2025
Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Washington Apple Health

United Healthcare Community Plan

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Welcome

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

Click 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**

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

Important information about using this care provider manual

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

This manual will be amended as policies change.

Terms and definitions as used in this manual (see **Glossary** for additional definitions):

- "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 professional subject to this manual, including physicians, clinicians, facilities and ancillary providers; except when indicated, and all items are applicable to all types of care providers subject to this guide
- "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 guide
- Any reference to "ID card" includes both a physical or digital card
- "HCA" refers to Washington State Health Care Authority. Any division, section, office, unit or other entity of HCA, or any of the officers or other officials lawfully representing HCA.

Participation Agreement

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

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

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Chapter 1: Introduction

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com** Chat with Provider Services: **UHCprovider.com/chat**	**1-877-542-9231**
Training	**UHCprovider.com/training**	
UnitedHealthcare Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID. Or go to **UnitedHealthcare Provider Portal Self Service**. New users: **UHCprovider.com/access**	
CommunityCare Provider Portal training	**UnitedHealthcare CommunityCare Provider Portal User Guide**	
One Healthcare ID support	Chat with a live advocate 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 Washington State goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits for Apple Health Integrated Managed Care (IMC) and Behavioral Health Services Only (BHSO) members. The following types of individuals can be enrolled in Apple Health (Medicaid) programs. Eligibility is determined by the Washington State Health Care Authority (HCA) depending on income and life situation:

- Children (from birth through 18 years of age)
- Adults (19 through 64 years of age)
- Parents/caretakers (adults with dependent children younger than 18 years)
- Pregnant individuals
- Individuals who are aged, blind or disabled

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com** or call **Provider Services** at **1-877-542-9231**.

How to join our network

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

Already in the provider network and need to make a change?

To change an address, phone number, add or remove physicians from your TIN, or other changes, visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

Integrated Managed Care

UnitedHealthcare Community Plan has Apple Health Integrated Managed Care (IMC) membership and BHSO membership in Clallam, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Snohomish, Thurston, Wahkiakum and Whatcom counties.

UnitedHealthcare Community Plan does not have Apple Health plans in counties other than those listed. A map and table identifying which managed care plans is available at hca.wa.gov/assets/free-or-low-cost/service_area_map.pdf.

Our approach to health care

Care Model

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

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

- Market-specific care management encompassing medical, behavioral and social care
- An extended care team, including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist
- Options that engage members, connecting them to needed resources, care and services
- Individualized and multidisciplinary care plans
- Assistance with appointments with PCP and coordinating appointments. The clinical health advocate (CHA) refers members to an RN, behavioral health advocate (BHA) or other specialists as required for complex needs.
- Education and support with complex conditions
- Tools for helping members engage with 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. Outcomes are measured by inpatient (IP) and ER admission 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 access to pharmacy
- Identify and remove social and environmental barriers to care
- Improve health outcomes, measured by improved Healthcare Effectiveness Data and Information Set (HEDIS®) and Centers for Medicare & Medicaid Services (CMS) Star Ratings metrics
- Empower the member to manage their complex/chronic illness or problem and care transitions
- Improve coordination of care through dedicated staff resources and to meet unique needs
- Engage community care and care provider networks to help ensure access to affordable care and the appropriate use of services

To refer your patient who is a UnitedHealthcare Community Plan member to the Care Model program, call **Member Services** at **1-877-542-8997**, TTY **711**. You may also call **Provider Services** at **1-877-542-9231**.

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** > Resources > Resource Library > Health Equity Resources > **Cultural Competency**.

UnitedHealthcare Community Plan provides the following:

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**.

Trauma-informed care education: Trauma is linked to certain health conditions. Free education is available on our **health education platform** including information about trauma-informed care, adverse childhood experiences, and the importance of promoting healing in health care.

Materials for limited English-speaking members: We offer simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials in alternative formats for members who are visually impaired. For more information, go to **uhc.com/legal/nondiscrimination-and-language-assistance-notices**.

Providers are required to provide interpreter services in a patient's primary language and for the hearing impaired for all appointments and emergency services.

HCA Interpreter Services: HCA offers interpreter services for Washington Apple Health clients in provider offices through Universal Language Services. HCA will pay for the interpreter services when the services are covered under the client's benefit package and the health care provider is an enrolled HCA Medicaid provider (with the exception of inpatient hospital, nursing facilities and administrative services). HCA has partnered with the Office of Deaf and Hard of Hearing (ODHH) to improve the process for requesting sign language interpreters.

Visit the HCA Interpreter Services website at **hca.wa.gov/billers-providers-partners/programs-and-services/interpreter-services** for more information.

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual for medical care determinations. UnitedHealthcare Community Plan uses nationally recognized and evidence-based clinical guidelines to guide our quality and health management programs.

Substance treatment is evaluated based on American Society of Addition Medicine Criteria (ASAM). Authorization review will be provided for all ASAM defined levels of care for which a care provider is contracted. For more information on our guidelines, go to **UHCprovider.com**.

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, including appeals requests and decisions, and 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 Exchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

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.

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. It makes it possible to:

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

Visit **UHCprovider.com/edi** for more information.

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 of 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

Our public website **UHCprovider.com** 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.

This secure portal is accessible from the public website. It allows you to access patient information, such as eligibility and benefit information and digital ID cards. You can also perform administrative tasks, such as submitting prior authorization requests, checking claim status, submitting appeal requests, and find copies of PRAs and letters in Document Library. All at no cost to you and without needing to pick up the phone.

To access the portal, you will need to create or sign in using a One Healthcare ID at **UHCprovider.com/access**. If you already have a One Healthcare ID (formerly known as Optum ID), go to **UHCprovider.com** and click Sign In in the upper right corner to access the portal.

Here are the most frequently used portal tools:

- **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 authorizations and notifications** – 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 drugs by selecting the Prior Authorization dropdown in the UnitedHealthcare Provider Portal. You will be directed to the Prior Authorization and Notification capability to complete your requests.
- **My Practice Profile** – View and update your care provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mpp**.
- **Document Library** – Access reports and correspondence from many UnitedHealthcare plans for viewing, printing or download. For more information on the available correspondence, go to **UHCprovider.com/documentlibrary**.

Direct Connect

Direct Connect is a free online portal that lets you securely communicate with payers to address errant claims. This portal can replace previous methods of letters, 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
- 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 our members access appropriate care and minimize out-of-pocket costs, you must have privileges at applicable in-network facilities or arrangements with an in-network 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 require assistance. It is staffed with representatives trained specifically for UnitedHealthcare Community Plan.

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

How to contact us

We no longer use fax numbers.

Topic	Contact	Information
Benefits	**UHCprovider.com/benefits**	Confirm a member's benefits and/or prior authorization.
Cardiology prior authorization	**UHCprovider.com/cardiology** > Sign In **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.
Care Model (care management/disease management)	**1-877-542-8997**	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
Chiropractor care	**myoptumhealthphysicalhealth.com** hca.wa.gov **1-800-873-4575**	Chiropractic services are not covered for members age 21 and older. Limited chiropractic services are covered for children age 20 and younger. Refer to the HCA billing guide for billing requirements, limits and covered services.
Claims	**UHCprovider.com/claims** Mailing address: **UnitedHealthcare Community Plan** P.O. Box 31361 Salt Lake City, UT 84131-0361 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 709 Grant Avenue - North Lobby Lake Katrine, NY 12449	Ask about a claim status or get information about proper completion or submission of claims.
Claim overpayments	See the Overpayment section for requirements before sending your request. Sign in to **UHCprovider.com/claims** to access the UnitedHealthcare Provider Portal. Mailing address: **UnitedHealthcare Community Plan** Attn: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.

Topic	Contact	Information
Crisis services — Behavioral health and short-term SUD	Great Rivers BH-ASO — Cowlitz, Grays Harbor, Lewis, Pacific, Wahkiakum: 1-800-803-8833 Greater Columbia BH-ASO — Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, Yakima: 1-888-544-9986 King BH-ASO — King: 1-866-427-4747 North Central BH-ASO (Beacon Health Options) — Chelan, Douglas, Grant, Okanogan: 1-800-852-2923 North Sound BH-ASO — Island, San Juan, Skagit, Snohomish, Whatcom: 1-800-584-3578 Pierce BH-ASO (Beacon Health Options) — Pierce: 1-800-576-7764 Salish BH-ASO — Clallam, Jefferson, Kitsap: 1-888-910-0416 Spokane BH-ASO — Adams, Ferry, Lincoln, Pend Oreille, Spokane, Stevens: 1-877-266-1818 Southwest BH-ASO (Beacon Health Options) — Clark, Klickitat, Skamania: 1-800-626-8137 Thurston-Mason BH-ASO — Mason, Thurston: 1-800-270-0041	• 24/7/365 regional crisis hotline for mental health and SUD crises • Mental health crisis services, including the dispatch of mobile crisis outreach teams, staffed by mental health professionals and certified peer counselors • Short-term SUD crisis services for people intoxicated or incapacitated in public Application of mental health and SUD involuntary commitment statutes, available 24/7/365 to conduct Involuntary Treatment Act assessments and file detention petition.
Electronic Data Intake (EDI) Issues	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315**	Contact EDI Support for issues or questions.
Eligibility	To access the app, sign in to **UHCprovider.com/eligibility** waproviderone.org	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/wacommunityplan** > Reporting Fraud, Waste and Abuse > Integrity of Claims, Reports, and Representations to the Government Reporting: **uhc.com/fraud** **1-844-359-7736** or **1-877-401-9430**	Learn about our payment integrity policies. Report suspected fraud, waste or abuse by a care provider or member by phone or online.

Topic	Contact	Information
Laboratory services	**Preferred Lab Network** Quest Diagnostics questdiagnostics.com Labcorp 1-800-833-3984	Labcorp and/or Quest Diagnostics are network laboratories.
Medical and behavioral claim, reconsideration and appeal	Sign in to **UHCprovider.com/claims** Most care providers in your state must submit reconsideration/appeal requests electronically. For further information on reconsiderations and appeals, see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at the following address: Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 31361 Salt Lake City, UT 84131-0361 Appeals mailing address: **UnitedHealthcare Community Plan** Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	**1-877-542-8997**/TTY **711** for help accessing member account **myuhc.com®** UnitedHealthcare App	Assist members with issues or concerns. Available 8 a.m.–5 p.m. PT, Monday–Friday.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	TDD **711**	Available 8 a.m.–5 p.m. PT, Monday–Friday, except state-designated holidays.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network management support	Chat with a live advocate 7 a.m.–7 p.m. CT at **UHCprovider.com/chat**.	Self-service functionality to update or check credentialing information.
NurseLine	**1-877-543-3409**	Available 24 hours a day, 7 days a week.

Topic	Contact	Information
Obstetrics/pregnancy and baby care	Healthy First Steps® **uhchealthyfirststeps.com** **1-800-599-5985** Washington Maternity Nurse Specialist: **1-800-224-6597** or email **maternalhealthwa@uhc.com**	For pregnant members, call Healthy First Steps at **1-800-599-5985**. Refer pregnant members to **uhchealthyfirststeps.com**.
Oncology prior authorization	**UHCprovider.com/oncology** Optum® **1-888-397-8129** Monday–Friday, 7 a.m.–7 p.m. CT	For current list of CPT codes that require prior authorization for oncology.
One Healthcare ID support center	Chat with a live advocate 7 a.m.–7 p.m. CT at **UHCprovider.com/chat** **1-855-819-5909**	Contact if you have issues with your ID. Available 7 a.m.–9 p.m. CT, Monday–Friday 6 a.m.–6 p.m. CT, Saturday 9 a.m.–6 p.m. CT, Sunday
Pharmacy services	UHCprovider.com/wacommunityplan > **Pharmacy Resources and Physician Administered Drugs** **1-877-305-8952** (Optum Rx) Pharmacy Help Desk **1-888-306-3243** Customer Service (Provider) **1-800-711-4555** Preferred Drug List **1-877-542-9231**	Optum Rx oversees and manages our network pharmacies. 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/ notification for pharmacy	**UHCprovider.com/priorauth** **1-800-310-6826**	Request authorization for medications as required.
Prior authorization requests/advanced and admission notification	To notify us or request prior authorization: EDI: Transactions 278 and 278N Online: **UHCprovider.com/priorauth** Phone: Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications." **1-877-542-9231**	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required • Complete the notification or prior authorization process • Upload medical notes or attachments • Check request status Information and advance notification prior authorization lists: **UHCprovider.com/wacommunityplan** in the Prior Authorization and Notification section.

Topic	Contact	Information
Provider Services	**UHCprovider.com/wacommunityplan** **1-877-542-9231**	Use the system to: • Get answers to general questions • Verify member eligibility • Check claims status • Ask questions about your participation • Notify us of demographic and practice changes • Request credentialing information
Radiology prior authorization	**UHCprovider.com/radiology** > Sign in **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Referrals	**UHCprovider.com/referrals** Provider Services **1-877-542-9231**	Submit new referral requests and check the status of referral submissions.
Reimbursement policy	**UHCprovider.com/wacommunityplan** > **Policies and Protocols**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical support	For chat options and contact information, visit **UHCprovider.com/contactus** **1-866-209-9320** for Optum support	Call if you have issues logging in to the UnitedHealthcare Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit Now	1-866-QUIT-4-Life (1-866-784-8454) myquitforlife.com/uhcwa	Ask about services for quitting tobacco/smoking.
Transportation	hca.wa.gov/transportation-help	HCA pays for transportation services to get members to and from non-emergency health care appointments through regionally based transportation brokers. To arrange non-emergent transportation, please contact the transportation broker at least 3 business days in advance.
Utilization management (UM)	Provider Services **1-877-542-9231**	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. Request a copy of our UM guidelines or information about the program. For UM policies and protocols, go to **UHCprovider.com/protocols.**

Topic	Contact	Information
Vaccines for Children (VFC) program	1-360-236-4501	Care providers must participate in the VFC Program administered by the Department of Health (DOH) and must use the free vaccine when administering vaccine to qualified eligible children (18 years and younger). You must enroll as VFC care providers with DOH to bill for the administration of the vaccine.
Vision services	marchvisioncare.com March® Vision Care 1-888-493-4070 TTY 1-877-627-2456	Apple Health covers routine eye exams, eyeglass fittings and contact lens fittings. Prior authorization is required for all routine eye exams. Authorizations must be obtained from March Vision Care. Call Monday–Friday, 8 a.m.–5 p.m. PT. March Vision processes claims for services by March Vision. We process claims for services our care providers furnish. Apple Health benefits do not cover eyeglasses for adults. However, UnitedHealthcare Community Plan offers a **$100 allowance for adult eyeglasses as a value-added benefit** if members go through our March Vision network. For more information, see **Chapter 6**.
Website for UnitedHealthcare Community Plan of Washington	**UHCprovider.com/wacommunityplan**	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**	**1-877-542-9231**
Eligibility	**UHCprovider.com/eligibility**	
Referrals	**UHCprovider.com/referrals**	
Provider Directory	**UHCprovider.com/findprovider**	
Training	**UHCprovider.com/training**	
UnitedHealthcare Provider Portal training	**CommunityCare Provider Portal User Guide** **UnitedHealthcare Provider Portal**, then Sign In using your One Healthcare ID	
UnitedHealthcare Provider Portal support	Chat with a live advocate 7 a.m.–7 p.m. CT at **UHCprovider.com/chat**.	**1-855-819-5909**
Enterprise Voice Portal	Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**	
Online service tools	**UHCprovider.com** > Tools and resources > **UnitedHealthcare Provider Portal**	

General care provider responsibilities

Nondiscrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them based on race, color, or national origin; gender; gender identity; age; veteran or military status; sexual orientation; the presence of any sensory, behavioral or physical disability; or the use of a trained guide dog or service animal by a person with a disability, type of illness or condition. You may only direct the member to another care provider type if that illness or condition may be better treated by someone else.

Communication between care providers and members

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

UnitedHealthcare Community Plan members and/or their representative(s) may take part in the planning and implementation of their care. To help ensure members and/or their representative(s) have this chance, UnitedHealthcare Community Plan requires 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 care manager in developing a specific care plan for members enrolled in high-risk care management.

Provide official notice

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

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

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

Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This may include providing service(s) for a reasonable time at our in-network rate. Provider Services is available to help you and our members with the transition.

Arrange substitute coverage

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

For the most current listing of network care providers, 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/mpp**. Or submit your change by:

- Visiting **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data
- Connect 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 in your schedule, refer them to an urgent care center.

Members can connect with UHC Doctor Chat from their **myuhc.com** home page for virtual after-hours care with a Washington-licensed physician. UHC Doctor Chat virtual care visits are available after-hours, 24/7. UnitedHealthcare has partnered with CirrusMD to deliver this service. CirrusMD doctors are licensed to practice in Washington state and can address acute care, chronic care, mental health, women's health, prescriptions and more.

Network training

You must take part in a training and support program to gain the appropriate skills and expertise needed to comply with network requirements.

The annual care provider training program addresses the following:

- Orientation to UnitedHealthcare
  - Credentialing and recredentialing
  - Care provider website orientation
  - Member eligibility verification
  - Claims and billing guidelines
- Clinical Model
  - Crisis management
  - Treatment planning
  - Use of evidence-based practices
  - Care coordination
- Cultural Competency
  - Cultural competency in health care is the ability of care providers to understand social, ethnic, religious and linguistic characteristics of a population and use this understanding to improve the quality of care providers deliver. We help ensure our members and their cultural needs are treated with dignity and respect.
  - Join us for free online care provider education through the UnitedHealthcare Provider Portal. Go to **UHCprovider.com**, log in with your One Healthcare ID and go to the Washington care provider training channel to find the required Cultural Competency Program.
  - All Washington IMC care providers must participate and attest to Cultural Competency Training
- Documentation requirements
- Utilization requirements

Participate in quality initiatives

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

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

Provide access to your records

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

Performance data

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

Submit to Clinical Data Repository

The Clinical Data Repository (CDR) is a database that collects and indexes clinical content for specific uses. The CDR is a direct response by HCA to help you share data. The CDR connects different electronic health record (EHR) platforms and places clinical information in one location. It helps the care team gain a more comprehensive understanding of the patient's medical history. This helps improve health care quality, better manage costs and improve health outcomes.

Contracted care provider organizations with certified EHRs, who see an Apple Health IMC member, are required to send a care summary (CCDA) from your EHR to the CDR. You must submit a CCDA to the CDR for a minimum of 80% of submitted claims. At least 85% of these CCDAs must be error-free. If you don't have an EHR certified to the 2014 or 2015 certification standards, these requirements do not apply.

To learn more about the CDR, visit onehealthport.com/clinical-portal and click on Getting Started.

Comply with protocols

You must comply with UnitedHealthcare Community Plan's and Payer's Protocols, including those contained in this manual. You may view protocols at **UHCprovider.com/protocols** > **For Community Plans**.

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 state and federal privacy laws. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of HIPAA and associated regulations. In addition, you will comply with applicable state laws and regulations. You will also comply with applicable state laws and regulations, including requirements in Chapter 42 of the Code of Federal Regulations (CFR) Section 431.306 (42 CFR §431.306) regarding Release of Information.

We use member information for treatment, operations and payment. We also have 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 members are trained on HIPAA and confidentiality requirements.

Follow medical record standards

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

Inform members of advance directives

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

Members are not required to have an advance directive or physician orders for life-sustaining treatment (POLST). You cannot refuse care or otherwise discriminate against a member based on whether they have executed an advance directive or POLST. Document in a member's medical record whether they have one and include a copy. Do not send a copy to us.

Mental health advance directives will be documented the same as any other type of advance directive.

A mental health advance directive form is available at hca.wa.gov > Free or low-cost health care > I need behavioral health support > Mental health advance directives.

Members may also call the Office of Consumer Partnerships at **1-800-446-0259** for a copy of the form.

Members may file a complaint with our medical director, our physician reviewer, and/or the state survey and certification agency about non-compliance with an advance directive or POLST requirement.

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. You may locate the member handbook at **uhc.com/communityplan/washington/plans/medicaid/imc**.

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

Appointment standards (Washington access and availability standards)

Providers must comply with the following appointment availability standards:

Primary care and specialist care

- After-hours care phone number: any time.
- Emergency care: 24 hours per day, 7 days per week, immediately upon presentation
- Urgent, symptomatic care appointment: within 24 hours
- Non-symptomatic (i.e., preventive care, EPSDT): within 30 calendar days
- Non-urgent, symptomatic care (i.e., routine): within 10 calendar days
- Transitional health care services by a PCP: within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program
- Second opinion: within 30 calendar days of the request unless the member requests a later date

Behavioral health

- Emergency care: 24 hours per day, 7 days per week, immediately upon presentation
- Urgent symptomatic urgent care: within 24 hours
- Non-urgent, symptomatic care (i.e., routine): within 10 calendar days
- Transitional health care services, home care nurse, home care registered counselor, a mental health professional, or other behavioral health professional: within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders, or discharge from a substance use disorder treatment program, if ordered by the member's PCP or as part of the discharge plan
- Second opinion appointments: within 30 calendar days of the request unless the member requests a later date

Monitoring

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.

If you are unable to take a referral, have the member call us at **1-877-542-8997** for a new referral.

Provider Directory

You are required to tell us, within 5 business days, if there are any changes to your ability to accept new patients. If a member, or potential member, contacts you, and you are no longer accepting new patients, report any Provider Directory inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional assistance in finding a care provider.

