency of your disclosures on persons convicted of crimes within 10 working days from the date it receives the information. The MCO must also promptly notify the Medicaid Agency of action it takes on your program participation application. The Medicaid Agency will notify the Inspector General within 20 working days of notification by the MCO.

# Credentialing and recredentialing process

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

Beginning January 1, 2025, care providers seeking initial credentialing with any managed care organization for Nebraska Medicaid will use the newly implemented centralized credentialing process along with an NCQA certified Centralized Verification Organization (CVO). The CVO, Verisys, will conduct one streamlined verification process for all three Nebraska Managed Care Organizations (MCO). A Centralized Credentialing system eliminates the need to perform a unique credentialing process with each MCO and is in alignment with the State of Nebraska's intent is to alleviate the duration and reduce administrative burdens of the MCO specific credentialing processes. Re-credentialing will begin later in 2025.

Please refer to the UnitedHealthcare Community Plan of Nebraska Homepage for more information at **uhcprovider.com/en/health-plans-by-state/nebraska-health-plans/ne-comm-plan-home.html**.

### Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- M.D.s (Doctors of Medicine)
- D.O.s (Doctors of Osteopathy)
- D.D.S.s (Doctors of Dental Surgery)
- D.M.D.s (Doctors of Dental Medicine)
- D.P.M.s (Doctors of Podiatric Surgery)
- D.C.s (Doctors of Chiropractic)
- C.N.M.s (Certified Nurse Midwives)
- C.R.N.P.s (Certified Nurse Practitioners)
- Behavioral health clinicians (psychologists, clinical social workers, masters prepared therapists)

Excluded from this process are practitioners who:

- Practice only in an inpatient setting
- Hospitalists employed only by the facility
- N.P.s and P.A.s who practice under a credentialed UnitedHealthcare Community Plan care provider

### Health facilities

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

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

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

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

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

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

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

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

## Peer review

### Credentialing process

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

### Recredentialing process

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

### Performance review

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

### Applicant rights and notification

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

You also have the right to receive the status of your credentialing application; please connect with a live advocate via chat. It is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**.

### Confidentiality

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

## Resolving disputes

### Contract concerns

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

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

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

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

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

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

## Health Insurance Portability and Accountability Act compliance – your responsibilities

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

### Transactions and code sets

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

### Unique identifier

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

### National Provider Identifier

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

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

### Privacy of individually identifiable health information

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

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

### Security

Covered entities must meet basic security measures:

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

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

Find additional information on HIPAA regulations at 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 7 elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

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

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

### Reporting and auditing

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

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

This department oversees coordination of anti-fraud activities. To report questionable incidents involving members or care providers, call our Fraud, waste and abuse line, go to **uhc.com/fraud,** or refer to the **Fraud, waste and abuse section** of this care provider manual for additional details.

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

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

## Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the state of Nebraska 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 Nebraska DHHS.

## 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 Nebraska program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

If any litigation, claim, negotiation, audit or other action involving the records has been started before the 10-year period ends, you agree to keep the records until 1 year after the resolution of all issues that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your Provider Agreement.

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

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

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

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

## Criteria for site visits

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

| QOC issue | Criteria | Threshold |
|---|---|---|
| Issue may pose a substantive threat to patient's safety | Access to facility in poor repair to pose a potential risk to patients<br>Needles and other sharps exposed and accessible to patients<br>Drug stocks accessible to patients<br>Other issues determined to pose a risk to patient safety | 1 complaint |
| Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space | Office facilities are dirty; smelly or otherwise in need of cleaning<br>Office exams rooms do not provide adequate privacy | 2 complaints in 6 months |
| Other | All other complaints concerning the office facilities | 3 complaints in 6 months |

# Chapter 11: Billing and submission

## Key contacts

| Topic | Link | Phone number |
|---|---|---|
| Claims | **UHCprovider.com/claims** | **1-866-331-2243** |
| National Plan and Provider Enumeration System (NPPES) | nppes.cms.hhs.gov | 1-800-465-3203 |
| EDI | **UHCprovider.com/edi** | **1-800-210-8315** |

## Our claims process

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

We follow the same claims process as UnitedHealthcare. See the claims process chapter of the Administrative Guide for Commercial, Medicare Advantage and D-SNP on **UHCprovider.com/guides**.