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

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

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

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

To help ensure we have your most current Provider Directory information:

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

The medical, dental and mental health care provider directory is located at **UHCprovider.com/findprovider.**

Care provider attestation

Confirm your data every quarter through **UHCprovider.com** or by calling Provider Services. If you have received the upgraded My Practice Profile and have editing rights, access the My Practice Profile app 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 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.

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

- Verify eligibility using **UHCprovider.com/eligibility** or by calling Provider Services. 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.

If you have questions, reach out to UnitedHealthcare Web Support chat options and contact information, visit **UHCprovider.com/contactus** 7 a.m.–9 p.m. CT, Monday–Friday.

Home health services and medical equipment physician signature requirements

HCA requires physicians to sign prescriptions for home health services and medical equipment. Non-physician practitioners (i.e., advanced nurse practitioners [ARNPs], physician [P.A.s]) may order supplies and equipment if within their scope of practice without a physician signature/co-signature. The items must be necessary for, or ancillary to, the administration of pharmaceuticals or monitoring their effectiveness. This includes glucose monitors or test strips, lancets and lancet devices, pen needles, syringes, inhalation masks and spacers. This applies to medical equipment (Chapter 182-543 WAC) dispensed at a pharmacy. It includes diabetic supplies (glucose monitors, glucose test strips, lancet devices, lancets, pen needles and syringes), inhalation masks and spacers.

Pharmacy claims will not reject or stop for a physician's signature. However, pharmacies must comply with this requirement.

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

Specialties include internal medicine, pediatrics or obstetrics/gynecology

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

The PCP plays a vital role as a case manager in the UnitedHealthcare Community Plan system by improving health care delivery in 4 critical areas: access, coordination, continuity and prevention.

As such, the PCP manages initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide anytime coverage and backup coverage when they are not available.

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

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

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

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

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

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support and benefit from the primary care case management system. The coverage will include anytime availability. 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.**

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

- Use lists supplied by 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 16 hours a week for a 1-M.D. practice
- Be available to members by telephone at any time
- Respond to after-hour patient calls within 45 minutes for non-emergent symptomatic conditions and within 15 minutes for emergency situations
- Tell members about appropriate use of emergency services
- Discuss available treatment options with members
- Provide culturally competent care and services. You must have a cultural competency program to educate and train your staff on addressing cultural and linguistic barriers to delivering health care services to members of all cultures.
- Tell members about the Washington Department of Social and Health Services (DSHS) substance use disorder services, including a list of substance use disorder clinics and contact information in the counties we serve
- Advise members on the availability of DSHS long-term care services, including the availability of home- and community-based services
- Take part in educational opportunities for PCPs, such as those produced by the Washington State Department of Health Collaborative, the Washington State Medical Association or the Washington State Hospital Association (WSHA)
- Help ensure services delivered to individuals with special health care needs are right for them
- Refer all pregnant members to the DSHS First Steps Maternity Support Services/Infant Case Management and the Healthy First Steps programs

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

Specialties include internal medicine, pediatrics or obstetrics/gynecology

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Screen members for behavioral health problems using the Behavioral Health Toolkit for Medical Provider found on **UHCprovider.com**. File the completed screening tool in the patient's medical record.
- Refer services requiring prior authorization to Provider Services, UnitedHealthcare Community Plan Clinical, or Pharmacy Department as appropriate
- Inform our Case Management Department at **1-877-542-8997** of any member showing signs of end-stage renal disease
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards
- Complying with the HCA Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment standards are covered in **Chapter 2** of this manual.

Rural health clinic, federally qualified health 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) or federally qualified health center (FQHC) as their PCP.

- **RHC**
  The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be in rural, underserved areas.
- **FQHC**
  An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a P.A., N.P., social worker or other clinician
  - Behavioral health services
  - Immunizations (shots)
  - Home nurse visits
- **PCC**
  A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a PCC that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

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 Washington 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.
- Tell members about DSHS substance use disorder services, including a list of substance use disorder clinics and contact information located in the counties served by UnitedHealthcare Community Plan
- Advise members on the availability of DSHS long-term care services, including availability of home- and community-based services
- Take part in educational opportunities for PCPs, such as those produced by the Washington State Department of Health Collaborative, the Washington State Medical Association or the WSHA
- Refer all pregnant members to the DSHS First Steps Maternity Support Services/Infant Case Management and the Healthy First Steps programs. If a pregnant member is identified as being at risk due to opioid use disorder, provide health education information about the effects of opioid use and the risks to both them and their infant(s).

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.

Primary care provider checklist

1. Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-877-542-9231.**
2. Check the member's ID card at the time of service. Verify member with photo identification. Plan participating specialists when needed.
3. Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth**.
4. Refer patients to UnitedHealthcare Community.
5. Identify and bill other insurance carriers when appropriate.
6. Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form.

Ancillary care provider responsibilities

Ancillary care providers include:

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

PCPs and specialists must use the UnitedHealthcare Community Plan ancillary network.

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

Ancillary care provider checklist

1. Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-877-542-9231** .
2. Check the member's ID card at the time of service. Verify member with photo identification.
3. Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth**.
4. Identify and bill other insurance carriers when appropriate.

Medicaid enrollment, non-billing care providers

You must have a signed Core Provider Agreement with HCA, even if you do not bill HCA for services. You may enroll with HCA as a "non-billing" care provider if you do not wish to serve fee-for-service (FFS) Medicaid clients. However, you must have an active NPI number with HCA. Not complying with this requirement will affect your credentialing.

You can access the application by:

1. Using the HCA Apple Health IMC Provider Enrollment web link to review instructions and required documents to register as a care provider with ProviderOne.
2. Completing the enrollment application.
3. Calling HCA at 1-800-562-3022, ext. 16137 if you have questions.

All participating care providers must have a signed Core Provider Agreement on file with HCA within 120 calendar days of contracting to serve Apple Health members.

Chapter 3: Care provider office procedures and member benefits

Key contacts

Topic	Link	Phone number
Member benefits	IMC benefits: **uhc.com/communityplan/washington/plans/medicaid/imc** BHSO benefits: **uhc.com/communityplan/washington/plans/medicaid/bhso**	**1-877-542-8997**
Member handbooks	IMC handbook: **uhc.com/communityplan/washington/plans/medicaid/imc** BHSO handbook: **uhc.com/communityplan/washington/plans/medicaid/bhso**	
Provider Services	**UHCprovider.com**	**1-877-542-9231**
Prior authorization	**UHCprovider.com/priorauth**	
D-SNP	**UHCprovider.com/wa** > Medicare > **Washington Dual Complete Special Needs Plan**	

We help ensure each Apple Health IMC member has a source of primary care right for their needs. This means we allow each new member to choose a participating PCP and a behavioral health professional within our network. The members' enrollment files will reflect their PCP if they have pre-selected theirs. American Indian/Alaska Native (AI/AN) members may choose any Indian Health Care Provider (IHCP) enrolled with HCA for primary care, behavioral health care or other covered services.

Upon receipt of the enrollment roster from HCA, we create an enrollment file. We auto-assign a PCP to members who have not preselected one or have chosen an inappropriate PCP. These assignments are based on the member's language, age, gender identification and sex. In addition, we base decisions on the following:

- If a member was previously enrolled with us, we re-assign the previous PCP, if available
- If there was no previous enrollment, we consider family members who were previously enrolled. We screen for appropriate assignments, such as not assigning a pediatrician if the member is an adult.
- We assign PCPs for all members based on urban distance standards of 10-mile radius and rural distance standards of 25-mile radius from the member's home address
- If the provider listed is not an actual care provider, the facility will be assigned

All members will have a PCP assignment within 15 business days after coverage begins.

Member benefit information

View member benefit coverage information online at **UHCCommunityPlan.com/wa**. Or go to **UHCprovider.com/eligibility** for more information.

Behavioral Health Services Only membership

The BHSO plan only covers mental health and substance use disorder (alcohol and drug treatment) services. Members may receive physical health services another way, such as Medicare, private health insurance or Indian Health Centers. BHSO members will not have an assigned PCP with us and must follow their physical health carrier's guidelines. They will still receive an ID card with no PCP listed.

Primary care provider panel roster

View the panel rosters electronically on the **UHCprovider.com** application. The portal requires a unique user name and password combination to gain access.

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

Go to **UHCprovider.com** and sign in. Then 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.

Billing a member

You cannot bill a member for services unless the requirements in WAC 1-182-502-0160 "Billing a client" are met. You and the member must sign and date HCA form 13-879, the Agreement to Pay for Healthcare Services, before the service is provided. The form must be translated into the member's primary language and interpreted if necessary.

Deductibles/copayments

Members do not have a deductible or copayments. Do not bill members for covered services. If you have questions about whether a service is covered or when to bill a member, please contact us.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary health care services or supplies as defined in Washington Administrative Code 182-500-007: Service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

Member assignment

Assignment to UnitedHealthcare Community Plan

HCA 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. HCA makes disenrollment decisions, not us. Disenrollment takes effect at month's end.

Each member will receive a Getting Started Guide that includes directions on how to obtain a copy of our member handbook. The handbook explains the member's health care rights and responsibilities through us.

Download a copy of the member handbook online at **UHCCommunityPlan.com/wa**. To find the member's plan, click on Plan Details. Handbooks are located in the Member Information section.

Earlier enrollment

Enrollment and disenrollment are transmitted electronically to UnitedHealthcare Community Plan on a daily basis. Members who become eligible within the month will be retroactively enrolled to the first of that month. For example, if a member became eligible for Medicaid April 10, 2024, the member's enrollment effective date will be April 1, 2024.

Enrollment and recertification

Members with Apple Health Family or Apple Health for Adult members should go to wahealthplanfinder.org or call 1-855-WAFinder (1-855-923-4633). Members with Apple Health Blind & Disabled can go to their local Community Services Office (CSO), call the CSO Customer Service Contact Center at 1-877-501-2233, or go online to washingtonconnection.org/home. This site also has a list of Community Partners who can help blind and disabled members enroll and recertify so they don't lose coverage. Click on "Find help in my community".

Members who need to recertify and active Medicaid members who want to switch to UnitedHealthcare Community Plan can also call us at **1-866-686-9323**.

Members have the right to change enrollment prospectively, from one Washington Apple Health managed care plan to another without cause, each month.

Children with special health care needs may request an exemption from, or an end to enrollment in, managed care. This exemption aligns with the Medicaid state plan and federal regulation (42 C.F.R. 438.50 (d)(3)).

Member in a facility at enrollment

If a member was admitted to a hospital the same month enrollment occurs, we are responsible for the admission and all related services. The exception is if the member is SSI Blind/Disabled and admitted to a CPE hospital. In this case, HCA is responsible for the inpatient claim, and we are responsible for professional services and management of the authorization requirements.

If a member is admitted to a skilled nursing or nursing facility the same month enrollment occurs, we are responsible for the admission and related services until the member no longer meets rehabilitation or skilled level of care criteria. If we deny the inpatient stay authorization, please refer to the Appeals process in the **Claim reconsiderations, appeals and grievances** section of this manual.

If the member admitted to a nursing facility is the responsibility of DSHS, we are responsible for all other services, except for room and board in the nursing facility, that are medically necessary and required to meet the member's needs. This includes professional services, specialty beds and specialty wheelchairs. We are responsible for management of the authorization requirements for these services.

Member in hospice at enrollment

If a member changes Apple Health Managed Care Organizations (MCOs), and the change becomes effective while the member is receiving hospice services, the Apple Health MCO the member was enrolled with on the date of hospice admission pays all covered hospice services regardless of place of service. This responsibility continues until the date the member no longer meets criteria for hospice or is discharged from hospice. The Apple Health MCO receiving the member coordinates discharge and helps ensure continuity of services.

Immediate enrollment changes

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

Get eligibility information by calling Provider Services.

Unborn enrollment changes

Encourage members to notify HCA when they know they are expecting. HCA notifies UnitedHealthcare Community Plan daily of unborn children when they learn an individual is expecting. UnitedHealthcare Community Plan and/or you may use the online change report through ProviderOne to report the baby's

birth. HCA verifies the birth through the mother's ProviderOne ID. To help speed up the process, the mother should notify HCA when the baby is born. Until the baby has been assigned their own UnitedHealthcare Community Plan subscriber number, you should submit claims using the mother's subscriber number or ProviderOne ID number.

Newborns, whose mothers are members of UnitedHealthcare Community Plan on the date of birth, are deemed members of UnitedHealthcare Community Plan as follows:

- If the mother's enrollment ends before the newborn receives a separate client identifier from HCA, the newborn's enrollment ends the last day of the month in which the 21st day of life occur or when the mother's enrollment ends, whichever is sooner
- A newborn who is determined eligible for Apple Health (Medicaid) in the month of birth prior to initial discharge, shall be enrolled according to HCA enrollments rules (if the newborn's mother is not covered by Apple Health or any comparable coverage). UnitedHealthcare Community Plan is responsible for the hospital cost for the newborn starting from the month of enrollment.

Foster care, adoption support and alumni

- Medicaid-eligible members placed in foster care will be enrolled in Apple Health Integrated Foster Care (AH-IFC) effective the first of the month of the state's Department of Children, Youth and Families (DCYF) Foster Care Placement
- Adoption Support and Alumni members will be placed in AH-IFC starting the first day of the current month if both the date of initial Medicaid eligibility and the managed care enrollment take place in the current month
- If the mother is enrolled in AH-IMC when their baby is born, and the newborn is placed in foster care during the month of birth, they are enrolled in the mother's AH-IMC MCO for the month of birth. The newborn will be enrolled in AH-IFC effective the first of the month following placement. The AH-IMC MCO pays hospital costs until the newborn is discharged from the birth hospitalization.
- If a newborn's mother is receiving FFS when the baby is born, and the newborn is placed in foster care during the month of birth, they will be enrolled in AH-IMC and assigned to an MCO based on system rules ("Early Enrollment"). The newborn will be enrolled in AH-IFC effective the first of the month that follows placement.
- If a newborn's mother is not covered by Apple Health or any comparable coverage, and the newborn is placed in foster care before discharge from their initial birth hospitalization, the baby will be enrolled in AH-IFC on the first of the month of placement
- If the newborn does not receive a separate client identifier from HCA, their enrollment will only be available through the end of the month the first 21 days of life occur
- If the mother is disenrolled before the newborn receives a separate client identifier, the newborn's coverage ends when the mother's coverage ends
- A newborn whose mother is enrolled in AH-IFC, with whom the newborn remains after birth, is automatically enrolled in the AH-IFC contractor's AH-IMC program, if available in the service area. Coverage begins on the newborn's date of birth, or the mother's date of enrollment, whichever is sooner.
- A newborn whose mother is enrolled in AH-IFC but is placed in foster care at birth is enrolled in AH-IFC
- If a child is enrolled in AH-IFC during the month of inpatient admission, the AH-IFC MCO is responsible for payment. This responsibility continues from the date of admission until the child either:
  - No longer meets criteria for the rehabilitative or skilled benefit
  - Is discharged from a facility to home or a community residential setting
  - Is readmitted to an inpatient or observation hospital stay
- When a child is enrolled in AH-IFC, the party responsible for payment pays until the date the child is enrolled in AH-IFC. The party responsible for payment remains responsible for medical necessity determinations and service authorizations.

Members need to report a newborn's birth by logging into their Washington Healthplanfinder account at wahealthplanfinder.org and selecting the "Report a Change" link.

Newborns not assigned a UnitedHealthcare ID number

Until the baby has been assigned their own UnitedHealthcare Community Plan subscriber number, submit claims using the mother's subscriber number or state-issued ProviderOne ID number.

Primary care provider selection

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

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

Enrollment termination

Members may submit a written request or call HCA to terminate enrollment. Blind and disabled members requesting disenrollment should call DSHS at 1-877-501-2233 or visit washingtonconnection.org.

Other members should call Apple Health Customer Service at 1-800-562-3022 to cancel/terminate Medicaid coverage. Hearing or speech impaired members should call TTY: **711**.

Member in a facility at enrollment termination

When a member is hospitalized or in another inpatient facility at termination of enrollment, we are responsible for payment until the member is discharged to the home or a community residential setting or their Medicaid eligibility ends. This includes behavioral health residential treatment facilities or a lower level of care.

When a member changes Apple Health MCOs, and the change becomes effective during an inpatient admission, the MCO the member was enrolled with on the date of admission is responsible for payment of all covered inpatient facility and professional services. This responsibility continues until the date the member no longer meets criteria for the rehabilitative or skilled benefit applicable to the skilled nursing facility (SNF) setting, or they are discharged from a facility to a home or a community residential setting. This includes behavioral health residential treatment facilities or a lower level of care.

Member eligibility

UnitedHealthcare Community Plan serves members enrolled with the Washington Apple Health (Medicaid) program. An individual who becomes eligible for Apple Health either chooses or is assigned to one of the HCA-contracted health plans. This means HCA determines eligibility for Apple Health, not the health plan. To view eligibility, visit **UHCprovider.com/eligibility**.

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.

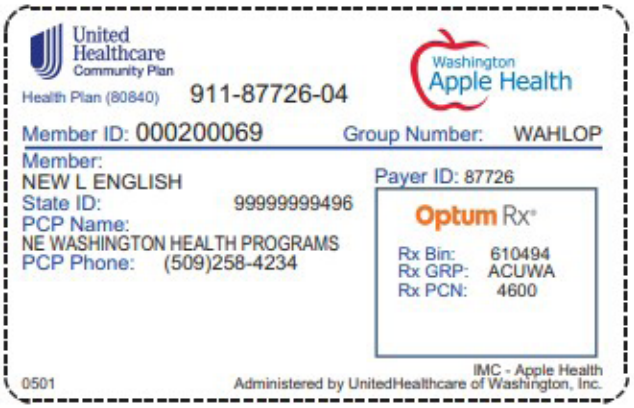
If a fraud, waste and abuse event arises from a care provider or a member's ID card, go to **uhc.com/fraud** to report it. Or call the **Fraud, waste and abuse hotline**.

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

Member identification numbers

Each member receives a 9-digit UnitedHealthcare Community Plan member ID number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. HCA also assigns each member a Medicaid (ProviderOne) number. This number can be found on the member's UnitedHealthcare Community Plan member ID card and on the member's ProviderOne card.

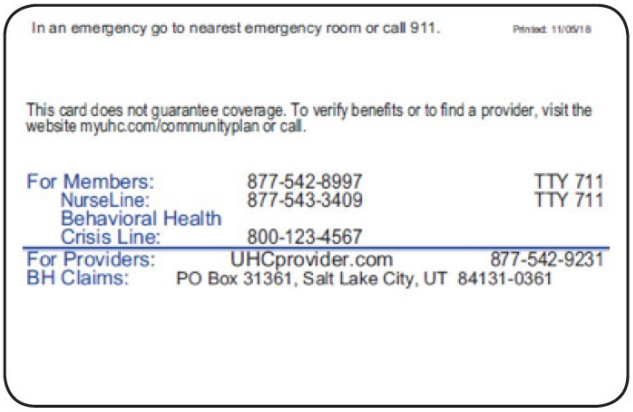
Sample member ID cards


United Healthcare Community Plan
Health Plan (80840) 911-87726-04
Washington Apple Health
Member ID: 000200069 Group Number: WAHLOP
Member:
NEW L ENGLISH
State ID: 99999999496
PCP Name:
NE WASHINGTON HEALTH PROGRAMS
PCP Phone: (509)258-4234
Payer ID: 87726
Optum Rx
Rx Bin: 610494
Rx GRP: ACUWA
Rx PCN: 4600
0501
IMC - Apple Health
Administered by UnitedHealthcare of Washington, Inc.


In an emergency go to nearest emergency room or call 911.
Printed: 01/30/23
This card does not guarantee coverage. To verify benefits or to find a provider, visit the website myuhc.com/communityplan or call.
For Members: 877-542-8997 TTY 711
NurseLine: 877-543-3409 TTY 711
Behavioral Health Crisis Line: 800-123-4567
For Providers: UHCprovider.com 877-542-9231
All Claims: PO Box 31361, Salt Lake City, UT 84131-0361
Pharmacy Claims:OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 877-305-8952

BHSO ID card sample


UnitedHealthcare Community Plan
Health Plan (80840) 911-87726-04
Washington Apple Health
Behavioral Health Only
Member ID: 000200046 Group Number: WAHLOP
Member:
REISSUE ENGLISH
State ID: 9999999946
Payer ID: 87726
0501
Behavioral Health Services Only
Administered by UnitedHealthcare of Washington, Inc.


In an emergency go to nearest emergency room or call 911.
Printed: 11/05/18
This card does not guarantee coverage. To verify benefits or to find a provider, visit the website myuhc.com/communityplan or call.
For Members: 877-542-8997 TTY 711
NurseLine: 877-543-3409 TTY 711
Behavioral Health Crisis Line: 800-123-4567
For Providers: UHCprovider.com 877-542-9231
BH Claims: PO Box 31361, Salt Lake City, UT 84131-0361

Primary care provider-initiated transfers

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

1. To transfer the member, contact UnitedHealthcare Community Plan by mail with the specific events documentation. Documentation includes the dates of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider's name.

   Mailing address:
   UnitedHealthcare Community Plan
   Attn: Health Plan Operations
   17930 International Blvd, Suite 1000
   SeaTac, WA 98188
2. We prepare a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP-member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have 5 business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

Verifying member enrollment

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

- Access the UnitedHealthcare Provider Portal through **UHCprovider.com/eligibility**
- UnitedHealthcare Provider Services is available from 7 a.m.–5 p.m. CT, Monday–Friday
- waproviderone.org

UnitedHealthcare Dual Complete

Dual Complete Special Needs Plan (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 UnitedHealthcare Dual Complete, please see the Medicare Products chapter of the Administrative Guide for Commercial, Medicare Advantage and D-SNP at **UHCprovider.com/guides**. For state-specific information, go to **UHCprovider.com/wa** > Medicare > **Washington Dual Complete Special Needs Plan**.

Chapter 4: Medical management

Key contacts

Topic	Link	Phone number
Referrals	**UHCprovider.com/referrals**	**1-877-542-9231**
Prior authorization	**UHCprovider.com/priorauth**	
Oncology prior authorization	**UHCprovider.com/oncology** > Prior Authorization	**1-888-397-8129**
Applied behavioral analysis (ABA) support line		**1-866-456-5376**
Healthy First Steps	**uhchealthyfirststeps.com**	**1-800-224-6597**
Pharmacy	**professionals.optumrx.com**	**1-877-542-9231**
Dental	hca.wa.gov > Free or low-cost health care > Find covered services and see if you're eligible > How do I get dental care?	1-800-562-3022

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

Ambulance services

Air ambulance and emergency ambulance transportation

HCA pays for emergent and non-emergent air and land ambulance services.

Non-emergent ambulance transportation

HCA pays for transportation services to get members to and from needed non-emergency health care appointments. Call the transportation service provider (broker) in the member's area. The regional broker will arrange the most appropriate, least costly transportation for the member.

A list of brokers can be found at hca.wa.gov/transportation-help.

Applied behavior analysis

Applied behavior analysis (ABA) may help members improve core symptoms associated with autism spectrum disorders or other developmental disabilities. ABA benefits support learning and assists with the development of social, behavior, adaptive, motor, vocational and cognitive skills.

For assistance obtaining ABA services and care coordination, please refer members to our dedicated ABA support line at 1-866-456-5376.

Covered services include:

- Evaluation and prescription completed by a recognized Center of Excellence.
- Functional assessment and treatment plan developed by a Lead Behavior Analysis Therapist (LBAT).
- ABA services delivered according to the treatment plan by an LBAT or a Certified Behavior Technician working with an LBAT.

Resources for more information:

- ABA licensing and credentialing
- Washington Administrative Code
  - Regulations for ABA provider licensing
  - Regulations for ABA services
- ABA provider billing information

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** from 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.

Children's health care coordination

For children who require behavioral health treatment, UnitedHealthcare Community Plan shall, as necessary:

- Coordinate treatment and appropriate care based on the child's assessed needs, whether the referral occurred through primary care, school-based services, or another provider
- Follow up to help ensure an appointment has been secured
- Coordinate with the care provider to develop a treatment plan, including medications management

Partnership Access Line

The Partnership Access Line (PAL) is a phone-based child mental health consultation system funded by the state legislature. PAL employs child psychiatrists, child psychologists, and social workers affiliated with Seattle Children's Hospital to deliver its consultation services. The PAL team is available to any PCP throughout Washington.

You may also use the Referral Assist Line at Seattle Children's Hospital. With this new resource, PCPs may talk to a psychiatrist or a social worker about the mental health services a child may need. A social worker reaches out to the family to help find service referrals. Call 1-866-599-7257 between 8 a.m.–5 p.m. PT for help with a child mental health concern.

PAL for Moms (Perinatal Psychiatry Consultation Line) is another phone consultation service. Like PAL, the call is free for Washington care providers who care for women with mental health needs during and after pregnancy. Perinatal psychiatrists can respond within 24 hours. Call 1-206-685-2924 Monday–Friday from 3–5 p.m. PT.

PAL provides even more educational opportunities for PCPs. Visit seattlechildrens.org/pal for information.

Collaborative Care

We cover Collaborative Care, Behavioral Health Integration and Primary Care codes per HCA with no limitations or barriers by care provider type or place of service. Exceptions are driven by CPT or correct coding initiatives.

Bree Collaborative

The Bree Collaborative, identifies and recommends evidence-based strategies that improve quality of care and health outcomes through integrated health care. One of the collaborative's lead focuses is incorporating behavioral health care into primary care. This practice has been shown to raise the delivery of best practice treatment and be a cost-effective model of care.

The group created the Bree Collaborative Model, which uses evidence-based models of assessment and 8 elements to define a minimum standard that promotes integrated care. Washington State has adopted the model's 8 elements to help bridge evidence-based management and integrated care services. These elements, with specified criteria, focus integrated, holistic care delivery on the member. These elements are:

1. Integrated care team.
2. Patient access to behavioral health as a routine part of care.
3. Accessibility and sharing of patient information.
4. Practice access to psychiatric services.
5. Operational systems and workflows to support population-based care.
6. Evidence-based treatments.
7. Patient involvement in care.
8. Data for quality improvement.

For more criteria, or to engage the Bree Collaborative, review the document at qualityhealth.org/bree/topic-areas/behavioral-health.

Care advocacy

The Behavioral Health Care Advocacy Center (CAC) focuses on activities that affect Medicaid members' stabilization and recovery. It also encourages members to be more involved in their care.

This approach consists of targeted interventions that identify members who may be at risk and leverage UnitedHealthcare Community Plan resources, such as a care advocate. Care advocacy activities may include:

- Emphasizing the integration of medical and behavioral care by promoting communication among all treating care providers involved in members' care
- Helping ensure members being discharged from facility-based care have apt discharge plans, can understand them and can access recommended services
- Reaching out to care providers to discuss at-risk members' care
- Connecting with members to educate, evaluate risk, support informed decision-making and offer help
- Offering clinical consultations with medical staff

The UnitedHealthcare CAC in Washington is open Monday–Friday from 8 a.m.–5 p.m. CT. The center is staffed at all times to discuss urgent and emergent situations (such as potential inpatient admissions). They also help handle members in crisis or any answer questions about the care advocacy process.

Dementia care planning

UnitedHealthcare Community Plan allows E&M procedure code 99483 Comprehensive Assessment and Care Planning for members with cognitive impairment at the following frequencies:

- 1 visit every 180 days
- Face-to-face visits up to 50 minutes, either in-person or audio/visual encounters

Physicians, P.A.s, N.P.s, clinical nurse specialists and certified nurse midwives can bill under this code.

Refer to the comprehensive assessment and care planning for persons living with cognitive impairment (CPT code 99483) in the HCA Physician-related/ Professional Services Billing Guide.

Dental services

We cover institutional and professional care and treatment of a dental condition or oral services in inpatient, outpatient, urgent care, ER, office settings and ambulatory surgical centers. We cover fluoride varnish for members of all ages, by a medical provider regardless of provider ABCD certification.

Go to hca.wa.gov > Free or low-cost health care > I need medical, dental, or vision care > How do I get dental care? for more information.

We do not cover services rendered by dentists or for claims billed with a CDT (dental code). For CDT coverage and authorizations, please contact HCA at hca.wa.gov/contact-hca.

For more details, or to find a medical professional, go to **UHCprovider.com**.

Access to Baby and Child Dentistry program

We provide access to Mouth Matters, the medical extension of the ABCD program for children age 5 and younger and for children 0 through age 12 with a disability, as defined by HCA. This program includes:

- Oral health evaluation (99499)
- Family oral health education (99429)
- Fluoride varnish (99188)

Department of Children, Youth and Families

The Department of Children, Youth and Families (DCYF) is Washington's public child welfare agency. The agency works with children and families to identify their needs and develop a plan for services that support families and ensure children's well-being. These services help reduce the risk of abuse, find safe alternatives to out-of-home placement and ensure safety for children in out-of-home care. Services include child safety and protection, foster parenting, and adoption. For more information, visit dcyf.wa.gov.

Developmental disabilities administration services

Find a list of the administration's programs at dshs.wa.gov.

Durable medical equipment

Durable medical equipment (DME) provides therapeutic benefits to a patient because of certain medical conditions.

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
- Medically necessary

DME may be covered when it does all of the following:

- Provides therapeutic benefit because of certain medical conditions and/or illnesses
- Is prescribed by a licensed provider
- Does not serve primarily as a comfort or convenience item
- Does not have significant non-medical uses (e.g., environmental control equipment, air conditioners, air filters, humidifiers)

DME and services are not covered when it:

- Has add-ons or upgrades intended for convenience or upgrades beyond what is medically necessary. Examples include decorative items, unique materials (e.g. magnesium wheelchair wheels, lights, extra batteries).
- Does not provide a therapeutic benefit to a patient because of certain medical conditions
- Has not been prescribed by a licensed provider
- Serves as a comfort or convenience item (e.g., trays, back packs, wheelchair racing equipment)
- Is used in a facility expected to provide patients with such items
- Enhances the environmental setting (e.g., air conditioners, humidifiers, air filters, portable Jacuzzi pumps, chair lifts used to go up and down the stairs). Equipment delivery services and setup, education and training for patient and family, and nursing visits are not eligible for separate reimbursement regardless of agreement to rent or purchase.
- Has add-ons or upgrades intended for member/caregiver convenience or that do not significantly enhance DME functionality

Emergency/urgent care services

Emergency services do not require prior authorization.

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

Covered services include:

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

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 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 professional is reached, or when one of these guidelines is met:

- A plan care provider with privileges at the treating hospital takes over the member's care
- A plan care provider takes over the member's care by sending them to another place of service
- An MCO representative and the treating care provider reach an agreement about the member's care
- 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. This is called Post Stabilization Services. Members do not pay for these services. This applies whether the member receives emergency services in or outside their service area.

Urgent care (nonemergent)

Urgent care services are covered.

For a list of urgent care centers, go to connect.werally.com > Medical Directory > Medicaid Plans > Washington > Washington Apple Health Integrated Managed Care (IMC) > Places > Clinics.

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 EDI 278N transaction, the Prior Authorization and Notification tool on **UHCprovider.com/portal**, or call Provider Services.

UnitedHealthcare Community Plan uses evidence-based, nationally accredited, clinical criteria for determinations of appropriateness of care. UnitedHealthcare Community Plan does not reward for denials.

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

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

If issues with quality of care, discharge planning, or follow-up occurred but cannot be reasonably considered the cause of the readmission, payment cannot be denied.

This policy applies only to hospital fees for inpatient admissions. This policy applies to medically necessary admissions. Critical access hospitals are excluded from denial of payment under this policy.

Family planning

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

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

Blood tests to determine paternity are covered only when the claim indicates tests were necessary for legal support in court.

Non-covered items include:

- Reversal of voluntary sterilization
- Hysterectomies for sterilization
- In-vitro fertilization, including:
  - GIFT (Gamete intrafallopian transfer)
  - ZIFT (zygote intrafallopian transfer)
  - Embryo transport
- Infertility services, if given to achieve pregnancy
  Note: Diagnosis of infertility is covered. Treatment is not.

Parenting/childbirth education programs

- Childbirth education is covered.
- Parenting education is not covered.

Voluntary sterilization

Sterilization for ages 21 and older are covered by UnitedHealthcare Community Plan if the provider is in-network. Out-of-network services require prior authorization.

Sterilization for ages 20 and under are covered by HCA. The member needs to give consent 30 days before surgery and be mentally competent for:

- Tubal ligation
- Vasectomy

Federal regulations prohibit payment for sterilization procedures until a properly completed Sterilization Consent form HHS-687 is received. View the Sterilization Procedures section for more information.

Care coordination/health education

Our care coordination program is led by our qualified, full-time care coordinators. You are encouraged to collaborate with us to 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 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 co-morbidities, 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 case manager collaborates with the member to identify educational opportunities, provides the appropriate health education and monitors the member's progress toward management of the condition targeted by the care coordination program.

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

Facility admission notification requirements

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

- Planned/elective admissions for acute care
- Unplanned admissions for acute care
- SNF admissions
- Admissions following outpatient surgery
- Admissions following observation

Health Home program

Our Health Home program is managed in partnership with HCA.

Health Home provides community-based intensive care coordination and comprehensive care management to improve health outcomes and reduce service costs for some of Washington's highest-need individuals. Washington Health Home helps improve coordination of care and quality, and increase individual participation in their own care. The program reduces Medicaid inpatient hospital admissions, avoidable ER visits, inpatient psychiatric admissions and the need for nursing home admissions. We work with area hospitals in providing transitional care services to members enrolled in Health Home. Hospitals and care providers may refer individuals to us for potential Health Home enrollment. Health Home eligibility is determined by HCA. The program provides services beyond those typically offered by care providers, including but not limited to:

- Comprehensive care management
- Care coordination and health promotion
- Individual and family support
- Referral to community services

For more information about Health Home, call Provider Services.

Health Risk Assessment

The Health Risk Assessment and our predictive modeling and stratification system are the primary tools for identifying members for the care management program.

The Health Risk Assessment is an initial assessment tool used for new and existing members to identify a member's health risks. Based on the member's responses, the tool assigns a score that corresponds to a level.

These levels are as follows:

- Level 1: Low-risk members who are typically healthy, stable or only have 1 medical condition that is well managed
- Level 2: Moderate-risk members who may have a severe single condition, or multiple conditions issues across multiple domains of care management
- Level 3: High-risk members who are medically fragile, have multiple comorbidities and need complex care management

Hearing services

The following devices and supplies are covered for all members, regardless of age:

- Monaural and binaural hearing aids, including fitting, follow-up care, batteries and repair
- Bilateral cochlear implants, including implants, parts, accessories, batteries and repairs

In addition to the above, the following devices and supplies are covered for members age 20 and younger:

- Bone anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries

Hepatitis C

Eliminating Hepatitis C by 2030 is a state priority and UnitedHealthcare is committed to supporting our state in these efforts. Hepatitis C is largely curable, and there are numerous resources and 1-page guides available to aid in this mission.

Here are links to those resources:

- hepatitisc.uw.edu
  - UW Infectious Diseases Education & Assessment (IDEA): This is a free educational site offering CME, CNE and Pharmacist CE
- Fibrosis-4 (Fib-4) Calculator
  - Utilize this tool by inputting age, AST, ALT and platelet count to assess fibrosis levels
- Health Care Provider Resources to Increase Hepatitis C Treatment
- indiancountryecho.org
  - Access the AASLD/IDSA guidelines, available for mobile devices
  - Explore the WA Medicaid ECHO program designed for both indigenous and non-indigenous peoples
- Bree Collaborative Hepatitis C recommendations
- npaihb.org (text HCV 97779)
  - Reach out to the Northwest Portland Indian Health Board for additional support and resources
- Eliminating hepatitis C | Washington State HCA
  - Stay updated on state initiatives and resources for eliminating Hep C

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.

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. Apple Health covers residential inpatient hospice services. Apple Health will cover hospice care provider benefits for both the hospice services provided and the facility residential services.

Laboratory

Use UnitedHealthcare Community Plan in-network laboratory when referring members for lab services not covered in the office. Medically necessary laboratory services ordered by a PCP, other care providers or dentist in one of these laboratories do not require prior authorization except as noted on our prior authorization list. For more information on our in-network labs, go to **UHCprovider.com/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 providers rendering clinical laboratory and certain other diagnostic services.

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

Maternity/pregnancy/well-child care

Perinatal behavioral health support

Perinatal Support Washington offers perinatal mental health resources to pregnant people and families who need emotional support. Find details at perinatalsupport.org or call 1-888-404-7763.

The Perinatal Psychiatry Consultation line offers care providers treating women with mental health needs during pregnancy and postpartum a phone consultation with a faculty member in the UW Department of Psychiatry and Behavioral Sciences with expertise in perinatal mental health. Call 1-206-685-2924, and leave a message with name and phone number. Calls are returned on weekdays from 3 p.m.–5 p.m., usually within 1 business day.

Pregnancy notification risk screening

Notify UnitedHealthcare Community Plan immediately of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program. This program supports you in caring for UnitedHealthcare Community Plan patients during the perinatal and postpartum period with a goal of better outcomes for mothers and babies. Healthy First Steps supports pregnant members with a relationship with a maternal health professional, community resources, appropriate referrals and incentives for attending.

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

Healthy First Steps – maternal care model

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 (POC)
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it
- Multidisciplinary support for pregnant members to overcome social and psychological barriers to prenatal care
- Increase the member's understanding of pregnancy and newborn care
- Encourage pregnancy and lifestyle self-management and informed health care decision-making
- Education regarding the benefits of doula care and connection with a doula if desired
- 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 Community Plan for care coordination

Pregnancy/maternity

Bill the initial pregnancy visit as a separate office visit.

Billing the initial prenatal care visit helps us engage members in early access to care coordination and case management for your high-risk patients. Our team of maternity nurses and professionals are available to support your patients. The sooner we're aware of their pregnancies, the more assistance we can provide, which will give your patients and their babies the best chance for healthy outcomes. For more information on UnitedHealthcare maternity support programs, call **1-800-599-5985** or email **maternalhealthwa@uhc.com**.

HCA requires valid and complete HCPCS codes for all prenatal services. For all pregnant members on the first prenatal visit, use the following HCPCS and ICD codes on all paper and electronic claims:

- Use HCPCS 0500F with ICD diagnosis codes Z33.1, Z34.00, Z34.80 or Z34.90

For more information on billing codes, please see the HCA Physician-Related Services/Health Care Professional Services guide at hca.wa.gov.

You may bill global days if the mother has been a UnitedHealthcare Community Plan member for 3 or more consecutive months or has 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 procedures will only be allowed for identified high-risk members. High-risk member claims must include the corresponding diagnosis code.

Pregnant UnitedHealthcare Community Plan members should receive care from UnitedHealthcare Community Plan care providers only. This includes obstetricians, family practitioners, certified midwives and licensed midwives. 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. They have an established relationship with a non-participating obstetrician.

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

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

Birthing doulas

Birth doulas play an important role in the journey of childbirth, providing continuous physical, emotional and informational support during pregnancy, delivery and postpartum. For providers, partnering with a doula enhances the overall care experience by ensuring holistic support for the birthing parent, therefore supporting the medical team. Doulas offer invaluable advocacy, comfort measures and encouragement throughout labor and delivery, complementing medical expertise with personalized attention. UnitedHealthcare is proud to offer our birthing members access to a doula through The Doula Network with the goal of optimizing patient satisfaction, improving birth outcomes and fostering collaborative healthcare partnerships. This pilot is currently funded through 2024. Refer your patient for doula services by calling **1-800-599-5985** or emailing **maternalhealthwa@uhc.com**.

Perinatal nursing care at home for your high-risk patients

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

OB Homecare helps members who are:

- At risk for preeclampsia
- Experiencing persistent nausea/vomiting
- In need of diabetes management

For more information or to prescribe OB Homecare, call **1-425-951-0761** or **1-800-950-3963**. You can also send an email to **maternalhealthwa@uhc.com**.

Maternity admissions

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

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

To notify UnitedHealthcare Community Plan of deliveries:

- Go to **UHCprovider.com/priorauth**
- Call Provider Services

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, care provider ID
- Facility name (care provider ID)
- Vaginal or cesarean delivery

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

- Date of delivery
- 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 mother's discharge require separate notification and will be subject to medical necessity review.

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

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

For additional pregnant member and baby resources, see Babyscripts in **Chapter 6**.

Post maternity care

UnitedHealthcare Community Plan covers post-discharge care to the member and their newborn. This care consists of a minimum of 2 visits according to accepted maternal and neonatal physical assessments. If home health care visits are desired, prior authorization is required.

Newborn enrollment

Members must report a newborn's birth by logging in to their Washington Healthplanfinder account and enrolling at wahealthplanfinder.org. They must select the "Report a Change" link.

Women, Infants and Children Supplemental Nutrition program

Women, Infants, and Children Supplemental Nutrition (WIC) is a state-funded program to help with nutritional needs for low-income families. For more information about WIC, go to doh.wa.gov.

Bright Futures assessment

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

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

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

Home care and all prior authorization services

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

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 Hysterectomy Consent and Patient Information form, 13-365 stating they were told before the surgery that the procedure will result in permanent sterility.

Find the form on the HCA website at hca.wa.gov.

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

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

UnitedHealthcare Community Plan requires, along with your claim, a copy of the signed Hysterectomy Consent and Patient Information form, 13-365. 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

These services are covered by the HCA FFS program.

Sterilization 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, UnitedHealthcare Community Plan must have documented evidence that all the sterilization requirements have been met before making a payment. The member must sign the Sterilization Consent Form HHS-687 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 behavioral 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 sterilization procedures, UnitedHealthcare Community Plan cannot pay the care provider, anesthetist or hospital. A sterilization consent form is not required when a hysterectomy is performed. Instead, we require the hysterectomy consent form.

Sterilization informed consent

A member has only given informed consent if the Sterilization Consent form HHS-687 is properly filled out. Other consent forms do not replace the Sterilization Consent Form HHS-687. Be sure the member fully understands the sterilization procedure and has been told of other family planning options. Informed consent may not be obtained while the member is in labor, seeking an abortion, or under the influence of alcohol or other substances that affect awareness.

Sterilization consent form

Use the consent form for sterilization:

- **Complete all applicable sections of the consent form** before submitting it with the billing form. UnitedHealthcare Community Plan cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.
- Your statement section should be completed after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.

- The state's definition of "shortly before" is not more than 30 days before the procedure. Explain the procedure to the member within that time frame. However, do not sign and date the form until after you perform the procedure.

You may also find the form on the U.S. Department of Health and Human Services website at opa.hhs.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.