### Claims process from submission to payment

You submit EDI claims to a clearinghouse or paper claims to us. We scan paper claims. All claims are checked for compliance and validated.

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

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

## National Provider Identifier

HIPAA requires you have a unique NPI. The NPI identifies you in all standard transactions. If you have not applied for a NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan. Call **Provider Services** at **1-866-331-2243**.

Your clean claims must include your billing and rendering NPI and federal tax identification number (FEIN).

## Nebraska DHHS MLTC Medicaid ID

You must have a Nebraska Medicaid provider ID number to render services for a Nebraska Heritage Health plan member and receive payment from us. You must receive this ID number prior to claims payment. This ID number is assigned by the Nebraska DHHS MLTC.

To apply for a Nebraska DHHS MLTC Medicaid ID, visit the Nebraska DHHS webpage to access the MC-19 form and Provider Screening and Enrollment information: dhhs.ne.gov.

# General billing guidelines

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

# Claims payment requirements

UnitedHealthcare Community Plan must pay care providers interest at an annualized rate of 12%, calculated daily for the full period in which a payable claim, in accordance with 42 CFR § 447.45, remains unpaid beyond the 60-day claims processing deadline. Interest owed to the provider must be paid the same day that the claim is adjudicated.

# Modifier codes

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

# Member ID card for billing

The member ID card has both the UnitedHealthcare Community Plan member ID and the state Document Control Number (DCN). UnitedHealthcare Community Plan 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 CMS 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services.

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

# 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. The claim requires no special treatment preventing timely payment under the Agreement terms. Please refer to your Agreement for timely filing guidelines.

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

All claims must have a valid rendering provider NPI number and billing provider NPI number combination matching the care provider information enrolled with the DHHS. We will reject electronic claim submissions and deny paper claims that do not have a matching rendering and billing provider NPI combination.

Claims must include the correct billing taxonomy code and 9-digit office ZIP code registered with DHHS. Because the Nebraska DHHS uses this data, it's important for your claim data to match the data used in your DHHS Provider Identification Number registration process.

# Care provider coding

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

For more information about ICD-10 coding and social determinants of health protocol and how they apply to the members you treat, see the Specific Protocols chapter in the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) at **UHCprovider.com/guides**. You can also visit **UHCprovider.com/policies.** Under Additional Resources, choose **Protocols** > Social Determinants of Health ICD-10 Coding Protocol.

# Dental

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

# 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 1-87726
- 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, see **EDI Claims** at **1-800-210-8315**.

# Electronic Data Interchange companion documents

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

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

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

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

## Clearinghouse and status reports

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

For clearinghouse options, go to **UHCprovider.com/edi** > **EDI Clearinghouse Options**.

# e-Business support

Call **Provider Services** at **1-866-331-2243** for help with online billing, claims, electronic remittance advices (ERAs), electronic funds transfers (EFTs).

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

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

## Important Electronic Data Interchange payer information

- Claim Payer ID: 1-87726
- ERA Payer ID: UFNEP

# Electronic payment solution: Optum Pay

UnitedHealthcare Community Plan has launched the replacement of paper checks with electronic payments and will no longer be sending paper checks for 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 Automated Clearing House/ direct deposit?

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

### What does this mean to you?

- If your practice/health care organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a virtual card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**
- If your practice/health care organization is already enrolled and receiving your claim payments through ACH/direct deposit from Optum Pay™ or receiving virtual cards, you don't need to take action
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and virtual card statement will be available online through Document Library
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

# Completing the CMS 1500 claim form

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

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

# Completing the UB-04 form

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

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

# Capitated services

Capitation is a payment arrangement for 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 or not that person seeks care. In most instances, the capitated care provider is either a medical group or an independent practice association (IPA). In a few instances, however, the capitated care provider may be an ancillary 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 providers who are capitated for certain UnitedHealthcare Community Plan products. This applies to all benefit plans for members:

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

Additionally, capitated care providers may be subject to any or all delegated activities. Capitated care providers should refer to their Delegation Grids within their participation agreements to determine which delegated activities the capitated 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 emergency room 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.