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

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

Inhaled nitric oxide

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

Patient review and coordination program

Patient Review and Coordination (PRC) is for all Apple Health IMC Programs. The HCA program helps control overutilization and inappropriate use of clinical services. It restricts members to certain care providers, including PCPs, pharmacies and hospitals. Washington Administrative Code (WAC182-501-0135) established the guidelines for the PRC program and allows us to perform this function.

PRC focuses on the health and safety of the member, who is often seen by several different prescribers, has a high number of duplicate medications, uses several different pharmacies and has high ER usage. Based on a clinical review of the utilization findings, the member may be placed into the PRC program for at least 2 years.

Primary care provider role

The PCP plays a critical role in managing the member's health care. When a member is restricted within the PRC program, the PCP must approve any non-emergent care that the member receives from other practitioners. This may include prescriptions for scheduled drugs, class (CII-CV).

Pharmacy role

The primary pharmacy is a critical player in managing the member's prescriptions. The pharmacist alerts that member's PCP, the plan PRC staff, or HCA PRC staff of misuse or potential concerns with the member's prescriptions. All standard pharmacy policies remain in effect. However, if the member goes to a non-assigned pharmacy for schedule drugs (CII-CV). The claim will be rejected. The medication may not be dispensed.

The pharmacist may refer the member back to their assigned pharmacy or may choose to fill the prescription and ask the member to pay cash. We may not reimburse the member, depending on a review of the pertinent clinic situation.

Hospital role

The ER staff members are key players in helping the PCP manage the member's care to avoid clinical unnecessary ER visits. If the ER is aware of the PRC restriction, the hospital can coordinate care by referring the member back to their PCP and/or pharmacy, whether emergency services are provided.

Find more information at hca.wa.gov > Billers, providers & partners > Program information for providers > Patient review & coordination (PRC).

Pharmacy

Preferred Drug List

UnitedHealthcare Community Plan uses the Apple Health prescription drug list (PDL) determined by HCA. This list applies to all UnitedHealthcare Community Plan of Washington IMC members. Specialty drugs on the PDL are identified by an "SP" in the "Requirements and Limits" section of each page. For drugs not included on the Apple Health PDL, we have developed and use a wraparound formulary.

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 Pharmacy Prior Authorization at **1-800-310-6826** or use the online Prior Authorization and Notification tool.

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**.

Prior authorization

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

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

Specialty pharmacy medications

The Specialty Pharmacy Management Program provides high-quality, cost-effective care for our members. A specialty pharmacy medication is a high-cost drug that generally has 1 or more of the following characteristics:

- It is used by a small number of people
- It treats rare, chronic and/or potentially life-threatening diseases
- It has special storage or handling requirements such as needing to be refrigerated
- It may need close monitoring, ongoing clinical support and management, and complete patient education and engagement
- It may not be available at retail pharmacies
- It 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** > **Clinical and specialty pharmacy**.

Radiology

We use our prior authorization process to improve compliance with evidence-based and professional society guidance for radiology procedures.

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

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

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

- 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 at:

- Online: **UHCprovider.com/radiology** > Sign In
- Phone: **1-866-889-8054** from 7 a.m.–7 p.m. local time, Monday–Friday. Make sure the medical record is available. An authorization number is required for each CPT code.

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

14-day readmission review

We conduct a medical record review of readmissions that fall within 14 days of a prior inpatient discharge. These quality reviews look for the causes of readmissions and how to prevent them. The reviews follow the Provider Potentially Preventable Readmission Review (PPPR) Program developed by HCA, the WSHA, hospital representatives and the Apple Health MCOs.

HCA has certain requirements for claims to be paid when a Medicaid member is readmitted to the hospital within 14 days of an inpatient stay, as referenced in Washington Administrative Code 182-550-2950. We will request complete records of both admissions to determine whether the readmission was preventable. A readmission is considered preventable if it could have resulted from any of the following:

- The quality of care provided during the initial admission
- Clinical instability of the member at the time of discharge
- Inadequate discharge planning, discharge process and/or discharge follow-up and care
- If our review determines a preventable readmission took place, we send the hospital a letter with the determination. We will recoup the readmission claim payment either by the hospital refunding the money or having us adjust the claim and offset future payments. We will also recoup if complete clinical records are not received within 30 days of the records request.

Common exclusions include:

- Readmission for reasons unrelated to conditions or care from the first admission
- Hospitalization with a discharge status of “left against medical advice” for prior admission
- Planned readmissions, including:
  - Required treatments for cancer
  - Repetitive, planned treatments or procedures for conditions such as chronic anemia, burn therapy and renal failure
  - Planned therapeutic or procedural admissions following diagnostic admissions, when the therapeutic treatment clinically could not occur during the same admit

For a complete list of exclusions, please see WAC 182-550-2950.

Request for records process

You have 30 days to submit records from the date of the letter. You can submit your records through the UnitedHealthcare Provider Portal:

Go to **UHCprovider.com** and click Sign In

- Search and select the readmission Claim Number to view the claim details
- Scroll down to bottom of page to Act on Claim
- Select Create Claim Reconsideration
- Select WA Medicaid Readmission in the Request Reason drop down menu on the form

Even though this process refers to reconsideration, it is the same location to upload your complete records.

14-day readmission review dispute process

The dispute process is as follows:

- Reconsideration
  - You have 30 calendar days from the date of the denial letter to submit a reconsideration to us
  - You can submit the reconsideration through the UnitedHealthcare Provider Portal using the Claims Tool. See complete process under Request for Records. (It is the same process to submit records as it is to submit a reconsideration.)
- Appeal
  - You have 30 calendar days from the date of the reconsideration denial letter to submit an appeal to us

  - Submit an appeal online through the UnitedHealthcare Provider Portal using the Claims Tool. Or send it by mail to:

    UnitedHealthcare Community Plan
    Attention: Formal Claim Appeals
    P.O. Box 31364
    Salt Lake City, UT 84131-0364

- Final dispute review with HCA
  - If you receive an appeal denial letter, you can submit a final dispute review to us within 30 calendar days from the date of the appeal denial letter. We will submit a dispute on your behalf to HCA within 14 calendar days. HCA will review all related documentation and make a final determination on the dispute within 30 calendar days. They will issue their determination letter directly to the hospital and us. Please submit your final dispute through the appeal process.

Screening, brief interventions and referral to treatment services

Screening, brief interventions and referral to treatment (SBIRT) services are covered when:

- Provided by, or under the supervision of, a certified care provider or other certified licensed care provider within the scope of their practice
- Determining risk factors related to alcohol and other drug use disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed
- An Evaluation and Management (E/M) exam occurs and is not billable with a separate code. You may provide a brief intervention on the same day as a full screen in addition to the E/M exam. You may also perform a brief intervention on subsequent days. Brief interventions are limited to 4 sessions per patient, per provider per calendar year.

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

Screening: With just a few questions on a questionnaire or in an interview, you can identify members who have alcohol or other substance use problems.

Three of the most widely used screening tools are the Alcohol Use Disorders Identification Test (AUDIT); the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST); and the Drug Abuse Screening Test (DAST).

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

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

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

- The billing and servicing care providers have submitted their SBIRT certification to the agency
- The billing care provider has an appropriate taxonomy to bill for SBIRT
- The CPT codes are 99408 and 99409
- The diagnosis code is Z71.41 or Z71.51
- The treatment or brief intervention does not exceed the limit of 4 encounters per member, per care provider per year

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

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

Becoming SBIRT certified: Completing Washington's 7-module SBIRT course meets the HCA's 3.5-hour training requirement to submit billing and provide – or supervise individuals providing – SBIRT services.

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

Smoking (tobacco) cessation — Quit For Life

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

Members can call Quit For Life at 1-866-QUIT-4-Life (1-866-784-8454). Or they can go to myquitforlife.com/uhcwa.

Medication for opioid use disorder

Medication for opioid use disorder (MOUD), formerly called medication-assisted treatment (MAT), combines behavioral therapy and medications to treat substance use disorders (SUD). The FDA-approved medications for SUD include buprenorphine/naloxone, methadone and naltrexone.

Prescribing buprenorphine for MOUD no longer requires completion of a waiver through the Substance Abuse and Mental Health Services Administration (SAMHSA) and a unique identification number from the United States Drug Enforcement Administration (DEA). The WSHA website states, "All practitioners who have a current DEA registration that includes Schedule III authority, may now prescribe buprenorphine for Opioid Use Disorder in their practice if permitted by applicable state law and SAMHSA encourages them to do so."

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

To find a medical MAT care provider in Washington:

1. Go to **UHCprovider.com/findprovider.**
2. Click on "Medical Care Directory."
3. Click on "Medicaid Plans."
4. Click on "Washington."
5. Select "Washington Apple Health Integrated Managed Care (IMC)."
6. Refine the search by typing "Medication Assisted Treatment."

For more information, please see "Medication for opioid use disorder" in the **Mental health and substance use** chapter of this manual.

If you have questions about MOUD, please call **Provider Services** at **1-877-542-9231** and enter your TIN. Say "representative," and "representative" a second time. Then say "something else" to speak to a representative.

Transgender health services

We provide health services for members with gender dysphoria. Please address all members using their preferred name, pronouns and gender identity. We cover hormone therapy and behavioral health services for all transgender members. We also cover puberty-blocking treatment for transgender adolescents. Members can call Member Services to ask for a call back from our Transhealth Care Coordinator.

HCA provides coverage for surgery, electrolysis and post-operative complications from surgery through the FFS program.

Hysterectomy and orchiectomy to treat gender dysphoria is also covered by HCA. To request prior authorization, submit your request via email to: applehealth.transhealth@hca.wa.gov. Your request must include:

- One comprehensive psychosocial evaluation completed within the past 18 months from a qualified and licensed behavioral health provider
- A letter written within the past 18 months from the provider managing the member's gender affirming hormone therapy
- The client's history and physical, as well as the surgical plan completed within the past 12 months from the surgeon who will perform the surgery

- For hysterectomy, a completed Hysterectomy Consent form, HCA 13-365

Note:

- If the requested procedure is required to treat a medical condition (e.g., dysmenorrhea or menorrhagia), the authorization must be obtained through UnitedHealthcare Community Plan and not through HCA
- It is a general requirement for the client to be on gender-affirming hormone therapy for a minimum of 12 months preceding hysterectomy or orchiectomy. However, it is not a requirement for the member to live in a gender role congruent with the member's gender identity for a minimum of 12 months preceding hysterectomy or orchiectomy.

You and members can view the HCA's transgender health services website at hca.wa.gov > Free or low-cost health care > I need medical, dental, or vision care > Other benefits & services > Transhealth program. Contact HCA for care coordination needs for HCA-covered benefits. Send an email to transhealth@hca.wa.gov.

Transitional services

We work with appropriate staff at any hospital, including a CPE facility, to implement a safe, comprehensive discharge plan that ensures continued access to medically necessary covered services that will support the member's recovery and prevent readmission. We have in place operational agreements with the contracted state and community physical and behavioral health hospitals, residential treatment facilities and long-term care facilities to help ensure member care transitions.

Tuberculosis screening and treatment; direct observation therapy

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

The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all members at increased risk unless they have documentation of prior positive test results or currently have active TB under treatment. You will coordinate and collaborate with 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.

Waiver programs

Human immunodeficiency virus/acquired immune deficiency syndrome/Home and Community-Based Services waiver program

The Human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) in-home waiver services program is available to members who would otherwise require long-term institutional services. **Identification** – Members with symptomatic HIV or AIDS who require nursing home level of care services may be eligible for the waiver. The care coordinator or the PCP may identify members potentially eligible for the waiver program. They may also inform the member of the waiver program services.

Referral – If the member agrees to participation, provide the waiver agency with supportive documentation, including history and physical, any relevant labs or other diagnostic study results and current treatment plan.

Continuity of care – The HIV/AIDS waiver program will coordinate in-home HCBS services in collaboration with the PCP and care coordinator. If the member does not meet criteria for the waiver program, or declines participation, the health plan will continue care coordination as needed to support the member.

Other federal waiver programs

Other waiver services, including the Nursing Facility Acute Hospital Waiver, may be appropriate for members who may benefit from HCBS services. These members are referred to the Long Term Care Division/ HCBS Branch to determine eligibility and availability. If deemed eligible, the health plan will continue to cover all medically necessary covered services for the member unless/until member is disenrolled from the Medicaid program.

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
- Rendering care provider and TIN/NPI
- ICD clinical modification (CM)
- Anticipated dates of service
- Type of service (primary and secondary) procedure codes and volume of service, when applicable
- Service setting
- Facility name and TIN/NPI, when applicable

Type of request	Decision turn-around time	Practitioner notification of approval	Written practitioner/ member notification of denial
Pharmacy preservice	Electronic standard authorizations: within 3 calendar days. Non-electronic standard authorizations: within 5 calendar days For standard authorizations, a possible extension up 14 additional calendar days if the member or practitioner requests an extension, or we justify and document how the extension is in the member's interest For electronic expedited authorizations: within 1 calendar day For non-electronic expedited authorizations: within 2 calendar days For expedited authorizations, a possible extension up to 10 calendar days if the member requests an extension, or we justify and document how the extension is in the member's interest	Electronic standard authorizations: within 3 calendar days Non-electronic standard authorizations: within 5 calendar days Electronic expedited authorizations: within 1 calendar day Non-electronic expedited authorizations: within 2 calendar days	Electronic standard authorizations: within 3 calendar days Non-electronic standard authorizations: within 5 calendar days Electronic expedited authorizations: within 1 calendar day Non-electronic expedited authorizations: within 2 calendar days

Type of request	Decision turn-around time	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent preservice	Electronic standard authorizations: Within 3 calendar days, excluding holidays Non-electronic standard authorizations: Notify or request additional information from the Provider within 5 calendar days For standard authorizations, a possible extension up 14 additional calendar days if the member or practitioner requests an extension, or we justify and document how the extension is in the member's interest	Electronic standard authorizations: within 3 calendar days, excluding holidays Non-electronic standard authorizations: Notify or request additional information from the provider within 5 calendar days	Electronic standard authorizations: Within 3 calendar days, excluding holidays. Non-electronic standard authorizations: Notify or request additional information from the provider within 5 calendar days
Urgent/expedited preservice	Electronic expedited authorizations: within 1 calendar day if the information provided is sufficient Non-electronic expedited authorization requests: within 2 calendar days if the information provided is sufficient	Electronic expedited authorizations: within 1 calendar day if the information provided is sufficient Non-electronic expedited authorization requests: within 2 calendar days if the information provided is sufficient	Electronic expedited authorizations: within 1 calendar day if the information provided is sufficient Non-electronic expedited authorization requests: within 2 calendar days if the information provided is sufficient
Concurrent review	Within 1 business day May be extended up to 3 business days	Within 1 business day of determination	Within 1 business day of determination
Retrospective review	Within 30 calendar days of receiving the authorization request and all pertinent clinical information	Within 3 business days of determination	Within 3 business days of determination

For behavioral health and substance use disorder authorizations, please contact our behavioral health department.

If you have questions, go to our prior authorization page at **UHCprovider.com/wacommunityplan** > **Prior Authorization and Notification**.

Case management

We provide case management services to members with complex medical conditions or serious psychosocial issues. The Health Services Department assesses members who may be at risk for multiple hospital admissions, increased medication use, or would benefit from a multidisciplinary approach to medical or psychosocial needs.

Refer members for case management by emailing **wa_carecoordinationrequests@uhc.com**. Additionally, UnitedHealthcare Community Plan provides the **Healthy First Steps program**, which manages individuals with high-risk pregnancies.

Pharmacy

Pharmacy management, including asthma-related care, is part of our Care Management program.

Otherwise, we provide pharmacy management through Optum Rx. Optum Rx administers clinical, patient-focused Disease Therapy Management (DTM) programs offered as part of Specialty Pharmacy Care Management services. These programs help improve patient quality of care through education and communication.

Specialty Pharmacy offers DTM programs for the following disease states/conditions required by the Board for the Washington Apple Health programs:

- Rheumatoid arthritis
- Growth disorders
- Risk of respiratory syncytial virus due to prematurity

Additional programs provided to Apple Health program members include:

- Hepatitis C
- Multiple sclerosis
- Anemia related to chemotherapy
- Comprehensive medication management therapy

The POC addresses the following areas of care:

- Psychosocial adjustment
- Nutrition
- Complications
- Pulmonary/cardiac rehab
- Medication
- Prevention
- Self-monitoring of symptoms and vital signs
- Emergency management/comorbid condition action plan
- Appropriate health care utilization

Our Care Management program is supported by our integrated clinical system. The system includes basic and comprehensive supplemental assessments, facilitates the development of integrated care plans, and uses ongoing monitoring and evaluation tools.

Concurrent review guidelines

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

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

Concurrent review details

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

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

Critical incident reporting

When one of our members experiences a critical incident, we follow up to help ensure they have the care they need. We report critical incidents to HCA through semi-annual reporting as well as HCA Incident Reporting System. So we can provide this follow-up, please report critical incidents to us as soon as the incident has been identified.

Critical incident reporting criteria

- A major injury or major trauma that occurs in a facility that provides behavioral health services that may lead to a member's prolonged disability
- A member's unexpected death in a facility that provides behavioral health services
- A member's alleged violent acts, such as:
  - Arson
  - Assault resulting in serious bodily harm
  - Homicide or attempted homicide by abuse
  - Drive-by shooting
  - Extortion
  - Kidnapping
  - Rape, sexual assault or indecent liberties
  - Robbery
  - Vehicular homicide
  - Attempted suicide and all completed suicides
  - Homicide or attempted homicide
  - Abuse, neglect or exploitation of a member (APS/CPS reporting)
- Unauthorized leave of a mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (i.e., evaluation and treatment centers, crisis stabilization units, secure detox units and triage facilities) that accept involuntary admissions
- Any event involving a member that has attracted or is likely to attract media attention as it relates to the criteria stated above

Do not report child abuse cases to us through the critical incident process. Report them directly to the Children's Administration/CPS as part of mandatory reporting requirements. However, if the incident also falls under one of the additional critical incident reporting criteria, follow our critical incident process.

The following are not critical incidents:

- Threatening suicide or suicidal ideation
- Routine car accidents and other accidents not resulting in a serious injury
- Unexpected death or serious injury of a member
- A credible threat to member safety
- Any allegation of financial exploitation of a member

How to report a critical incident

Once you learn of an incident, make sure the member is safe. Then report as soon as possible. Some critical incidents require notification to HCA within 1 business day of notifying us.

Email the completed Critical Incident form on **UHCprovider.com/wacommunityplan** > **Provider Forms and References** > Critical Incident Report Form to **wa_criticalinc@uhc.com**.

Determination of medical necessity

Examples of medically necessary services (also see medically necessary in the **Glossary** of this document) or supplies include:

- Prevent, diagnose, alleviate or cure a physical or behavioral 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

For requests for experimental and investigational services, UnitedHealthcare Community Plan is required to follow HCA's medical necessity determinations as described in WAC 182-501-0165, including the option to approve an experimental or investigational service when there is:

- A humanitarian device exemption for the requested service or device from the Food and Drug Administration (FDA); or
- A local Institutional Review Board (IRB) protocol addressing issues of efficacy and safety of the requested service that satisfies both HCA and the requesting provider

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.

Medical and drug policies and coverage determination guidelines

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

Referral guidelines

We do not process or require referrals to participating care providers. However, 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 **UHCprovider.com**, contacting Provider Services or ProviderOne
- 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
- Be aware that if we deny authorization for a service that requires authorization, we will deny any ancillary services associated with the denied service as well

UnitedHealthcare Community Plan will not reimburse:

- Services UnitedHealthcare Community Plan decides are not medically necessary
- Non-covered services
- Services provided to members not enrolled on the dates of service

Second opinion benefit

If a 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 HCA. These access standards are defined in **Chapter 2**.

We allow a second opinion about the member's health care from a qualified care provider within our network. However, we will provide authorization for a non-network second opinion if our network cannot provide an independent and impartial qualified care provider. The second-opinion appointment must occur within 30 calendar days of the request unless the member requests a further delay.

If an in-network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact Provider Services.

If we do not authorize a second opinion, or a second opinion from the member's chosen care provider, the refusal is an adverse benefit determination. It may be subject to appeal under the provisions of the Grievance System section of our contract with HCA.

Services not covered by UnitedHealthcare Community Plan

The following services are not covered by UnitedHealthcare Community Plan (not a comprehensive list):

- Any health care provided by a out-of-network provider (except for emergency treatment or care previously authorized by UnitedHealthcare Community Plan)
- Any care covered by Medicaid but not through managed care:
  - Long-term care services in a nursing home
  - Non-SNF services
  - Intermediate care facilities for members with mental handicap
  - Home- and community-based waiver services
- Phones and TVs used when in the hospital
- Personal comfort items used in the hospital such as a barber
- Infertility services
- Non-emergency medical transportation
- Emergency transportation, ground and air
- Voluntary pregnancy termination
- Glasses and contact lenses for adults 21 and older (see Value Added Services for options)
- Cosmetic surgery (except to correct physiological defects or for mastectomy reconstruction for post cancer treatment)

Services requiring prior authorization

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

Direct access services — Native American and Alaska Native members

Native Americans or Alaska Natives do not need prior authorization to seek care from a tribal clinic or Indian Health hospital, regardless of network participation status.

All other standard service authorization requirements apply.

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
- **Non-emergency admissions and/or outpatient services (except maternity):** at least 14 business days beforehand; if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time

Utilization management guidelines

Call Provider Services to discuss the guidelines and utilization management.

UM is based on a member's medical condition and is not influenced by monetary incentives. UnitedHealthcare Community Plan pays its in-network PCPs and specialists on a fee-for-service basis. We also pay in-network hospitals and other types of care providers in the UnitedHealthcare Community Plan network on a FFS basis. The plan's UM staff works with

care providers to help ensure members receive the most appropriate care in the place best suited for the needed services. Our staff encourages appropriate use and discourages underuse. The UM staff does not receive incentives for UM decisions.

Utilization management begins at intake

We have intake policies that provide immediate access to treatment. This helps ensure members can access services when they first notice symptoms:

- A member can contact a network care provider's office and request an appointment
- A family member can contact a network care provider's office and request an appointment
- Member Services is available any time. It connects members with someone who can help identify a network care provider most appropriate to their needs and preferences. If requested, we contact the care provider for the member. We can also help the member get to the care provider's office or access emergency/crisis services.

Utilization management appeals

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

Chapter 5: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/prevention

Key contacts

Topic	Link	Phone number
EPSDT	hca.wa.gov > Free or low-cost healthcare > I help others apply for and access Apple Health > General eligibility requirements that apply to all Apple Health programs > Scope of care Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	1-800-562-3022
Vaccines for Children	doh.wa.gov > For Public Health & Health Care Providers > Public Health System Resources and Services > Immunization > Childhood Vaccine Program	1-800-219-3224

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 members. EPSDT screening includes immunizations, hearing, vision, speech screening and nutritional assessments; dental screening; and growth and development tracking.

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

Government Childhood and Adolescent Immunizations Guide: cdc.gov/vaccines/parents/resources/childhood.html

Government Quick Reference Guide: cdc.gov/vaccines/schedules/index.html

HCA EPSDT Billing Guide for Additional Recommended Frequencies: hca.wa.gov

Effective Jan. 1, 2023, HCA is aligning with the Bright Futures Periodicity schedule. As a result, the EPSDT Billing Guide published in January 2023 will include the following covered EPSDT well-child visit schedule:

- 6 well-child visits before age 1 (first week, 1 month, 2 months, 4 months, 6 months, 9 months)
- 7 well-child visits between ages 1 and 4 (12 months, 15 months, 18 months, 24 months, 30 months, 3 years, 4 years)
- 1 well-child visit every 365 days from ages 5–21

Developmental Disability Administration and coordination with regional centers

Developmental disabilities are severe and chronic disabilities due to a mental or physical impairment that begins before the member reaches adulthood. These disabilities include intellectual disability, cerebral palsy, epilepsy, autism and disabling conditions related to intellectual disability or requiring similar treatment.

Referral – If you determine supportive services would benefit the member, refer the member to Developmental Disability Administration (DDA) for approval and assignment of a regional center case manager who is responsible for scheduling an intake assessment. Determination of eligibility is the responsibility of the regional center interdisciplinary team. While the regional center does not provide overall case management for their clients, they must ensure access to health, developmental, social and educational services from birth throughout the lifespan of individual who has a developmental disability.

Continuity of care – The DDA will determine the most appropriate setting for eligible HCBS services and will coordinate these services for the member in collaboration with the PCP and health plan coordinator. The care coordinator and PCP continue to provide and manage primary care and medically necessary services. If the member does not meet criteria for the program or placement is not currently available, UnitedHealthcare will continue care coordination as needed to support the member's screening, preventive, medically necessary and therapeutic covered services.

Early Start program

The Early Start program provides early intervention services to infants and toddlers with disabilities and their families.

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

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

Call **1-866-482-4325** for more information.

Full screening

Perform a full screen. Include:

- Interval history
- Unclothed physical examination
- Anticipatory guidance
- Lab/immunizations (lab and administration of immunizations is reimbursed separately)
- Lead assessment (use the Lead Risk Assessment form)
- Personal-social and language skills
- Fine motor/gross motor skills
- Hearing
- Vision
- Dental (screen and fluoride)

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

Interperiodic screens

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

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

Lead screening/treatment

The DOH recommends screening all children at 12 and 24 months of age using this clinical algorithm.

Call Provider Services if you find a child has a lead blood level over 10 ug/dL. Children with elevated blood lead levels will be offered enrollment in a care coordination program. Federal regulations require that all children enrolled in Medicaid receive a blood lead test at 12 and 24 months of age, or at 24–72 months of age if no record of a previous test exists.

Reference:

Blood Lead Testing Information for Health Care Providers | Washington State Department of Health

Medically Intensive Children's program

The Medically Intensive Children's program serves children ages 17 and younger who have complex medical issues (e.g., ventilator dependent, tracheostomy care) that require the support of a registered nurse for at least 4 continuous hours per day. Skilled nursing services may be provided in the family home, foster homes, and in participating medically intensive children's group and staffed residential homes.

Services include such skilled nursing interventions as:

- Assessments and systems management
- Multi-step approaches on a daily basis for complex respiratory issues related to technological dependence
- Parameters/machinery maintenance
- Multiple IV/parenteral medications and nutritional substances on a continuing or interment basis with frequent interventions
- Enteral nutrition and medications requiring multi-step approaches daily

Direct applications for MICP services to micp@dshs.wa.gov

Targeted case management

Targeted case management (TCM) consists of case management services for specified targeted groups to access medical, social, educational and other services provided by a Regional Center or local governmental health program as appropriate.

Identification – The 5 target populations include:

- Children younger than 21 at risk for medical compromise
- Medically fragile individuals
- Individuals in frail health, older than 18 and at risk of institutionalization
- Members in jeopardy of negative health or psychosocial outcomes
- Members infected with a communicable disease, including TB and HIV/AIDS, or who have been exposed to communicable diseases, until the risk of exposure has passed

Referral – Refer eligible members to a Regional Center or local governmental health program, as appropriate, for TCM services.

Continuity of care – UnitedHealthcare Community Plan is responsible for coordinating the member's health care with the TCM provider and for determining the Medical Necessity of diagnostic and treatment services recommended by the TCM provider that are covered services under the contract.

Vaccines for Children program

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

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

Contact VFC if you have questions.

Phone: 1-360-236-4501

Care providers administering Apple Health vaccines must agree to participate in the state's Immunization Registry. We will submit a monthly report containing a list of care providers, their contact information, claimant information and corresponding vaccine administrations to the Washington state Department of Health.

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

- Eligible for Medicaid
- American Indian or Alaska Native, as defined by the Indian Health Services Act
- Uninsured
- Underinsured. (These children have health insurance, but the benefit plan does not cover immunizations. Children in this category may not only receive vaccinations from an FQHC or RHC. They cannot receive vaccinations from a private care provider using a VFC-supplied vaccine.)

Chapter 6: Value-added services

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com**	**1-877-542-9231**
Healthy First Steps	**uhchealthyfirststeps.com**	**1-800-599-5985**
Value-added services	**UHCCommunityPlan.com/wa** > View plan details	**1-877-542-9231**

UnitedHealthcare Community Plan offers value-added services (benefits) in addition to Apple Health covered benefits. Value added services are no cost to members. If you have questions or need to refer a member, call **Provider Services** at **1-877-542-9231**, unless otherwise noted.

Rewards program

Healthy Rewards – Members earn rewards for completing important preventive care visits, including well-child visits and immunizations, breast cancer screening, diabetes monitoring and more. Up to $200 per member per year. Eligible members will be notified by mail or email.

Vision (adults 21 and older)

Eyeglasses – Members receive up to $100 for a single pair of frames and lenses every 2 years through March Vision's network of providers. Members can visit marchvisioncare.com.

Maternity support

- **Babyscripts™** – Educational content, appointment reminders and helpful gift card rewards for enrollments ($75), 1 prenatal appointment ($50) and 1 postpartum appointment ($25). Members can download the Babyscripts myJourney app through the App Store or Google Play.
- **Healthy First Steps program** – Pregnant members work directly with a maternity professional for extra support, access community resources (including WIC) and get help finding a doctor, midwife or specialist. Members can call Healthy First Steps at **1-800-599-5985** or visit **uhchealthyfirststeps.com**.
- **Doula care** – All pregnant members are eligible for doula services through The Doula Network. Doulas help with planning for delivery and parenthood, provide emotional and physical support during labor, and offer breastfeeding and other support after delivery. Members can reach out to Healthy First Steps for assistance or request a doula themselves through this link: Home | The Doula Network (select For Birthing Persons > Request a Doula). The doula care value-added benefit ends Dec. 31, 2024.
- **Car seat** – A family can choose between two car seat models per newborn to be shipped directly to them. The car seat must be ordered no later than 12 months from the date of birth. The car seat restraint system meets all applicable federal motor vehicle safety standards. To order, members can email **maternalhealthwa@uhc.com**.
- **Mom's Meals** – People with high-risk pregnancies who are engaged with a Healthy First Steps care manager may be eligible for home-delivered meals for a 2-week period after delivery. Meals are provided for the birthing person and up to 4 additional household members. Members can call Healthy First Steps at **1-800-599-5985**.
- **Wellhop** – Virtual group peer support. Pregnant members can connect with other moms for support during your pregnancy and beyond. Learn more, members can go to momandbaby.wellhop.com.
- **Text4Baby** – Education and support. To sign up, members can text BABY to 511411 for messages in English and BEBE to 511411 for messages in Spanish.

Transition support for jail/detention

Members transitioning out of jail/detention may receive duffel bags containing essentials upon leaving an incarcerated setting in addition to care coordination services. Member Services can refer incarcerated members to their assigned case manager. Members can call **1-877-542-8997**.

Housing support

On My Way™ (OMW) program – Helps prepare youth members to reach their housing, employment and financial management needs for the future. Members can learn more at **uhcomw.com**.

Fitness/healthy lifestyles

AbleTo – Able To® Self-care app with emotional health tools, including meditations, breathing exercises, videos, blogs and more. Members can visit ableto.com/begin and follow the online steps to sign up. Members should use their UnitedHealthcare member ID number as their access code.

Kids activities/clubs

- Boys and Girls Club
  - Memberships for 6–18 years old at no cost
  - To redeem, members should present their UnitedHealthcare Community Plan ID card when registering
  - Memberships grant access to all programs and benefits – members can call their local Boys and Girls Club to learn more
  - This program is offered at all Boys and Girls Clubs, with locations across various WA counties
- Sports physicals in addition to well-child visits at no additional cost

Chapter 7: Mental health and substance use

Key contacts

Topic	Link	Phone number
Behavioral health Provider Services	**UHCprovider.com**	**1-877-542-9231**

UnitedHealthcare Community Plan provides our members with behavioral health and substance use benefits as defined by the Apple Health (Medicaid) benefit package (see **Covered services** section). We focus on improving health equity through access to treatment, expanding the array of covered services, and improving the quality of care and treatment outcomes. Our goal is to grow the Washington behavioral health system and make it easier for people to access appropriate care in their community or virtually, according to their preference.

We are committed to recovery, resiliency and person-centered care. This includes helping people learn to manage their behavioral and physical health. Our practices are anchored in the belief that people with behavioral health diagnoses can live, work and be fully connected to their communities.

UnitedHealthcare Community Plan offers Care Management and/or Care Coordination services to help members, clinicians and PCPs access and coordinate medically necessary BH treatment resources, ensure coordination of care between Primary Care and Behavioral Health providers and assist with Health Related Social Needs (HRSN) linkages. We provide easily accessible information and tools for behavioral health diagnoses, symptoms, treatments, self-care and prevention resources for Providers and members.

We support integrated care by working with providers to move members along the continuum of care, to support a "No Wrong Door" approach to treatment.

To support members in receiving appropriate care at any point of entry, PCPs may offer behavioral health care services or partner with a specialty provider agency to provide coordinated physical and behavioral health interventions. Behavioral health practices may offer primary care to support a holistic approach to treatment.

Apple Health members must be provided a standard of care equal to those offered to all other persons treated by the providers.

Resources for providers and members

- Website: **UHCprovider.com**
  - Access the UnitedHealthcare Provider Portal, the gateway to UnitedHealthcare Community Plan's online services. Use the UnitedHealthcare Provider Portal to verify eligibility, review electronic claim submission, view claim status, access the Prior Authorization list, locate forms, and submit notifications or prior authorization requests. **Provider Services** at **1-877-542-9231** is able to offer assistance if needed.
- **Healthcare Professional Education and Training | UHCprovider.com**
- Optum Health Education: **optumhealtheducation.com**
  - Optum Joint Accredited Provider Health Education (OHE) is a jointly accredited education company with over 30 years of experience as a full-service provider of interprofessional continuing education
  - OHE is accredited to provide medical, nursing, optometry, pharmacy, psychology, social work, dental and dietitian continuing education activities by the Accreditation Council for Continuing Medical Education (ACCME), the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy Education (ACPE), The Council on Optometric Practitioner Education (COPE), the American Psychological Association (APA), the Approved Continuing Education (ACE) program, American Dental Association Continuing Education Recognition Program (ADA CERP) and Commission on Dietetic Registration (CDR)
- Washington Recovery Help Line: warecoveryhelpline.org Phone: 1-866-789-1511
- **myuhc.com**
  Member portal to access information on:
  - Coverage and benefits, prescription drug list, provider directory and member ID card

  - Live and Work Well site for:
    - Behavioral health and well-being articles and information
    - Articles on health conditions, substance use and coping
    - Self-assessments on a variety of topics
    - Community resources
- Behavioral Health Advocates - The Office of Behavioral Health Advocates (formerly called Behavioral Health Ombudsman) is available to assist members with free and confidential assistance with:
  - Resolving concerns related to behavior health services
  - Filing a behavioral health grievance, appeal, or fair hearing

Behavioral Health Advocates operate independently of UnitedHealthcare Community Plan and have personal or familial experiences with behavioral health services.

Members can request a Behavioral Health Advocate at https://www.obhadvocacy.org/ or by calling 1-800-366-3103.

Credentialing

Initial credentialing is completed within 60 days of receipt of a completed credentialing application. A completed credentialing application includes all necessary documentation, attachments and a signed Agreement.

Physician addiction specialists must be certified by the American Society of Addictions Medicine (ASAM) or the American Board of Addiction Medicine (ABAM) or have added qualifications in Addiction Psychiatry through the American Board of Psychiatry and Neurology (ABPN). Once the completed credentialing application is received, the committee will decide within 60 calendar days. Written notification will be sent within 15 calendar days of the decision.

Eligibility

UnitedHealthcare is only responsible for members with active coverage on the date of service. To ensure eligibility, verify the member's Medicaid eligibility on day of service before treating them. View eligibility online at waproviderone.org or on the Eligibility and Benefits application on **UHCprovider.com**.

Medicaid behavioral health (mental health and substance use disorder) benefits

UnitedHealthcare Community Plan offers medically necessary covered behavioral health services for mental health and substance use disorders.

Benefits included but are not limited to:

- Crisis services
- Psychiatric hospitalization services (voluntary and involuntary)
- Residential treatment (SUDS and MH)
- Assessment/psychiatric evaluations
- Stabilization services
- Withdrawal management
- Day support
- Peer support
- Peer Respite
- Intensive outpatient
- Medication management
- Case management
- Outpatient therapy (individual, family or group)
- Psychological evaluation and testing
- Hospital observation room services (up to 23 hours and 59 minutes in duration)
- Electroconvulsive therapy (ECT)
- Virtual visits
- Neuropsychological testing
- EPSDT services
- Annual depression screenings for members and caregivers younger than 6 months of age as well as members ages 12–20

Crisis services

Crisis services for community plan members are managed by and provided via regional Behavioral Health Administrative Services Organizations (BH-ASOs). The BH-ASOs provide and manage crisis services for all community members in their regional service area, regardless of payor. This includes the responsibility to provide crisis services for those with no coverage or ability to pay.

H2011 encounters for UnitedHealthcare enrolled members are sent directly to UnitedHealthcare **except** for H2011 encounters with an HW modifier, these encounters must be submitted directly to HCA.

Crisis services include:

- A behavioral health crisis hotline
- Behavioral health crisis services, including mobile crisis outreach teams
- Designated Crisis Responder (DCR) services: Mental Health Professionals who evaluate members for involuntary commitment under state law criterion and, when appropriate, complete court filing of detention paperwork

Behavioral health-Administrative services only contacts

- Great Rivers: 1-800-803-8833
- Greater Columbia BH-ASO: 1-888-544-9986
- King County BH-ASO – Crisis Connections: 1-866-427-4747 or 1-206-461-3222
- North Sound BH-ASO – Community Crisis Line: 1-800-584-3578 and 1-800-747-8654
- Pierce Carelon Behavioral Health: 1-800-576-7764, TTY 711
- Salish: 1-800-525-5637
- Southwest WA – Carelon Behavioral Health: 1-800-626-8137, TTY 866-835-2755
- Spokane County BH-ASO Regional Behavioral Health: 1-877-266-1818
- Thurston Mason: 1-800-270-0041

988 Lifeline

988 Lifeline is a free and confidential service available 24/7 to all WA.

Call, text or chat 988 for:

- Supportive listening
- Thoughts of suicide
- Mental health or substance use concerns
- Identification of resources
- Prevention information
- If you are worried about a loved one who may need support

988 can coordinate with local crisis providers to access mobile crisis teams or Designated Crisis Responders (DCR) as needed.

988 can also access Indigenous and Strong Lifeline, specifically available for Washington's American Indian and Alaska Native communities. Calls are answered by Indigenous crisis counselors who are tribal members and descendants closely tied to their communities. Native and Strong counselors are fully trained in crisis intervention and support, with special emphasis on cultural and traditional practices related to healing.

Authorizations

Members may access all behavioral health outpatient services (behavioral health and substance use) without a referral. Prior authorization is not required for outpatient, withdrawal management or residential SUD services.

Authorization may be required for more intensive services. This includes:

- Intensive outpatient program
- Day treatment
- Partial hospitalization programs, inpatient hospitalization or residential treatment facility

Ensure prior authorizations are in place before rendering non-emergent services.

Out-of-network

All BH services (except emergency services) performed by out-of-network providers require prior authorization except for admission to a DOH-licensed substance use withdrawal management or residential treatment facility located in WA.

Inpatient authorizations

- Prior-authorization is not required for emergency mental health inpatient services, including involuntary treatment for MH or SUD. Notification is required within 24 hours of an admission for emergency services.
- Prior authorization is required for non-emergent admissions
- Ongoing utilization review is required for all inpatient stays

Residential treatment

- Prior authorization is not required for substance use residential treatment
- Prior authorization is required for mental health residential treatment

UnitedHealthcare members with Apple Health (Medicaid) coverage in a state hospital or incarcerated setting will resume coverage under their UnitedHealthcare Medicaid plan at time of release, unless they switch managed care plans or lose eligibility for coverage. Benefits can be confirmed at the time of discharge. HCA can take up to 1 business day to update member's status in ProviderOne from suspended to active. UnitedHealthcare may provide approval for services contingent upon the reinstatement of benefits.

Outpatient authorizations

Outpatient services requiring prior authorization:

- ECT
- Psychological testing. No prior authorization is required for first 12 units of service per member per lifetime. Prior authorization is required for additional units of service. Complete a standard evaluation (CPT code 90791 or 90792, including clinical interview, direct observation and collateral input, as needed). The following cases must exist:
  - Significant diagnostic questions remain that can only be clarified through testing
  - You have questions about the appropriate treatment course for a member
  - A member has not responded to standard treatment, and testing would have a timely effect on the treatment plan
  - A cognitive, intellectual and/or neurological deficit or impairment may affect functioning or interfere with the member's ability to participate in or benefit from treatment. Testing would verify the presence or absence of this issue.

Generally, we do not cover psychological testing solely for education or school evaluations, learning disorders, legal and/or administrative requirements. We also do not cover tests performed routinely as part of an IEP assessment. Call Provider Services for more information.

Outpatient services

When a member initially requests behavioral health services the provider agency is required to submit an H0046UB encounter documenting the member's request for services as outlined in the Service Encounter Reporting Instructions (SERI), page 133.

Assessment

Assessments completed by a DOH licensed behavioral health services from a licensed and certified behavioral health agency must be performed by an appropriately licensed professional (per WAC 246-341 and HCA's IMC Service Encounter Reporting Instructions [SERI] on hca.wa.gov). Assessments must be age-specific, person centered, culturally relevant and are the basis for the ongoing POC. Crisis and stabilization services may be provided prior to an assessment being completed.

Assessments should include:

- A biopsychosocial history with information on current and previous medical and behavioral health conditions, medications, interventions and outcomes
- A list of current and previous medical and behavioral health care providers
- A mental status exam revealing a risk of harm to self or others

For members aged 13 and above, assessments should also include:

- A history of substance use
- Relevant legal history
- Assessment of social supports
- Education and employment history

Global Assessment of Individual Needs – Short Screener

Assessments performed by a Behavioral Health Agency licensed by DOH require the completion of a Global Assessment of Individual Needs – Short Screener (GAIN-SS) for members 13 years old and above. Legislation requires intake personnel use a screening tool identifying the most common types of co-occurring disorders. Washington Department of Social and Health Services adopted the GAIN-SS to screen for co-occurring disorders among Medicaid members.

GAIN-SS forms can be accessed at hca.wa.gov > Billers, providers, and partners > Program information for providers > Behavioral health and recovery > Contractor and provider resources > Global Assessment of Individual Needs-Short Screen (GAIN-SS):

- GAIN-SS target data elements setup form (14-479)
- GAIN-SS target data elements admission and assessment form (04-416)

Learn more at gaincc.org. Or call the GAIN Project Coordination Team at 1-309-451-7900.

You must also share the results of the screening via Behavioral Health Supplemental Data (BHSD) transactions (see Data Guide at hca.wa.gov/billers-providers-partners/program-information-providers/resources-behavioral-health-providers).