# Subrogation and coordination of benefits

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

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

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

# Hospital and clinic method of billing professional services

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

# Global days

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

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

# Correct Coding Initiative

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

## Comprehensive and component codes

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

- **Separate procedures**
  Only report these codes when performed independently
- **Most extensive procedures**
  You can perform some procedures with different complexities. Only report the most extensive service.
- **With/without services**
  Don't report combinations where 1 code includes and the other excludes certain services
- **Medical practice standards**
  Services part of a larger procedure are bundled
- **Laboratory panels**
  Don't report individual components of panels or multichannel tests separately
- **Sequential procedures**
  Only report the procedure that achieves the expected result

## Mutually exclusive codes

Mutually exclusive code edits apply to procedures that are unlikely or impossible to perform at the same time, on the same member, by the same care provider.

CCI guidelines are available in hard copy, on CD-ROM and in software packages from your CPT and ICD CM code vendor, many specialty organizations, and the U.S. Department of Commerce's National Technical Information Service.

## 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. Note: Block 23 can only contain 1 condition. Additional conditions should be reported on a separate CMS 1500 claim form.

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 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 1 unit with the appropriate charge in the charge column
- The beginning date of service is equal to the initial prenatal visit and the ending date of service is equal to the last prenatal visit prior to delivery
- Nebraska allows billing antepartum care with 1 visit on a separate line
- Use CPT Evaluation and Management codes (99201-99215*) or OB visits (59425-59426) to report prenatal visits
  - Only use CPT Evaluation and Management (E/M) codes 99201-99215 when 3 or fewer prenatal visits are performed
  - Use global delivery codes 59400, 59519, 59610 and 59618

## Ambulance claims (emergency)

Ambulance claims must include the point of origin, destination address, city, state and ZIP. The accident state must be listed in box 10 and ambulance claims must not bill diagnosis code 799.99.

## 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.

In field 24A shaded area of the CMS 1500 claim form, enter the N4 NDC qualifier in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC units of measure qualified, followed by the NDC quantity. All should be left-justified in the pink shaded area above the date of service.

The billed units in column G (days or units) should reflect the HCPCS units and not the NDC units. Do not base billing on the NDC units. Billing based on the NDC units may result in underpayment.

## Medical necessity

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

# Place of Service codes

Go to cms.gov for Place of Service codes.

# Asking about a claim

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

## Provider Services

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

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

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

## UnitedHealthcare Community Plan Provider Portal

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

# Resolving claim issues

To resolve claim issues, contact Provider Services through the **UnitedHealthcare Provider Portal**, or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

**UnitedHealthcare Community Plan**
P.O. Box 5240
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 screenshot from your accounting software that shows when you submitted the claim. The screenshot must show the correct:

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

## Timely filing

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

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

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

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

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

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

# Balance billing

Do not balance bill members if:

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

You may balance bill the member for noncovered services if the member provides written consent prior to getting the service. If you have questions, please contact your provider advocate. If you don't know who your provider advocate is, connect with a live advocate via chat on **UHCprovider.com/chat**, available 7 a.m.-7 p.m. CT.

# Third-party resources

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible members. Therefore, you must bill and obtain an 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.

# Medicare crossover claims

You are required to enter Medicare information at both the claim and line level. When entering Medicare information at the claim level, please help ensure the amount entered is the sum of the amounts entered at the line level.

# 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 agreement. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

For claims, billing and payment questions, go to **UHCprovider.com/claims**. We no longer use fax numbers. Please use our online options or phone number.