Birth–5 mental health assessments

Children from birth through age 5 are eligible for up to 5 assessment sessions per episode of care, to support a comprehensive evaluation and accurate diagnosis, leading to an individualized treatment plan. To support in-home assessments as clinically indicated, UnitedHealthcare Community Plan reimburses provider travel to members' homes for these assessments. Providers should submit encounters as per identified standards and processes. Travel is reimbursed through a separate A-19 payment process. Assessments are used to inform diagnosis. Diagnosis should be made using the appropriate version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or for members 0–5, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5). Assessments and diagnosis should initially lead to a mutually agreed-upon, medically necessary POC.

HCA Provider Link – hca.wa.gov/billers-providers-partners/program-information-providers/mental-health-assessment-young-children

Additional clinical assessments, such as developmental or cognitive functioning assessments, should be completed as clinically indicated.

Additional information

Clinicians must inform members who present for mental health services of their right to a Mental Health Advance Directive, and shall provide technical assistance to those who express an interest in developing and maintaining a mental health advance directive. See **Chapter 2** for more information.

Medication management services

Psychiatrists, prescribing ARNPs and medical psychologists are not required to get prior authorization for the initial consultation, routine medication management sessions and other routine outpatient services. These include 90791, 90792, 90833, 90834 and evaluation and management (E&M) codes as applicable.

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

Peer services and supports

This program involves a certified peer specialist using their training and experiential knowledge to help the member and their family achieve their recovery and resiliency goals. The specialist can give and provide information about services or self-care as well as support skill development. Helping the member become more socially connected and empowered, and increasing engagement in treatment. Peer services provided through UnitedHealthcare Community Plan may be delivered before, during or after the member is receiving behavioral health treatment. Community based peer services may be provided in conjunction with services offered by a DOH licensed behavior health agency.

Wraparound with Intensive Services

Washington's Wraparound with Intensive Services (WISe) program helps provide comprehensive behavioral health services and supports to Medicaid-eligible individuals 21 years or younger and their families who have complex behavioral health needs. The program's values are family-driven and youth-guided, community-based, and culturally and linguistically appropriate.

WISe's goals are for eligible youth to:

1. Live and thrive in their homes and communities.
2. Avoid or reduce out-of-home placements while receiving behavioral health treatment services.

The WISe care provider, youth and family work together to create a personalized POC with services and supports that identify and enhance the capabilities, knowledge, skills and assets of the youth and family, their community and other team members. WISe services may be provided in the home and in community locations, at times and locations that help ensure meaningful participation of youth, family members and natural supports. The WISe team is available for crisis responses at all times.

WISe practices use the Washington State Children's Behavioral Health and Recovery principles in service delivery, policies and procedures, and quality assurance. They help:

- Increase resiliency and reduce the impact of behavioral health symptoms on youth and families
- Keep youth safe at home, in the community and school
- Promote youth development, maximizing their potential to grow into healthy and independent adults

You must use the WISe Manual as a guide to help ensure consistency of service delivery and quality improvement across the state. The manual is located at hca.wa.gov > Billers Providers & Partners > Program information for providers > Child and youth behavioral health services > Wraparound with Intensive Services (WISe). It helps explain WISe's:

- Purpose and goals
- Required agency infrastructure and expectations
- Service requirements
- Member rights
- Governance and coordination
- Background: T.R. settlement agreement
- Guidance on team functioning and facilitation to incorporate the core elements of WISe in each of the following phases: Engagement, Assessing, Teaming, Service Planning and Implementation, Monitoring and Adapting, and Transition
- Team meeting components and team structure
- Attestation(s) for managed care entity
- Service array and SERI coding
- Washington's CANS algorithm
- Cross system care plan and crisis plan example template
- Quality plan

WISe care provider requirements

1. WISe providers must adhere to the WISe Manual.
2. Anyone can make a referral for a WISe screening for any eligible Medicaid-eligible youth who might benefit from WISe. Child and Adolescent Needs and Strength (CANS)-certified screeners must offer and complete the WISe screen within 10 business days of receiving a referral. UnitedHealthcare Community Plan must provide the youth or parent/caregiver (for youth under 13) with written Notice of Adverse Benefit Determination.

   Submit notification forms to UnitedHealthcare Community Plan within 24 hours when:
   - A member is denied services due to eligibility, or if services are reduced, suspended and/or terminated without the member in agreement
   - The WISe member is discharged with their consent

   Provider must prioritize access to WISe services for all youth qualified to receive WISe services that the Contractor has been notified are discharging from CLIP and juvenile rehabilitation facilities.
3. Take part in the required state-sponsored trainings and coaching sessions offered through the WISe Workforce Collaborative. This organization is the primary resource for ongoing technical help related to training and coaching for WISe practitioners. WISe leadership staff are required to participate in all WISe-related quality activities and UnitedHealthcare Community Plan-sponsored meetings, such as your regional WISe Leadership Collaborative meetings.
4. Follow the SERI instructions for WISe on hca.wa.gov.
5. Submit invoices and WISe Tracker Reports to Finance and to our SFTP site by the 5th of each month. Finance information is on the invoice. Tracker must be completely filled out with member summary and interest list information. Providers are required to meet monthly benchmarks for regional caseload target and maintain a regional service intensity (10.5 hours).
6. Provider interest lists must be monitored at least monthly and tracked in a timely manner in BHAS.
7. Include information regarding WISe services on your website.
8. Participate in a review of WISe services using the WISe Quality Improvement Review Tool (QIRT) at least annually. This review can be conducted by internal WISe care provider staff, a peer WISe care

provider or external partner. You must conduct a full review of components every 3 years.

For more information, contact our Children's Behavioral Health Services Administrator at 1-763-321-2358.

Program for Assertive Community Treatment

The Program for Assertive Community Treatment (PACT) is a person-centered, recovery-oriented mental health service delivery model that helps reduce psychiatric hospitalizations, facilitate community living and enhance recovery for persons with serious mental illnesses.

PACT is designed for persons who have the most severe and persistent mental illnesses, severe symptoms and impairments, and have not benefited from traditional outpatient programs. A group of transdisciplinary mental health staff members provide PACT services. It provides the treatment, rehabilitation and support services consumers need to achieve their goals. The team is directed by a team leader and a psychiatric prescriber and includes:

- Staff from the core mental health disciplines
- At least 1 peer specialist
- Administrative support staff, who provide intensive services. Contacts with PACT may be as frequent as 2–3 times per day, 7 days per week; frequency of contact is based on consumer need and a mutually agreed-upon plan between the consumer and PACT staff. PACT teams deliver community-based care 7 days a week to support consumers living independently and taking part in their community. The PACT team provides an average of 3 face-to-face contacts a week for all consumers as well as primary responsibility for crisis intervention coverage for PACT members 24 hours a day. Crisis services include developing individualized crisis plans and coordinating care with other crisis/emergency service providers through Point Click Care or other collaborative systems.

PACT providers must adhere to HCA standards. These standards are on hca.wa.gov.

New Journeys

New Journeys (NJ) Coordinated Specialty Care is a treatment curated to meet the needs of those experiencing a first episode of psychosis with treatment services of a higher intensity than those offered in regular outpatient settings. Treatment provides evidence-based health and recovery support interventions for youth and young adults when first diagnosed with psychosis.

NJ services are delivered by multi-disciplinary mental health providers who work as a team and provide the treatment, rehabilitation and support services for individuals to achieve their own goals. The service range is provided on an outpatient basis with options for home and community settings, based on the individual's own needs and what they identify as helping them achieve a more meaningful life. Service components include individual and/or group psychotherapy, supported employment and education, family psychoeducation and support, psychiatry and peer support.

Community Behavioral Health Support

Community Behavioral Health Support services are individually tailored services designed to help clients acquire, retain, restore, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community-based settings. The supportive supervision service is part of the new Community Behavioral Health Services (CBHS) benefit. The goal of CBHS services is to help people living with severe mental health diagnosis to access care in the least restrictive environment promoting recovery and resiliency. Services are individualized to meet each person's needs.

Supportive supervision

- A voluntary service
- One-on-one in-person monitoring, redirection, diversion, and cueing of the client to prevent at risk behavior that may result in harm to the client or to others
- Providing individuals with assistance to build skills and resiliency to support stabilized living and integration
- Coordinated as appropriate with other services, such as behavior support and/or crisis plans to help ensure community stability
- Supportive supervision is coordinated as appropriate with other services such as behavior support and/or crisis plans to help ensure community stability

- Supportive supervision does not cover environmental modifications, such as requests for individual rooms or other material goods or servicesProviding individuals with assistance to build skills and resiliency to support stabilized living and integration
- Coordinated as appropriate with other services, such as behavior support and/or crisis plans to help ensure community stability

Provider types

- Adult family homes (AFH)
- Enhanced service facilities (ESF)
- Assisted living facilities (ALF)

Who may be eligible?

A person may be eligible for CBHS services if they:

- Are 18 years of age or older and are Apple Health (Medicaid) eligible
- Are eligible for or receiving Home and Community Services (HCS) ***All referrals begin with HCS to complete a CARE and evaluate eligibility.
- Have one of the qualifying behavioral health diagnoses as a primary reason for needing supportive supervision from a licensed/credentialed professional.
- Are transitioning from an inpatient psychiatric setting or experience challenges living in community settings. These challenges include:
  - Frequent hospitalizations
  - Difficult maintain stays in residential settings
  - Having high caregiver turnover within the past 2 years due to behaviors caused by the client's behavioral health condition.
- Have qualifying behaviors that create a risk to safety and/or cause distress to and escalate the client or other residents to crisis if not monitored and redirected by staff.

For additional resources on this program, please visit hca.wa.gov.

Required risk criteria

1. Individual has behaviors caused by their behavioral health condition that require additional staffing available only under the Community Behavioral Health Support services benefit, including at least 1 or more of the following within the past year:
   - Multiple assaultive incidents related to a BH condition during inpatient or long-term care
   - Self-endangering behaviors that would result in bodily harm if not prevented
   - Intrusiveness (e.g., rummaging, unawareness of personal boundaries) behaviors that places the individual at risk of assault by others if not prevented
   - Chronic psychiatric symptoms that cause distress to and escalate the individual and/or other residents to crisis if not monitored and redirected by staff
   - Sexual inappropriateness that redirection to maintain safety of the individual and other vulnerable adults
   - A history of any of the above behaviors, which are currently only prevented by additional skilled staff intervention (BHPC)

In addition to the above behaviors, the individual must also meet 2 and/or 3 to qualify:

2. History of being unsuccessful in community living settings, including 1 or more of the following:
   - History of multiple failed stays in residential settings within the past 2 years
   - In imminent danger of losing a current community living setting due to behaviors related to behavioral health conditions
   - Frequent caregiver turnover due to behaviors related to behavioral health condition(s) within past 2 years
3. Past psychiatric history where significant functional improvement has not been effectively maintained due to the lack of CBHS-like services and/or supports, including 1 or more of the following:
   - 2 or more inpatient psychiatric hospitalizations in the last 12 months
   - An inpatient stay in a community hospital (acute or psychiatric) or free-standing evaluation and treatment facility for 30 days or more in the last 12 months, with barriers to discharge related to behavioral health conditions

- Discharge from a state psychiatric hospital or long-term 90/180-day inpatient psychiatric setting in the last 12 months

Outpatient care coordination and case management

Behavioral health treatment agencies must develop policies and procedures that enhance care coordination for members in their care, including transitions between levels of care.

To effectively manage a member's behavioral health and medical care, we require providers to coordinate care with the member's PCP and other care providers before, during and after treatment, based on HIPAA guidelines.

After the initial assessment, provide other treating professionals with the following information within 2 weeks:

- Summary of member's evaluation
- Diagnosis
- Treatment plan summary
- Primary clinician

Outpatient behavioral health agencies must ensure there is adequate coordination for members transitioning between levels of treatment services. This includes coordinating with inpatient or residential providers during the member's stay, for continuity of care and active participation in discharge planning for members enrolled in outpatient services at admission. Outpatient providers should use the rehab case management code for discharge planning services provided while a Medicaid recipient is inpatient. Outpatient providers are responsible to ensure there is a follow-up appointment available for the member within 7 days of discharge, and there is a mechanism for enrolled members to have medications reviewed and refilled in a timely manner.

Outpatient providers should also provide an appointment for service within 7 days of discharge from a residential treatment facility and an ER visit for behavioral health. Outpatient care providers should work with crisis providers for care coordination, and with jail health services if members are incarcerated and need medication or other treatment information to promote continuity of care.

Intensive Outpatient Program and Partial Hospitalization Program

Intensive Outpatient Program (IOP) and Partial Hospitalization Programs (PHP) are covered by UnitedHealthcare Community Plan when provided by a DOH licensed behavioral health agency. Services should be provided in accordance with SERI guidelines and evidence based best practices.

Inpatient and residential services

Psychiatric inpatient facilities

Inpatient psychiatric hospitals and units are required to:

- Notify UnitedHealthcare of discharge at least 24 hours prior to discharge:
  - For an anticipated discharge, no later than 24 hours prior to the planned discharge date; or
  - For all the other discharges, including if the member leaves against medical advice, no later than the date of discharge
  - Engage with UnitedHealthcare and outpatient providers in discharge planning; and
- Educate and connect inpatient members to UnitedHealthcare care coordination to support maintenance of stability post-discharge

It also documents the services they will receive post-discharge. The final discharge plan documents the:

- Discharge date
- Post-discharge services
- Plan to coordinate discharge with the care provider at the next level of care (when indicated)
- Plan to reduce the risk of relapse

UnitedHealthcare Behavioral Health Care Advocates monitor discharge planning. They can help identify and facilitate access to treatment services and community resources. Best practice for discharge planning includes person centered care planning with the member and/or family during treatment, recovery and discharge planning whenever possible.

Inpatient psychiatric hospitals and units required reporting for admission, discharge and transfer notifications

- Use interoperable Health Information Technology (HIT) to create and send admission/discharge/transfer notifications (ADTs) to providers, facilities or practitioners on behalf of members admitted to inpatient psychiatric hospitals and units that have access to HIT/EHRs
- Inpatient psychiatric hospitals and units will have access to or receive the ADTs for tracking and reporting of members who are placed, transferred or discharged from inpatient psychiatric hospitals and units
- Inpatient psychiatric hospitals and units will create and exchange ADTs using the HL7 2.5.1 or later ADT message standard

Substance use disorder residential treatment care providers

- May not deny services to any eligible member based on:
  - Their drug of choice,
  - Use of FDA-approved, medically prescribed medications, and/or
  - Use of over-the-counter nicotine-cessation medications or participation in a nicotine replacement therapy regimen
- Cannot require members to give up custody of minor children to access residential SUD treatment services. If a pregnant member cannot access residential treatment due to lack of capacity and needs withdrawal management, refer them to a Substance Using Pregnant program (SUPP) for admission within 24 hours. Pregnant people are often motivated to improve their physical and behavioral health, making it an opportune time to offer compassionate education on the impact of substance use on the member and their child. If additional support is needed to educate and motivate pregnant members with SUD, refer to the Healthy First Steps program by calling the maternity nurse specialist at **1-800-224-6597**.
- Must refer members to appropriate community services for their substance use, mental health, physical health and/or housing needs after they are discharged from their facility.

  If a member discontinues services, you must document the termination of services and any attempts to help the member transition back to the community.
- Have policies in place to quickly exchange member information between agencies. Please complete a warm hand-off when possible. Document phone numbers and addresses for community-based peer support and recovery resources and provide them to the member when they are discharged. The member or their authorized representative must verify their housing status for you to document. Please refer members to housing and community support services as needed and document this effort in the record.
- If an individual is receiving FDA-approved medications for SUD, providers must document their efforts to obtain housing to fit member needs. At the time of discharge, arrange transportation to appointments and recovery-based housing as needed.
- If a member is discharging from an inpatient facility and has been inducted or continued on FDA-approved medications for SUD, schedule them for a same-day appointment with an outpatient care provider. If a member is discharging from an outpatient setting, help them schedule a follow-up appointment to occur within 7 calendar days of discharge. Members must be provided with sufficient medications until their appointment with a community provider.

Substance use disorder outpatient services

UnitedHealthcare Community Plan will cover assessments and treatment for gambling disorder and problem gambling concern provided by a licensed DOH behavioral health agency. Assessment services must be performed by a DOH licensed and certified practitioner who holds a gambling Counselor Certification as defined in state law, or performed under the supervision of a licensed or certified Gambling Counselor Supervisor.

Discharge planning

Inpatient and residential services require discharge planning. Providers must:

- Coordinate an agreed upon community-based discharge plan for each member beginning at intake, including tribal community resources and services

when applicable. Discharge planning should apply to all members regardless of length of stay or whether they complete treatment.

- Coordinate, as needed, with tribal governments and IHCPs for applicable services, including but not limited to assessment and treatment, education support and early childhood services, vocational or employment services, housing services and supports, and tribal courts
- Help members with their recovery by providing information about their condition, its treatment and self-care resources. The treatment plan helps note realistic and measurable treatment goals as well as the evidence-based treatment that achieve treatment goals.
- Include documenting discharge plans and facilitation to post-discharge services in the member's electronic health record. The following must occur when the member is discharged or transitioned to a lower or higher level of care:
  - Appropriate referrals are made to new or existing behavioral health care providers, along with and in coordination with the UnitedHealthcare Community Plan
  - Follow-up appointments are scheduled to occur within 7 calendar days of member discharge and documented as such in the member's electronic health record
  - Date and time of appointment
  - Any current medications
  - If applicable, sufficient supply and compliance plan for prescribed medications as part of the discharge process
- The member's counselor or a designated outreach coordinator at the facility will follow up with the member by phone, text or email within 72 hours of discharge

Hospitals will take the following actions to prevent the occurrence of a readmission within 14 calendar days of a prior admission:

- Create a discharge summary, including summary of diagnoses, care provided, medication list and follow-up plan
- Determine the member's needs to support a safe discharge and write orders accordingly
- Ensure the discharge summary is sent to the PCP or follow-up provider
- Provide all required prescriptions and educate the member about appropriate use of the medication(s)
- Provide written discharge instructions, accompanied by an explanation, to the member and family/guardian
- Provide appropriate contact telephone numbers to member or family/guardian to call for discharge related questions
- Document clearly in a readable format the content of discussion with UnitedHealthcare Community Plan (call, fax, etc.)

Program evaluation and quality audits

UnitedHealthcare may perform program or other agency audits via encounters, claims, finance or member record reviews to support agencies in high-quality service delivery, and to ensure that all claims or encounters are submitted for services rendered.

We may review member records to help ensure treatment plans are consistent with WAC 388-877-0620 and 388-877A-0135. These reviews help ensure services are appropriate based on diagnosis and based on the patient's needs. Progress notes support each service:

- Timeliness of service
- Cultural, ethnic, linguistic, disability or age-related needs are addressed
- Coordination with PCP
- Adherence to practice guidelines, as relevant
- Processes for reporting, tracking and resolving complaints/grievances
- Compliance with reporting and managing critical incidents
- Information security

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

Oversight of outpatient services

Part of UM involves finding cases where the length or frequency of outpatient behavioral health treatment is higher than most other members with complex clinical needs. When we identify high-outpatient utilization, a licensed clinician calls the treating care provider to start a clinical case discussion. The clinician may schedule a conversation between the treating care provider and a UnitedHealthcare Community Plan-licensed peer reviewer.

Based on member clinical needs and our external clinical guidelines, the peer review discussion may result in either:

- Continued payment of services
- Agreed-upon change in treatment plan
- Fewer approved routine outpatient services

If services are deemed to be not medically necessary, either in part or in whole, you will be notified verbally and in writing. The member will be notified in writing of this decision as well as receive appeal rights.

Substance use disorder best practices

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

Summary of framework

Prevention

- Prevent SUD before it occurs through early intervention, education, community support and evidenced-based care provider practices

Harm reduction

- Access to Naloxone
- Facilitation of the safe use, storage, testing and disposal of substances, medications and equipment used to take substances

Treatment

- Reduced barriers to accessing evidence-based and integrated treatment, including pharmacological management of SUD
- Improved strategic community relationships and approaches to tailor solutions to local resources
- Enhanced solutions for pregnant member and child to prevent neonatal abstinence syndrome and support moms in recovery
- Enhanced data infrastructure and analytics to better identify member needs and measure progress

Recovery

- Supportive case management and referrals to person-centered recovery resources to increase our member's support network

Increasing education and awareness of SUD

The UnitedHealthcare Community Plan Provider Portal offers SUD trainings and resources to help ensure you have the information you need, when you need it. This will assist you in meeting your professional responsibility to be aware of current research and evidence-based clinical practice guidelines.

The UnitedHealthcare Provider Portal offers:

- State-specific Behavioral Health Toolkits that provide access to clinical practice guidelines, free SUD assessments and screening resources, and other important state-specific resources
- Pain Management Toolkits that provide resources to help you identify members who present with chronic physical pain and could benefit from behavioral health services to address the psychological aspects of pain management
- Educational resources, including our Drug Utilization Review Provider Newsletter, which summarizes substance use trends, prescribing and key resources

Access these resources at **UHCprovider.com/pharmacy**. Click "Opioid Programs and Resources – Community Plan" to find a list of tools and education.

Evidence-based MOUD is central to SUD treatment. MOUD 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 SUD.

These services are a medical benefit. Providers billing for MOUD services should use the appropriate medical CPT codes. UnitedHealthcare Community Plan is following the state-outlined requirements and forms for prior authorization for related drugs. For more information, go to hca.wa.gov. You can also call **Provider Services** at **1-877-542-9231**.

To find a behavioral health MOUD care provider in Washington:

1. Go to **UHCprovider.com/findprovider.**
2. Select "Behavioral Health Directory."
3. Click on "Medicaid Plans."
4. Set your location.
5. Type "Medication Assisted Treatment" in the search bar.

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

Participating SUD facilities must offer MOUD on site or facilitate access to off-site providers so members can obtain or be continued on MOUD at any point during treatment. Facilities must adjust medications based on medical necessity when working with the prescribing care provider.

At the time of discharge, the discharging care provider will help ensure continuity of MOUD services for the member, even if the member moves out of the region. Intake appointments should occur within 7 calendar days of discharge unless the member is discharging from an inpatient level of care. In the case of inpatient level of care discharges, schedule the intake appointment for the same day as discharge. The discharging care provider should make sure the member has sufficient medications to last until their appointment with a community care provider or behavioral health treatment agency.

Members may not be denied services for the use of FDA-approved medications for SUD treatment. For more information, please see "Medication for opioid use disorder" in the **Medical management** chapter.

Evidence-based MOUD is central to SUD treatment. MOUD takes a chronic condition approach and incorporates medication use in addition to other services, such as treatment, recovery and resiliency.

Claims

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

Behavioral health supplemental data

Licensed behavioral health agencies are required to report and update BHSD as described in the current version of the HCA's Behavioral Health Supplemental Transaction Data Guide (BHSDG) on hca.wa.gov. Agencies must meet data completion and quality standards as defined by HCA.

- A service episode is required for all SUD and MH outpatient members.
  The service episode is also required when a member enrolls into any program listed in the program ID for a single agency/provider
- Only 1 service episode transaction can be open for a member at an agency at a time
- Once the treatment has ended or has been completed, the service episode is closed (end date reported). If the member comes back for services, a new service episode can be opened for that treatment episode.

You must identify an internal subject matter expert who will serve as a point of contact for BHSD outreach and respond to us or our contracted vendor within 3 business days. Submit supplemental data transactions for services provided to members within 30 calendar days from the date of service or event.

BHSD corrections for data completion are finalized within 30 days of notification, and those related to quality are completed within 21 days of notification. HCA recommends closing episodes of care if no contact with the member has occurred at 45 days for SUD or 90 days for mental health after following guidelines around contacting the member outlined in the data guide.

Chapter 8: Member rights and responsibilities

Key contacts

Topic	Link	Phone number
Member Services	**UHCCommunityPlan.com/wa**	**1-877-542-8997**
Member handbook	**UHCCommunityPlan.com/wa** > Community Plan > Member benefits	

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

Privacy regulations

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

Access to Protected Health Information

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

Amendment of Protected Health Information

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

Accounting of disclosures

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

Right to request confidential communications

Members have the right to request communications from you or us be sent to a separate location or other means. 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.

For information on Washington state's Address Confidentiality Program, go to sos.wa.gov/acp/compliance.aspx.

Member rights and responsibilities

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

Native American and Alaska Native members access to care

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

Member rights

Members have the right to:

- Request information on medical or mental advance directives
- Be treated with respect, dignity and privacy. Discrimination is not allowed. No one can be treated differently or unfairly because of their race, color, national origin, gender, sexual preference, age, religion, creed or disability.
- Receive courtesy and prompt treatment
- Receive cultural assistance, including having a certified interpreter during appointments and procedures
- Receive information about us, their rights and responsibilities, their benefit plan and which services are not covered
- Know the qualifications of their care provider
- Give their consent for treatment unless unable to do so because life or health is in immediate danger
- Refuse treatment directly or through an advance directive
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do
- Receive medically necessary services covered by their benefit plan
- Receive information about in-network care providers and practitioners, and choose one from our network
- See a non-network care provider, if no participating care provider is available, at no cost beyond what they would pay for network services
- Change care providers at any time for any reason
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response
- Tell us their opinions and concerns about services and care received
- Register grievances or complaints concerning the health plan or the care provided
- Appeal any adverse determination or payment we make and get assistance from you
- Review the medical records you keep and request changes and/or additions to any area they feel is needed
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, and talk with you when making decisions about their care
- Get a second opinion with an in-network care provider
- Expect care providers are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage
- Make suggestions about our member rights and responsibilities policies
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply

Member responsibilities

Members should:

- Understand their benefits so they can get the most value from them
- Show you their UnitedHealthcare Community Plan member ID card and ProviderOne card
- Prevent others from using their ID card
- Understand their health problems and give you true and complete information
- Ask questions about treatment
- Work with you to set treatment goals
- Follow the agreed-upon treatment plan
- Get to know you before they are sick
- Keep appointments or tell you when they cannot keep them

- Treat your staff and our staff with respect and courtesy
- Get any approvals needed before receiving treatment
- Use the ER only during a serious threat to life or health
- Notify us of any change in address or family status
- Make sure you are in-network
- Follow your advice and understand what may happen if they do not follow it
- Give you and us information that could help improve their health

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

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

Chapter 9: Medical records

Medical record charting standards

You are required to keep complete and orderly medical records, on paper or electronic format, which fosters efficient and quality member care. Members or their representative are entitled to 1 free copy of their medical record. Additional copies may be available at member 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 are required for lifetime).

You are subject to our periodic quality medical record review. The review could include any of the following items to determine compliance:

Topic	Contact
Confidentiality of record	Office policies and procedures exist for: • Privacy of the member medical record • Initial and periodic training of office staff about medical record privacy • Release of information • Record retention • Availability of medical record if housed in a different office location • Process for notifying UnitedHealthcare Community Plan upon becoming aware of a patient safety issue or concern • Coordination of care between medical and behavioral health care providers
Record organization and documentation	• Have a policy that provides medical records upon request. Urgent situations require you to provide records within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing Medical records. • Release only to entities as designated consistent with federal requirements • Keep in a secure area accessible only to authorized personnel

***Critical element**

Topic	Contact
Procedural elements	**Medical records are readable*** • Sign and date all entries • Member name/identification number is on each page of the record • Document language or cultural needs • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member's first language is something other than English • Procedure for monitoring and handling missed appointments is in place • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions*
History	An initial history (for members seen 3 or more times) and physical is performed. It should include: **Medical and surgical history*** • A family history that includes relevant medical history of parents and/or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance abuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults • Screenings of/for: – Recommended preventive health screenings/tests – Depression – High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit – Medicare members for functional status assessment and pain – Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

***Critical element**

Topic	Contact
Problem evaluation and management	Documentation for each visit includes: • Appropriate vital signs (measurement of height, weight and BMI annually) – Chief complaint* – Physical assessment* – Diagnosis* – Treatment plan* • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines • Documentation of all elements of age-appropriate federal EPSDT • Clinical decisions and safety support tools are in place to ensure evidence-based care, such as flow sheets • Treatment plans are consistent with evidence-based care and with findings/diagnosis: – Time frame for follow-up visit as appropriate – Appropriate use of referrals/consults, studies and tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review • There is evidence of care provider follow-up of abnormal results • Unresolved issues from a previous visit are followed up on the subsequent visit • There is evidence of coordination with behavioral health care provider • Education, including lifestyle counseling, is documented • Member input and/or understanding of treatment plan and options is documented • Copies of hospital discharge summaries, home health care reports, emergency room care and practitioner are documented

***Critical element**

Medical record review

On a routine 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	Contact information
Credentialing	Medical: Network Management support team Chat with a live advocate 7 a.m.–7 p.m. CT at **UHCprovider.com/chat.** Chiropractic: **myoptumhealthphysicalhealth.com**	Chat support can help with claims, prior authorizations, credentialing and member benefits.
Fraud, waste and abuse (payment integrity)	**uhc.com/fraud**	**1-844-359-7736**

What is the Quality Improvement program?

The UnitedHealthcare Community Plan comprehensive Quality Improvement program falls under the leadership of the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO). A copy of our Quality Improvement program is available upon request.

The program consists of:

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

As a participating care provider, you may offer input through representation on our Provider Advisory Committee.

Cooperation with quality-improvement activities

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

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

We require your cooperation and compliance to:

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

Care provider satisfaction

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

- Annual care provider satisfaction surveys
- Regular visits

- Town hall meetings

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

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

Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. We respect our network care providers. We appreciate the collaboration to promote better health, improve health outcomes and lower overall costs to offer our members. You are encouraged to visit **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 Washington statutes and the NCQA. The following items are required to begin the credentialing process:

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

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

Credentialing and recredentialing process

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

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- 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

Health facilities

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

Facilities must meet the following requirements or verification:

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

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

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

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

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. Once the completed credentialing application is received, the committee will decide within 60 calendar days. Written notification will be sent to you within 15 calendar days of the decision.

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.

Once the completed recredentialing application is received, the committee decide within 60 calendar days. Written notification will be sent to you within 15 calendar days of the decision.

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 your credentialing application status. Please chat with a live advocate 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
P.O. Box 31361
Salt Lake City, UT 84131-0361

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

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

Transactions and code sets

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

Unique identifier

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

National Provider Identifier

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

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

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

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

Ethics and integrity

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

Compliance program

As a segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Community Plan Compliance program incorporates the required 7 elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

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

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

Reporting and auditing

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

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

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 Washington Apple Health 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 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 Washington program standards.

You must cooperate with the state or any of its authorized representatives, HCA, CMS, the Office of Inspector General, General Accountability Office, the Office of Management and Budget, 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 agreement must include all requirements of your applicable Provider Agreement and this manual.

In addition to UnitedHealthcare Community Plan's termination rights under your Provider Agreement, UnitedHealthcare Community Plan has the right to revoke any functions or activities UnitedHealthcare Community Plan delegates to you under your Provider Agreement, or impose sanctions consistent with UnitedHealthcare Community Plan's contract if, in UnitedHealthcare Community Plan's reasonable judgment, your performance under the Provider Agreement is inadequate. UnitedHealthcare Community Plan has the right to suspend, deny, refuse to renew or terminate you in accordance with the terms of the state contract and applicable law and regulation.

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of care (QOC) and services concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to ensure 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

Tax credits are available for certain care providers who complete physical improvements to meet ADA accessibility standards. These care providers must qualify as small businesses with up to 30 full-time employees or less than $1 million in gross revenue. These credits range from $250 to $10,250. Tax deductions are available up to $15,000 per year for expenses associated with the removal of barriers. We may conduct periodic site visits to identify PCP offices that meet ADA standards. If a PCP is planning to relocate an office, we may perform a site visit before members receive care at the new location.

Criteria for site visits

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

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

Chapter 11: Billing and submission

Key contacts

Topic	Link	Phone number
Behavioral health invoicing	**wa_imc_finance@uhc.com**	**1-877-542-9231**
Claims	**UHCprovider.com/claims**	**1-866-633-4449**
NPPES	nppes.cms.hhs.gov	1-800-465-3203
EDI	**UHCprovider.com/edi**	**1-866-633-4449**

Our claims process

UnitedHealthcare Community Plan follows the same claims process as UnitedHealthcare.

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

For a complete description of the process, go to **UHCprovider.com/guides** > View Guide > Our Claims Process chapter.

Bill all behavior health claims based on the HCA's IMC Service Encounter Reporting Instructions (SERI) on hca.wa.gov > Billers, providers, and partners > Program information for providers > Behavioral health and recovery > Contractor and provider resources > Service Encounter Reporting Instructions (SERI).

National Provider Identifier

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

If you have not applied for an NPI, contact NPPES. Once you have an identifier, report it to UnitedHealthcare Community Plan, call **Provider Services** at **1-877-542-9231**. Your clean claims must include your NPI and federal TIN.

Claims process from submission to payment

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

General billing guidelines

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

Fee schedule

Reimbursements depend on the fee schedule attached to your contract and the procedure performed.

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.

Administrative days

Administrative days are days of an inpatient hospital stay when an acute inpatient or observational level of care is no longer medically necessary. When billing for administrative days, please bill on a separate claim using appropriate revenue codes. A separate authorization for the administrative days is required in addition to the initial acute care or observation level of care authorization(s).

Claims for administrative days for patients waiting to be discharged to home or to a location other than an SNF require the appropriate discharge reason. However, they do not require an occurrence span code.

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 CMS 1500 and UB-04 claim forms.

Use the CMS 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services.

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

Washington state Medicaid prepayment and case rate invoicing, encounter and reimbursement guidance

The following requirements supersede those outlined in our prepayment and case rate Agreement and Amendments as of the date of this publication.

When UnitedHealthcare Community Plan reimburses for Washington State Apple Health (Medicaid) members using a prepayment and/or case rate payment methodology, the following instructions apply.

Invoicing for prepayment

- Submit a monthly invoice by the 30th calendar day following the end of the service month for all behavioral health services covered under the prepayment methodology
- For "Monthly Population-Based Payment": Detail on the invoice each program and UnitedHealthcare Community Plan proportional share of utilization as applicable. Provide a list of members served by each program.
- For "Per Member Per Month Payment": Detail on the invoice each demographic group as applicable as well as the per member per month (PMPM) rate for each demographic group. Also provide a list of members in each demographic group/ZIP code
- Submit a UnitedHealthcare Community Plan-issued invoice template using our form to **wa_imc_finance@uhc.com**

Invoicing for case rates

- Case rates are on a per unduplicated member per month basis for members served for the particular case rate
- Case rates are all-inclusive of professional services
- Submit all invoices by the fifth calendar day following the end of the service month to **wa_imc_finance@uhc.com**
- Submit encounter data for each UnitedHealthcare Community Plan member for which the case rate is paid as described in the invoicing section

Encounter submission for prepayment and case rates

- For services contracted using prepayment or case rate reimbursement, submit service encounter data for each service rendered during the service month.
- Report encounters monthly and within 30 days from the end of each month. For example, if you render services in January, the encounter data is due by March 1. We will reject original encounters received beyond this time limit. In addition to the reporting frequency for original encounters, we will reject revised encounters submitted more than 180 days beyond the original date of service.
- If you do not submit encounter data within this time frame, UnitedHealthcare Community Plan may take corrective action. This may include withholding future payment or terminating the contract.

Certification of encounter data

You are responsible for providing complete, accurate and timely encounter information. All care providers must implicitly attest to the accuracy and completeness of their submitted encounter data with each file upload. We may perform routine medical record chart audits to verify the completeness and accuracy of the encounter submissions.

Payment reconciliation of prepayment

- Only accepted encounters are used in the valuation of services rendered by each care provider against prepayments made by UnitedHealthcare Community Plan
- We make reconciliation payments for each quarter. If a care provider's agreement or amendment begins before the next regular quarter, the reconciliation will not occur until after the close of the next regular quarter.
- Within 120 days after the end of each calendar quarter, we reconcile prepayment amounts to accepted encounters. We apply a relativity factor to the published unit cost for each code. The relativity factor will be derived based on the average variance between the reimbursement for all care providers in the service area and the published unit cost-weighted by the utilization from the previous calendar year. The factor is updated only once per calendar year. Rates are developed individually for the following 3 service areas and are applicable to services rendered by care providers within the respective service area:
  - Pierce
  - North Sound
  - Salish, Thurston-Mason and Great Rivers
- After the quarterly reconciliation, if our quarterly prepayment amount is less than the value of the services rendered, we reimburse the care provider in the next monthly prepayment. If the value of services is less than the quarterly total of payments we made to the care provider, we withhold the overpayment and prorate it over the next 3 monthly prepayments.

Clean claims and submission requirements

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

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

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

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

Care provider coding

UnitedHealthcare Community Plan complies with 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 Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) at **UHCprovider.com/guides**. You can also visit **UHCprovider.com/protocols**. Under Additional Resources, choose **Protocols** > Social Determinants of Health ICD-10 Coding Protocol.

Date spans

Exact dates of service are required when the claim spans a period of time. Please indicate the specific dates of service in Box 24 of the CMS 1500, Box 45 of the UB-04, or the Remarks field. This will eliminate the need for an itemized bill and allow electronic submission.

Electronic claims submission and billing

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

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

For more information, contact **EDI Claims**.

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. These documents should be shared 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 for help with online billing, claims, Electronic Remittance Advices (ERAs) and Electronic Funds Transfers (EFTs).

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

To find out more about EDI online, go to **UHCprovider.com/edi.**

Electronic payment solution: Optum Pay

UnitedHealthcare 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 AHC/direct deposit from Optum Pay™ or receiving Virtual Cards there is no action you need to take
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Library
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

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

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on **UHCprovider.com/EDI**.

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

Claim form reminders

- Include the following on all claim forms:
  - Member's name, Medicaid ID number and date of birth
  - Your federal TIN
  - Your NPI (unique NPIs for rostered clinicians)
- Use nationally recognized CMS Correct Coding Initiative (CCI) standards
- Note the attending care provider name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims
- Send the referring care provider NPI and name on outpatient claims when this care provider is not the attending physician
- Include the attending care provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims
- Behavioral health care providers can bill using multiple site-specific NPIs

Subrogation and coordination of benefits

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

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

All other health insurance, including Medicare and Tricare, are primary over Medicaid. Medicaid is only primary to any Tribal Health coverage unless the member is employed by a tribe and is self-insured. When billing UnitedHealthcare Community Plan, submit the primary payer's Explanation of Benefits (EOB) or remittance advice with the claim.

HCA enrolls some FFS Apple Health members who have other primary health insurance. HCA covers some members under the FFS Apple Health program, such as dual-eligible members whose primary insurance is Medicare.

This means:

- Affected members will have 3 ID cards: a ProviderOne card, a primary insurance card and a UnitedHealthcare Community Plan card
- You must verify eligibility. To verify member COB, please verify with UnitedHealthcare, not ProviderOne.
- If you bill us as a secondary payer, we will not require prior authorization. However, if the member's primary health insurance does not cover the service, you must follow our requirements.
- When COB payment is equal to or more than the allowable rate, the primary insurance has no patient responsibility, and the claim is paid in full, we require no additional payment
- When COB payment is equal to or less than allowable rate with a patient responsibility from the primary insurance, we reimburse the patient responsibility up to the allowable rate
- When the COB payment is less than primary's allowable rate for services performed, we pay for the difference between the primary payment and our allowable rate
- Claims received with pediatric preventive, private duty nursing procedure codes and ABA procedure codes follow our Pay & Chase policy
- We may bill or adjust claims with COB within 30 months of the initial process date
- We pursue, negotiate and settle TPL/subrogation recoveries

We will terminate COB/TPL information in our system for any member identified with good cause so claims process as primary.

Opioid treatment benefit

As of Jan. 1, 2020, CMS covers opioid treatment benefit (OTP) services for Medicare certified OTP providers. These services are codes G2067–G2080. These services include MOUD, toxicology testing and counseling as authorized under SUPPORT Act and final rule CMS-1715-F.

UnitedHealthcare Community Plan may have these members dually enrolled in our Medicare DSNP and our BHSO Medicaid plans. UnitedHealthcare Community Plan will coordinate and crosswalk any claims billed for OTP services with a Medicare EOB attached to their claims to their Medicaid coverage, as appropriate.

We will continue to pay as primary while care providers are enrolling with Medicare. You need to notify UnitedHealthcare Community Plan upon Medicare-approved enrollment.

Medicare crossover claims

The Apple Health (Medicaid) program requires additional information to successfully submit Medicare crossover claims through direct data entry for professional claims. You must enter Medicare information at both the claim level and the line level. When entering Medicare information at the claim level, check that the amounts entered are the sum of the amounts entered at the line level.

Behavioral health services only coverage for professional services

Billing for Behavioral health services only members

If the member is covered by the Behavioral health services only (BHSO) plan, the HCA ProviderOne system determines if payment responsibility belongs to HCA or the MCO (medical or behavioral health). For professional services, payment is based off billing taxonomy.

UnitedHealthcare Community Plan reimburses Community Mental Health Center providers with taxonomies 251S00000X or 261QM0801X. The MCO pays the following SUD services billing taxonomies:

- 261QR0405X
- 261QM2800X
- 324500000X
- 3245S0500X
- 261QM3000X
- 2083P0901X

For other billing taxonomies HCA considers to be for lower acuity services, claims will process and pay as a medical claim regardless of diagnosis. Bill these directly to HCA.

Hospital and clinic method of billing professional services

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

Global days

Global days include the billable period involving pre-operative visits, the procedure itself and post-operative visits in which the care provider performs all necessary services. The visits must be performed by the same 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 CCI and other nationally recognized sources.

Comprehensive and component codes

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

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

Evidence-based practice codes

Evidence-based practice (EBP) codes are identifiers on a claim or encounter used in research to improve children's public mental health care provided by licensed or certified mental health care providers to children ages 18 and younger in Washington.

The rules for coding and submitting EBPs under Apple Health IMC are:

- Report the EBP code as a 9-digit number beginning

with 860. The next 3 digits must represent the appropriate EBP code as outlined in the Evidence-Based Practices Reporting Guide. The last 3 digits must be reported as 000. Example: Use 860163000 when reporting Child-Parent Psychotherapy.

- Report one EBP code per encounter in the 2300 REF02 Prior Authorization field of the standard 837 file submission
- Include the G1 qualifier (prior authorization) in the REF01 field
- Include the 9-digit EBP code in the REF02 field Example: REF*G1*860163000

Please review the Evidence-Based and Research-Based Practices page on hca.wa.gov for reporting guides and other resource information.