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

**Appeals and grievances standard definitions and process requirements**

| Situation | Definition | Who may submit? | Submission address | Online form for mail | Contact phone number | Website (care providers only) for online submissions | Care provider filing time frame | UnitedHealthcare Community Plan response time frame |
|---|---|---|---|---|---|---|---|---|
| Care provider claim correction (resubmission) | Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission. | Care provider | **UnitedHealthcare Community Plan**<br>P.O. Box 5270<br>Kingston, NY 12402-5270 | UHCprovider.com/claims | **1-866-331-2243** | Use Claims Management or Claims on the UnitedHealthcare Provider Portal or **UHCprovider.com/claims** | Must receive within the time frames specified in your Agreement | 30 business days |
| Care provider claim reconsideration (step 1 of dispute) | Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with | Care provider | Most care providers in your state must submit reconsideration requests electronically.<br>For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide.**<br>For those care providers exempted from this requirement, requests may be submitted at the following address:<br>**UnitedHealthcare Community Plan**<br>P.O. Box 5240<br>Kingston, NY 12402-5240 | | **1-866-815-5334** | For online submissions using the UnitedHealthcare Provider Portal, go to:<br>**Pre- and post-service appeals and reconsiderations** | Must receive within 365 calendar days of the claim processing date | 30 business days |
| Care provider claim formal appeal (step 2 of claim dispute) | A second review in which you did not agree with the outcome of the reconsideration | Care provider | Most care providers in your state must submit appeals requests electronically.<br>For further information on appeals, see the **Reconsiderations and Appeals interactive guide.**<br>For those care providers exempted from this requirement, requests may be submitted at the following address:<br>**UnitedHealthcare Community Plan**<br>P.O. Box 31364<br>Salt Lake City, UT 84131-0364 | | **1-866-331-2243** | For online submissions using the UnitedHealthcare Provider Portal, go to:<br>**Pre- and post-service appeals and reconsiderations.** | Within 60 calendar days of the provider remittance advice/ reconsideration decision | 30 business days |
| Care provider grievance | A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member | Care provider | **UnitedHealthcare Community Plan**<br>**Attn: Appeals and Grievances**<br>P.O. Box 31364<br>Salt Lake City, UT 84131-0364 | | **1-866-331-2243** | Use Prior Authorization on the UnitedHealthcare Provider Portal.<br>Go to **UHCprovider.com** > Sign In | N/A | 15-90 calendar days |

## Appeals and grievances standard definitions and process requirements

| Situation | Definition | Who may submit? | Submission address | Online form for mail | Contact phone number | Website (care providers only) for online submissions | Care provider filing time frame | UnitedHealthcare Community Plan response time frame |
|---|---|---|---|---|---|---|---|---|
| Member appeal | A request to change an adverse benefit determination that we made.<br><br>In a case involving an initial determination, the MCO must provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request informal reconsideration of an adverse determination by the physician or dentist or clinical peer making the adverse determination. | • Member<br>• Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent | **UnitedHealthcare Community Plan**<br>**Attn: Appeals and Grievances**<br>P.O. Box 31364<br>Salt Lake City, UT 84131-0364 | **providerforms.uhc.com/ProviderAppealsandGrievance.html**<br><br>AOR Consent Form on this site for member appeals | **1-800-641-1902** | Use Prior Authorization on the UnitedHealthcare Provider Portal.<br>Go to **UHCprovider.com** > Sign In | Standard appeals – 60 calendar days | Urgent appeals – 72 hours<br><br>Standard appeals – 30 calendar days<br><br>c) The informal reconsideration should occur within 1 business day of receipt of the request and should be conducted between the provider rendering the service and the MCO's physician or dentist authorized to make adverse determinations, or clinical peer designated by the Medical or Dental Director if the physician or dentist who made the adverse determination cannot be available within 1 business day. The informal reconsideration will in no way extend the 30 calendar day required timeframe for a Notice of Appeal Resolution. |
| Member grievance | A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns. | • Member<br>• Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent | **UnitedHealthcare Community Plan**<br>**Attn: Appeals and Grievances**<br>P.O. Box 31364<br>Salt Lake City, UT 84131-0364 | | **1-800-641-1902** | Use Prior Authorization on the UnitedHealthcare Provider Portal. Go to **UHCprovider.com** > Sign In | N/A | 15-90 calendar days<br><br>We will acknowledge we received the grievance within 10 calendar days of receipt. |

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

UnitedHealthcare Community Plan and its contracted providers may agree to more stringent requirements within provider agreements than described in the standard process.

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

The grid lists the types of disputes and processes that apply. 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.

**Duplicate denials** – To reduce receiving duplicate denials, submit 1 claim with all billed services for 1 member, 1 date of service when rendered by same care provider. If you bill for multiple dates of service, please ensure all billable services are listed for the dates of service.

The exception to these guidelines applies when the service(s) include:

- Different procedure codes
- Different modifiers
- Different NDC numbers
- Different place of service (POS)
- Billing by care provider of different specialty

All services billed on a UB-04 form need to be listed on 1 claim form.

**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:**

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

**Additional information**

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

# Resubmitting a claim

**What is it?**

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

**When to use it:**

Resubmit the claim if it was rejected. Since rejected claims have not been processed yet, there is no appeal – the claim needs to be corrected through resubmission. You have up to 12 months from the date of service to submit a clean claim.

**Common reasons for rejected claims:**

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

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

**How to use:**

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

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

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

# Claim reconsideration (step 1 of dispute)

**What is it?**

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

**When to use:**

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

**For administrative denials –**

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

**For medical necessity denials –**

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

**How to use:**

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

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

## Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved
- Call **Provider Services** at **1-866-331-2243** 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?**

Valid proof of timely filing a claim 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

The date on the other carrier's payment

correspondence starts the timely filing period for submission to UnitedHealthcare Community Plan. To be considered timely, the claim must be received by UnitedHealthcare Community Plan within the timely filing period from the date on the other carrier's correspondence. If the claim is received after the timely filing period, it will not meet timely filing criteria.

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

**How to use:**

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

Submit a screenshot from your accounting software that shows the date you submitted the claim. The screenshot must show:

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

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

# Overpayment

**What is it?**

An overpayment happens when we overpay a claim.

**How to use:**

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

If you prefer we recoup the funds from your next payment, call **Provider Services** at **1-866-331-2243**.

If you prefer to mail a refund, send an Overpayment Return Check or the Overpayment Refund/Notification form.

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

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

**Where to send:**

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

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

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

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

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

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

### Sample overpayment report

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

| Member ID | Date of service | Original claim # | Date of payment | Paid amount | Amount of overpayment | Reason for overpayment |
|---|---|---|---|---|---|---|
| 11111 | 01/01/24 | 14A000000001 | 01/31/24 | $115.03 | $115.03 | Double payment of claim. |
| 2222222 | 02/02/24 | 14A000000002 | 03/15/24 | $77.29 | $27.29 | Contract states $50.00, claim paid $77.29. |
| 3333333 | 03/03/24 | 14A000000003 | 04/01/24 | $131.41 | $98.56 | You paid 4 units, we billed only 1. |
| 44444444 | 04/04/24 | 14A000000004 | 05/02/24 | $412.26 | $412.26 | Member has other insurance. |
| 55555555 | 05/05/24 | 14A000000005 | 06/15/24 | $332.63 | $332.63 | Member terminated. |

# Care provider claim appeals (step 2 of dispute)

**What is it?**

An appeal is a review of a claim reconsideration decision (step 1). It is a one-time formal review of a processed claim that was partially paid or denied.

**When to use:**

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

**How to use:**

Submit related documents with your appeal within 60 calendar days from the provider remittance advice (PRA) date. These may include a cover letter, medical records and additional information. Send your information electronically or by mail. In your appeal, please include any supporting information not included with your reconsideration request.

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

**Questions about your appeal or need a status update?**

Call **Provider Services** at **1-866-331-2243** for questions about your appeal or if you need a status update.

If you filed your appeal online, you should receive a confirmation email or feedback through the secure UnitedHealthcare Provider Portal.

# Care provider grievance

**What is it?**

A grievance is a written or verbal expression of dissatisfaction about any matter other than an adverse benefit determination. You may file a grievance on your behalf.

**When to file:**

You may file a grievance about:

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

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

**How to file:**

File verbally or in writing. View the **appeals and grievances grid** for submission information. You may only file a grievance on a member's behalf with the written consent of the member.

# Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses CMS definitions for appeals and grievances.

## Member appeals

**What is it?**

An appeal is a formal way for a member to request a reconsideration of any adverse benefit determination, including:

- 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
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner, as defined by the state
- The failure of the MCO to act within the time frames provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments and other member financial liabilities

**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, mail or submit the information electronically within 60 calendar days from the date of the adverse benefit determination.

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

You, acting on the member's behalf, or a member have the right to present the appeal in person 8 a.m.–5 p.m., CT, Monday–Friday, at:

**UnitedHealthcare Community Plan**
2717 N. 118th St.
Suite #300
Omaha, NE 68164

**How to use:**

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

- Receive a copy of the rule used to make the decision
- Present evidence, and allegations of fact or law, in person and in writing
- If someone else helps the member with their appeal, the member will need to sign a form called Designation of Authorized Representative form. The form grants permission to the other party to help the member on their behalf with the appeal process.
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal
- Ask for an expedited appeal if waiting for this health service could harm the member's health
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the care provider, you cannot ask for a continuation. Only the member may do so.

We resolve a standard appeal 30 calendar days from the day we receive it. We resolve an expedited appeal 72 hours from the time we receive it. We may extend the response up to 14 calendar days if the following conditions apply:

1. Member requests we take longer.
2. We request additional 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 **providerforms.uhc.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, mail or submit the information electronically anytime.

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

We will send an answer no longer than 90 calendar days from when you filed the complaint/grievance, or as quickly as the member's health condition requires

# Member state fair hearings

**What is it?**

A state fair hearing is a request by a member or you (on a member's behalf) to appeal a decision made by the health plan, addressed to the state.

**When to use:**

The member or their representative may request the state of Nebraska for a state fair hearing only after receiving notice that the health plan is upholding the adverse benefit determination.

**How to use:**

Write a letter to the state within 120 calendar days from the appeal decision notice to:

Department of Health and Human Services
MLTC Appeal Coordinator
P.O. Box 94967
Lincoln, NE 68509-4967

- The member may ask UnitedHealthcare Community Plan Member Services for help writing the letter
- The member may call the Nebraska DHHS MLTC Legal Services at 1-402-471-7237
- The member may have an authorized representative present their case at a state fair hearing. This may be a family member, friend, care provider or lawyer. Written consent is required for an authorized representative to file or present their case at a state fair hearing.

## Member continuation of services

Members may ask for continuation of services during the state fair hearing. However, the member may be required to pay for the health service if the service is continued and it is decided that the member should not have received the service.

UnitedHealthcare Community Plan provides for continuation of benefits/services while the appeal and state fair hearing are pending if:

- The member files in a timely manner for continuation of benefits – defined as on or before the later of the following:
  - Within 10 days of the mailing of the notice of adverse benefit determination
  - The intended effective date of the proposed adverse benefit determination
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment
- The services were ordered by an authorized care provider
- The period covered by the original authorization has not expired

# Processes related to reversal of our initial decision

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

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

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

# Timelines for grievances and appeals

| | |
|---|---|
| **Grievance** | |
| Time to file | Members and care providers may submit at any time. |
| Time to resolve | We will try to resolve within 15 days, but when additional time is needed, a resolution analyst will notify the care provider with the reason for the delay and help ensure the complaint is resolved within 90 days. |
| **Claims adjustment – claims reconsideration** | |
| Time to file | Must be filed within 365 calendar days of the claim processing date |
| Time to resolve | 30 business days |
| **Claims adjustment – claims appeal** | |
| Time to file | Within 60 calendar days of the provider remittance advice/reconsideration decision |
| Time to resolve | 30 business days of receipt |
| **Claims adjustment – claims appeal – overpayment refund request** | |
| Time to file | Within the time frame listed in your contract |
| Time to resolve | Within 30 business days |
| **Utilization management (UM) appeal** | |
| Time to file | Upon receipt of an adverse benefit decision, the member or care provider must submit an appeal within 60 calendar days. |
| Time to resolve | 30 days. Expedited reviews/decisions are available within 72 hours when medically necessary. |

# Fraud, waste and abuse

Call the toll-free Fraud, waste and abuse Hotline at **1-844-359-7736** to report questionable incidents involving plan members or care providers. You can also go to **uhc.com/fraud** to learn more or to report and track a concern.

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies according to state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health. UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its Anti-Fraud, Waste and Abuse Program. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

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

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

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

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

## Exclusion checks

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

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

## What you need to do for exclusion checks

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

# Chapter 13: Care provider communications and outreach

## Key contacts

| Topic | Link | Phone number |
|---|---|---|
| Provider education | **UHCprovider.com/resourcelibrary** | **1-866-331-2243** |
| News and bulletins | **UHCprovider.com/news** | |
| Provider manuals | **UHCprovider.com/guides** | |

## Communication with care providers

UnitedHealthcare is on a **multi-year effort** to enhance our digital delivery channels and transition paper transactions to electronic, whenever possible. Our goal is to make it easier for you to work with us and reduce the time it takes for you to perform claim and clinical activities. We may provide electronic notice of policy, protocol and payment policy changes; news and other important updates.

Accordingly, there are a number of ways clinicians, practice managers, administrative staff, facilities and hospitals can stay up to date on items of interest from UnitedHealthcare:

- **UHCprovider.com**
  This public website is available 24/7 and does not require registration to access. You'll find valuable resources, including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates and quality programs.
- **UnitedHealthcare Community Plan of Nebraska page**
  **UHCprovider.com/necommunityplan** has resources, guidance and rules specific to Nebraska. Be sure to check back frequently for updates.
- **Health plans by state**
  **UHCprovider.com/ne** is the fastest way to review all of the health plans UnitedHealthcare offers in Nebraska. To review plan information for another state, use the drop-down menu at **UHCprovider.com** > Resources > **Health Plans.** Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **Policies and protocols**
  This **library** includes UnitedHealthcare Community Plan policies and protocols.
- **Social media**
  Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics.
  - Facebook
  - Instagram
  - LinkedIn
  - YouTube
  - X (Twitter)
- **UnitedHealthcare Community & State newsletter**
  Stay current on the latest insights, trends and resources related to Medicaid. **Sign up** to receive this twice-a-month newsletter.
- **UnitedHealthcare Provider Portal**
  This secure portal is accessible from **UHCprovider.com**. It allows you to access patient information such as eligibility and benefit information and digital ID cards.
  - You can learn more about the portal in Chapter 1 of this care provider manual or by visiting **UHCprovider.com/portal.**
  - You can also access **self-paced user guides** for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News**
  Bookmark **UHCprovider.com/networknews**. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans.
  - Get news related to your role, specialty, health plan and state. When you **subscribe** to Network News, you can update your preferences to select what news you receive.

# Care provider education and training

To help ensure you are reimbursed accurately and patients have access to the care they need, we have developed a full range of training resources, including interactive self-paced courses and quick reference guides along with registration for instructor-led sessions. Topics include the digital solutions available on the UnitedHealthcare Provider Portal, plan and product overviews, clinical tools and state-specific training.

View the training resources at **UHCprovider.com/training**. Content is updated frequently and organized by categories to make it easy to find what you need.

# Email communication – required contact information

We must have a valid email address on file to send you required notifications and important information.

Submit your email address in one of the following ways:

1. Sign up for a **One Healthcare ID**, which also gives you access to the **UnitedHealthcare Provider Portal**.
2. **Subscribe** to Network News email briefs to receive regular email updates. Need to update your information? It takes just a few minutes to manage your **email address** and **content preferences**.
3. Already have a One Healthcare ID? To review or update your email, simply sign in to the **UnitedHealthcare Provider Portal**. Go to "Profile & Settings," then "Account Information" to manage your email.

# Care provider office visits

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

# Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for **Provider Services** at **1-866-331-2243** and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting **Provider Services** at **1-866-331-2243**.

# State websites and forms

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

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

# Care provider marketing guidelines

UnitedHealthcare Community Plan of Nebraska will comply with the following care provider marketing guidelines requirements:

UnitedHealthcare Community Plan of Nebraska will obtain and keep on file your written consent when conducting any form of marketing in your office. We will not require you to distribute health plan-prepared marketing communications to your patients. We will not provide you with incentives or giveaways to distribute to (potential) health plan members.

We will not allow you to solicit enrollment or disenrollment in a health plan or distribute health plan-specific materials at a marketing activity. We will not provide printed materials to you with instructions about how to change health plans to other health plan members.

We will instruct you about the following communication requirements:

- If you wish to inform your patients of your affiliation with 1 or more health plans, you must list each health plan with whom you contract
- You may display or distribute health education materials for all contracted health plans, or you may choose not to display or distribute for any contracted health plan
- Health education materials must adhere to the following guidelines:
  - Health education posters can be no larger than 16 x 24 inches
  - Children's books, donated by us, must be in common areas
  - Materials may include our name, logo, telephone number and website address
  - You are not required to distribute and/or display all provided health education materials from each health plan with whom you contract

- You can choose which items to display as long as you distribute items from each contracted health plan, and that the distribution and quantity of items displayed are impartial
- You may display Managed Care Organizations (MCOs) marketing materials, provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all health plans with whom you have a contract
- You may display health plan participation stickers, but if you do, you must display stickers for all contracted health plans, or choose not to display stickers for any contracted health plans
- Health plan stickers indicating that you participate with a particular health plan cannot be larger than 5 x 7 inches and cannot indicate anything more than "the health plan is accepting or welcomed here"
- You may inform your patients of the benefits, services and specialty care services offered through the health plans in which you participate. However, you may not recommend one health plan over another, offer patients incentives for selecting one health plan over another, or assist the patient in deciding to select a specific health plan in any way, including but not limited to faxing, using the office phone or a computer in the office.

Upon health plan contract termination, if you contract with other health plans you may notify your patients of the change and the impact of the change on them, including the contract termination date. You must continue to see current patients enrolled with us through the termination date, according to all terms and conditions specified in your Agreement.

We will not produce branded materials instructing members about how to change to a different health plan.

You must use MLTC-provided or approved materials and refer members directly to the enrollment broker for needed assistance.

# Glossary

**Assistance to the aged, blind and disabled**

**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.

**Acute inpatient care**

Care provided to members sufficiently ill or disabled requiring:

- Constant availability of medical supervision by attending care provider or other medical staff
- Constant availability of licensed nursing personnel
- Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

**Advance directive**

Legal papers that list a member's wishes about their end-of-life health care

**Adverse benefit determination**

- 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
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner, as defined by the state
- 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
- For a resident of a rural area, the denial of an member's request to exercise their right, to obtain services outside the network
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities

**Ambulatory care**

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

**Ambulatory surgical facility**

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

**Ancillary care provider services**

Extra health services, like laboratory work and physical therapy that a member gets in the hospital

**Appeal**

A member request that their health insurer or plan to 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."

**Auto assignment**

An automated method of enrolling a Nebraska DHHS MLTC-eligible member with a contracted health plan

**Billed charges**

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

**Capitation**

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

### Centers for Medicare and Medicaid Services

**CMS** – a federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and SCHIP programs

### Children's Health Insurance Program

**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

### Clinical coordinator

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)

### Contracted health professionals

PCPs, 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 2 or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute

### Covered services

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

### Credentialing

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

### Current procedural terminology codes

- **CPT -** A current procedural terminology (CPT®) codes 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 2 or more organizations.

**Electronic funds transfer**

**EFT** – the electronic exchange of funds between 2 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 written or verbal expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee. Or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO 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

### Health Insurance Portability and Accountability Act

**HIPAA –** 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 care provider

A care provider who has a written Agreement with UnitedHealthcare Community Plan to provide services to members under the terms of their Agreement

### Katie Beckett

**KB** - A program that provides home health nursing and other medical services to children less than 18 years of age who otherwise would be hospitalized because of their high level of health care needs.

### 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
- They would have serious problems with their bodily functions
- 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

### National Provider Identifier

**NPI** – 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

### Participating Care Provider

A care provider who has a written agreement with UnitedHealthcare Community Plan to provide services to members under the terms of their Agreement

### 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), N.P., clinical nurse specialist or P.A., 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 care providers seek approval prior to rendering health care services, drugs or DME as required by UnitedHealthcare Community Plan policy

### Quality Improvement Program

**QIP** -A formal set of activities to ensure the quality of clinical and non-clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

**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 Nebraska DHHS MLTC.

**Specialist**

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

**State fair hearing**

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

**Temporary Assistance to Needy Families**

**TANF** – a state program that gives cash assistance to low-income families with children

**Third-party liability**

**TPL** – a company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan pays claims for covered benefits and pursues refunds from the third party when liability is determined.

**Timely filing**

When UnitedHealthcare Community Plan puts a time limit on submitting claims

**Title XIX**

Section of Social Security Act describing the Medicaid program coverage for eligible persons

**UnitedHealthcare Community Plan**

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

**Utilization management**

**UM** - Involves coordinating how much care members get. It also determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.