Clinical Laboratory Improvements Amendments

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

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. For more information about the CLIA number, contact the CMS CLIA Central Office at 1-253-395-6745 or go to the cms.gov.

Billing multiple units

When billing multiple units:

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

Billing guidelines for obstetrical services

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

- If billing for both delivery and prenatal care, use the date of delivery
- Use 1 unit with the appropriate charge in the charge column

Billing guidelines for transplants

The Department of Health and Human Services covers medically necessary, non-experimental transplants. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation. Gather all required referrals and evaluations to complete the pre-transplant evaluation process once the member is a possible candidate.

National Drug Code

Claims must include:

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

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

Medical necessity

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

Place of Service codes

Go to cms.gov for Place of Service codes.

Asking about a claim

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

Provider Services

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

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

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

UnitedHealthcare Community Plan Provider Portal

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

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

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

You can even customize the screen to put these common tasks just one click away. See more in **Chapter 1**.

Resolving claim issues

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

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 31361
Salt Lake City, UT 84131-0361

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

Paper claims

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

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

Timely filing

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

- A denial/rejection letter from another carrier
- Another carrier's 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 submit the claim within the timely filing period from the date on the other carrier's correspondence. If we receive the claim after the timely filing period, it will not meet the criteria.

If a claim is rejected, and corrections are not received within 90 days from date of service or close of business from the primary carrier, the claim is considered late billed. It will be denied timely filing.

Washington requires claims be filed within 365 days from the date of service.

Additional member billing

In most cases, you cannot bill a member for services. Situations when a member can and cannot be billed for services are contained in Washington Administrative Code (WAC) 182-502-0160 "Billing a client." If the WAC requirements for billing a member are met, in most cases, you and the member must sign and date the **Agreement to Pay for Healthcare Services – HCA form 13-879** before the services are rendered. There are limited circumstances when you may bill a member without the executed Agreement to Pay for Healthcare Services form. See WAC 182-502-0160 for complete information.

Third-party resources

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

Chapter 12: Provider claim reconsiderations and appeals; member appeals and grievances

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

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

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

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider claim 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** P.O. Box 31361 Salt Lake City, UT 84131-0361	N/A	**1-877-542-9231**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**.	24 months from initial process date	30 business days
Care provider claim reconsideration (step 1 of dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care provider	Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at the following address: **UnitedHealthcare Community Plan** P.O. Box 31361 Salt Lake City, UT 84131-0361	N/A	**1-877-542-9231**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**.	24 months from initial process date	45 business days
Care provider claim formal appeal (step 2 of dispute)	A review when you do not agree with how a claim was paid.	Care provider	Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at the following address: **UnitedHealthcare Community** Plan Provider Grievances P.O. Box 31364 Salt Lake City, UT 84131-0364	N/A	**1-877-542-9231**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**.	24 months from initial process date	45 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 Provider Grievances P.O. Box 31364 Salt Lake City, UT 84131-0364	N/A	**1-866-815-5334**	N/A	120 business days	30 business days

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Member appeal	A request to change an adverse benefit determination that we made.	• Member or authorized representative • Care provider on behalf of a member with written member consent • For expedited provider request on behalf of the member, member's oral consent can be used.	Mail to: **UnitedHealthcare Community Plan** Appeals and Grievances P.O. Box 31364 Salt Lake City, UT 84131-0364 Members can also submit online: Log in to **myuhc.com**, then click the Grievance and Appeal tile on their home page.	N/A	**1-877-542-8997**	N/A	Standard and Expedited appeals – within 60 calendar days	Expedited appeals – within 72 hours Standard appeals – 14 calendar days; up to 28 days with approved extension
Member grievance	A member's written or oral expression of dissatisfaction about any matter other than an adverse benefit determination.	• Member • Care provider on behalf of a member with written member consent	Mail to: **UnitedHealthcare Community Plan** Appeals and Grievances P.O. Box 31364 Salt Lake City, UT 84131-0364 Members can also submit online: Log in to **myuhc.com**, then click the Grievance and Appeal tile on their home page.	N/A	**1-877-542-8997**	N/A	N/A	Within 45 calendar days

The prior 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 care providers may agree to more stringent requirements within provider contracts than described in the standard process.

Provider claim denials

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

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

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

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

Other top reasons for denial include:

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

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

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

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

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

Warning! A denied claim has been through claim processing and we determined it cannot be paid. You may appeal a denied claim by submitting the corrected claim information or appealing the decision. See **Claim correction and reconsideration** sections of this chapter for more information or learn about denial versus rejection at therabill.zendesk.com.

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. Resubmit the corrected claim within 24 months of the initial process date. Resubmit a COB claim with the EOB within 30 months from initial process date.

How to use:

Use the claims reconsideration application on our portal. Sign in to **UHCprovider.com** using your One Healthcare ID.

Most care providers in your state must submit appeals requests electronically.

For further information on appeals, see the **Reconsiderations and Appeals interactive guide**.

For those care providers exempted from this requirement, requests may be submitted at the below address: You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Mailing address:

UnitedHealthcare Community Plan
P.O. Box 31361
Salt Lake City, UT 84131-0361

Additional information:

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

Resubmitting a claim

What is it?

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

When to use it:

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

Common reasons for rejected claims:

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

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

How to use:

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

Most care providers in your state must submit reconsideration requests electronically.

For further information on claims, see the **Reconsiderations and Appeals interactive guide.**

For those care providers exempted from this requirement, requests may be submitted at the following address: To mail your resubmission, provide all claim information to:

UnitedHealthcare Community Plan
P.O. Box 31361
Salt Lake City, UT 84131-0361

Claim reconsideration

What is it?

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

When to use:

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

For administrative denials:

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

For medical necessity denials:

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

How to use:

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

- **Electronically:** Most care providers in your state must submit reconsideration requests electronically.
  - Go to **UHCprovider.com**, find and select the claim, under Act on Claim section select "Create Claim Reconsideration" and complete requested information. Include electronic attachments. When submitting electronically, you do not need to attach the Claim Reconsideration Request Form.
  - You may also check your status using the UnitedHealthcare Provider Portal
  - For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide**
- For those care providers exempted from the electronic submission requirement, the following options are also available:
  - **Phone:** Call Provider Services or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.
  - **Mail:** Submit the Claim Reconsideration Request Form to:

    UnitedHealthcare Community Plan
    P.O. Box 31361
    Salt Lake City, UT 84131-0361

    This form is available at **UHCprovider.com/claims**.

Tips for successful claims resolution

To help process claim reconsiderations:

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

Valid proof of timely filing documentation (reconsideration)

What is it?

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

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

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

How to use:

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

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

Additional information:

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

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	$27.19	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

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

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

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

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

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

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

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

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

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

If you do not agree with the overpayment findings, submit a dispute within the required 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 **Dispute** section in this chapter.

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

Provider claim appeals

What is it?

A claim appeal is a review of how a claim was paid. 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, use the claim appeal process.

How to use/file:

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

- **Electronic claims:** Use the Claims Management tool on our UnitedHealthcare Provider Portal. You may upload attachments.
- Most care providers in your state must submit reconsideration requests electronically
  - For further information on appeals, see the **Reconsiderations and Appeals interactive guide**
  - For those care providers exempted from this requirement, requests may be submitted at the following address:

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

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

Care provider grievance

What is it?

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

When to file:

You may file a grievance about:

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

How to file:

File verbally or in writing.

- **Phone:** Call Provider Services at **1-877-542-9231**
- Most care providers in your state must submit reconsideration requests electronically
  - For further information on grievances, see the **Reconsiderations and Appeals interactive guide**
  - For those care providers exempted from this requirement, requests may be submitted at the address below:
- **Mail:** Send care provider name, contact information and your grievance to:

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

You may only file a grievance on a member's behalf with their written consent. See Member appeals and grievances definitions and procedures.

Member appeals and grievances

See the Glossary of this document for the definitions of appeal, grievance, and adverse benefit determination.

Member appeals

What is it?

An appeal is a review UnitedHealthcare Community Plan performs of any adverse benefit determination, including prior authorization denials.

When to use:

If a member receives an adverse benefit determination, you may submit an appeal on the member's behalf with their written consent. You may provide medical records and supporting documentation as appropriate.

Where to send:

A member appeal must be submitted to UnitedHealthcare Community Plan within 60 calendar days from the date of the adverse benefit determination letter.

Mail to:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 8413-0364

Phone: Call Member Services toll-free: **1-877-542-8997**

Online: Member can log in to **myuhc.com** and click on Grievance and Appeal tile on their home page.

How to use:

When UnitedHealthcare Community Plan denies a service, we must provide the member with their Apple Health IMC 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
- 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 an appeal. If continuation of services is necessary, the appeal must be filed within 10 calendar days of the date the notice of benefit determination was mailed. However, the member may have to pay for the cost of the Medicaid benefits received for the first 60 calendar days after the appeal or hearing request was received if the service is continued or if the member should not have received the service. As the provider, you cannot ask for a continuation. Only the member may do so.

For standard appeals, UnitedHealthcare Community Plan will make a decision within 14 calendar days from the date we receive the appeal, unless an extension is requested. The extension cannot delay the decision beyond 28 calendar days from the date of the appeal request.

The member can request an extension, or UnitedHealthcare can request an extension. If we request the extension, we will call the member to let them know how the delay is in their best interest, and we will also notify the member in writing.

For expedited appeals, we will make a decision within 72 hours from the date we receive the appeal.

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 QOC or service concerns and aspects of interpersonal relationships, such as a care provider's or employee's rudeness.

When to use:

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

Where to send:

Mail to:

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

Phone: Call Member Services toll-free: **1-877-542-8997**

We will send an answer no longer than 45 calendar days from the date the complaint or grievance was filed.

Member administrative hearings

What is it?

An administrative hearing is an adjudicative proceeding before an administrative law judge or a presiding officer governed by Chapter 34.05 RCW, the agency's hearings rules found in Titles 388 or 182 WAC, or other law. It lets members share why they think Washington Medicaid services should not have been denied, reduced or terminated.

When to use:

If a member does not agree with UnitedHealthcare Community Plan's resolution of their appeal, they can request an administrative hearing.

Only members or their authorized representative may request a hearing. A provider may not request a hearing on the member's behalf. Members have 120 days from the date of the appeal resolution letter to ask for a hearing. At that point, they will be mailed a hearing form. Once they complete the form and send it back, we set a hearing date.

How to use:

UnitedHealthcare Community Plan members may ask for an administrative hearing by writing a letter to:

Office of Administrative Hearings
P.O. Box 42489
Olympia, WA 98504-2489

They may also call 1-800-583-8271.

- The member may have someone represent them at the hearing. This may be a family member, friend, care provider or lawyer. Written consent is required.
- Hearings are held on the phone

Member request for independent review organization

An independent review is a review a by doctor or specialist at a certified independent review organization (IRO). The doctors or specialists do not work for UnitedHealthcare Community Plan.

If a member does not agree with the decision from their administrative hearing, they can ask for an independent review. The request must be made within 21 calendar days of the administrative hearing decision.

No later than 3 business days from receipt of the IRO notice, by a certified IRO, our appeals representative will forward with the case file, including the member's written request for hearing, copies of the entire appeal file with supporting documentation (i.e., pertinent findings and medical records), a copy of the Notice of Appeal Resolution, and other information relevant to the appeal. This includes any transcripts, records or written decisions from participating care providers or delegated entities to the IRO.

Member petition for review by the Board of Appeals

The HCA Board of Appeals (BOA) reviews administrative hearing decisions issued by administrative law judges at the OAH and IROs. BOA review judges are attorneys who review hearing decisions for legal and factual errors, and change the decisions as necessary. All BOA review judges are members of the Washington State Bar Association.

To request a review by HCA's Board of Appeals, the member must contact the HCA Board of Appeals within 21 calendar days of the date on the administrative hearing decision letter (if member decided to skip the independent review option), or within 21 calendar days of the date on the IRO decision letter.

Call: 1-844-728-5212

or

Write to:

HCA Board of Appeals
P.O. Box 42700
Olympia, WA 98504-2700

The decision by the BOA review judge is final.

Processes related to reversal of our initial decision

If the administrative hearing, IRO or petition for review reverses a decision to deny, limit or delay services not provided while the appeal was pending, we authorize or provide the disputed services as quickly as the member's health condition requires. If the decision reverses denied authorization of services and the disputed services were received pending appeal, we pay for those services as specified in policy and/or regulation.

Fraud, waste and abuse

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

Within 5 business days of learning of the allegation, report the incidents to HCA at hottips@hca.wa.gov. Or email the Medicaid Fraud Control Unit, Office of Attorney General at mfcureferrals@atg.wa.gov.

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.

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

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

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

Whistleblower and whistleblower protections

The federal False Claims Act and State of Washington Medicaid Fraud False Claims Act permit private citizens with knowledge of fraud against the U.S. government or state government to file suit on behalf of the government against the person or business that committed the fraud.

Individuals who file such suits are known as a "qui tam" plaintiff or "whistleblower." The federal False Claims Act and State of Washington Medicaid Fraud False Claims Act prohibit retaliation filing or participating in a whistleblower action.

Fraud and whistleblower complaints should be reported to HCA at hottips@hca.wa.gov or by calling 1-833-794-2345.

UnitedHealthcare expressly prohibits retaliation against those who, in good faith, report or participate in the investigation of compliance concerns, or who, in good faith, investigate, file or participate in a whistleblower action.

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**	**1-877-542-9231**
News	**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:

- **Chat support available**
  Have a question? Skip the phone and chat with a live service advocate when you sign in to the **UnitedHealthcare Provider Portal.**
  Available 7 a.m.–7 p.m. CT, Monday–Friday, chat support can help with claims, prior authorizations, credentialing and member benefits
- **UHCprovider.com:** This public website is available 24/7 and does not require registration to access. You'll find valuable resources, including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.
- **UHCprovider.com/wacommunityplan:** The UnitedHealthcare Community Plan of Washington page has state-specific resources, guidance and rules
- **Policies and protocols: UHCprovider.com/policies** > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols
- **Social media:** Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics
  - Facebook
  - Instagram
  - LinkedIn
  - YouTube
  - X (formerly Twitter)
- **Washington health plans: UHCprovider.com/wa** is the fastest way to review all of the health plans UnitedHealthcare offers in Washington. To review information for another state, use the drop-down menu at **UHCprovider.com/plans**. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **UnitedHealthcare Community & State newsletter:** Stay current on the latest insights, trends and resources related to Medicaid. **Sign up** to receive this twice-a-month newsletter.
- **UnitedHealthcare Provider Portal**
  This secure portal is accessible from **UHCprovider.com. I**t 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 care provider group to deliver face-to-face support. We do this to create program awareness, promote compliance and problem resolution.

If you don't know who your provider advocate is, chat with a live advocate 7 a.m.–7 p.m. CT at **UHCprovider.com/chat**.

Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for Provider Services 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.

State forms and websites

Find the following forms online:

- Sterilization Consent Form on hhs.gov
- Informed Consent for Hysterectomies Form on hca.wa.gov
- Core Provider Agreement (HCA 09-015) on hca.wa.gov

Glossary

AABD

Assistance to the aged, blind and disabled

Abuse (by 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 physician 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

Administrative hearing

An adjudicative proceeding before an administrative law judge or a presiding officer that is governed by chapter 34.05 RCW, and the agency's hearings rules found in chapter 182-526 WAC, or other law

Advance directive

A written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the state of Washington, relating to the provision of health care when an individual is incapacitated (WAC 182-501-0125, 42 C.F.R. § 438.3, 438.10, 422.128, and 489.100)

Adverse benefit determination

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit;
2. The reduction, suspension or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service, except when the denial of payment is solely because the claim does not meet the definition of a "clean claim" (42 C.F.R. § 447.45(b));
4. The denial of request for "good cause" designation that would preclude usual third-party liability procedures;
5. The failure to provide services or act in a timely manner as required herein, including failure to issue an authorization or denial within required time frames;
6. The failure of the contractor to act within the time frames for resolution and notification of appeals and grievances;
7. The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other enrollee financial liabilities; and
8. For a rural area resident with only 1 MCO available, the denial of an enrollee's request under 42 C.F.R. § 438.52(b)(2)(ii) to obtain services outside the Contractor's network; or, for a plan's denial of coverage by an out-of-network care provider when the in-network care providers do not have the needed training, experience and specialization; or do not provide the service the enrollee seeks, when receiving all care in-network would subject the enrollee to unnecessary risk, or when other circumstances warrant out-of-network treatment.

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, which a member gets in the hospital

Appeal

UnitedHealthcare Community Plan review of an adverse benefit determination

Apple Health

A health insurance program for eligible Medicaid recipients under Title XIX of the SSA

Authorization

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

Billed charges

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

Business day

Monday–Friday, 8 a.m.–5 p.m. PT, except for holidays observed by the state of Washington

Case manager

The individual responsible for coordinating the overall service plan for a member in conjunction with the member, the member's representative and the member's PCP

Centers for Medicare & Medicaid Services

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

Children's Health Insurance Program

CHIP – a program that provides access to medical care for children under Title XXI of the Social Security Act, the Children's Health Insurance Program Reauthorization Act of 2009, RCW 74.09.470 and chapter 182-505 WAC

Children with special health care needs

CSHCN – children younger than 19 years who are any one of the following:

- Eligible for Supplemental Security Income (SSI) under Title XVI of the Social Security Act
- Eligible for Medicaid under section 1902(e)(3) of the act
- In foster care or other out-of-home placement
- Receiving foster care or adoption assistance
- Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V of the Social Security Act

Clean claim

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

Community Service Office

CSO – an office under HCA that administers social and health services and determines eligibility for benefits at the local community level

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.

Contracted services

Covered services provided by UnitedHealthcare Community Plan under the terms of our contract with HCA and as outlined in the Medicaid State Plan

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

Core Provider Agreement

A basic contract that HCA holds with medical care providers serving HCA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Covered services

Health care services HCA determines are covered for enrollees

Credentialing

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

Current procedural terminology code

CPT code – a code assigned to a task or service a 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.

Department of Children, Youth and Families

DCYF – the Washington State agency responsible for keeping Washington children safe, strengthening families and supporting foster children in their communities

Disallow amount

Amt – medical charges for which the network care 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

Care provider claim reconsideration: Step 1 when a care provider disagrees with the payment of a service, supply or procedure

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

Department of Social and Health Services

DSHS – is the Washington state agency responsible for providing a broad array of health care and social services. DSHS administrations with which the contractor may interface include:

- Aging and Long-Term Support Administration – responsible for providing a safe home, community, and nursing facility array of long-term supports for Washington citizens
- Developmental Disabilities Administration – responsible for providing a safe, high-quality array of home, community, and facility-based residential services and employment support for Washington citizens with disabilities
- Behavioral Health Administration (BHA) – responsible for providing mental health services in state psychiatric hospitals

Dual coverage

When a member is enrolled with 2 UnitedHealthcare Community Plan plans at the same time

Durable medical equipment

DME – medical equipment and appliances, and medical supplies as defined in WAC 182-543-1000

The equipment:

- Is primarily and customarily used to serve a medical purpose
- Is generally not useful for a person in the absence of illness or injury
- Can withstand repeated use
- Can be reusable or removable
- Is suitable for use in any setting where normal life activities take place

Medical supplies are:

- Consumable or disposable or cannot withstand repeated use by more than 1 person
- Required to address an individual medical disability, illness or injury

- Suitable for use in any setting that is not a medical institution and in which normal life activities take place
- Generally not useful to a person in the absence of illness or injury

Early and Periodic Screening, Diagnostic, and Treatment

EPSDT – comprehensive screening, diagnostic and treatment services for children younger than 21 years, as defined in Section 1905(r) of the Social Security Act (SSA), codified in 42 C.F.R § 441.50-441.62, and chapter 182-534 WAC and described in the HCA EPSDT and Provider Billing Guide

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

Emergency medical condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part (42 C.F.R. § 438.114(a))

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

An eligible client enrolled in managed care through an MCO having a contract with HCA (42 C.F.R. § 438.2). "Enrollee" is interchangeable with the term "member." Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber.

Enrollment

The process whereby a person is determined eligible to receive Medicaid or Medicare benefits and becomes a 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

Federally Qualified Health Center

FQHC – a community-based organization that provides comprehensive primary care and preventive care, such as health care, dental and behavioral health/substance abuse services to people of all ages, regardless of their ability to pay or health insurance status

Fee-for-service

FFS – a method of payment to care providers on an amount-per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule

FHC

Family Health Center

Fraud

An intentional deception or misrepresentation made by a person (individual or entity) with the knowledge that the deception could result in some unauthorized benefit to them or some other person. It includes any act that constitutes fraud under applicable federal or state law (42 C.F.R § 455.2).

Good cause

Enrollees have the right to be exempted from billing third-party coverage when additional privacy and precaution is needed. In this context, good cause means the use of third-party coverage would violate an enrollee's confidentiality because:

- The third party routinely sends verification of services to the third-party subscriber, but that subscriber is someone other than the enrollee
- The third party requires the enrollee to use a PCP who may report to the subscriber the enrollee's request for family planning services
- The enrollee has a reasonable belief that cooperating with us in identifying third-party liability coverage could result in serious physical or emotional harm to the enrollee, a child in their care or a child related to them
- The enrollee is incapacitated without the ability to cooperate with us

Grievance

"Grievance" means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination.

Possible subjects for grievances 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 we propose to make an authorization decision.

Health Care Authority

HCA – Washington State Health Care Authority. Any division, section, office, unit or other entity of HCA, or any of the officers or other officials lawfully representing HCA.

Health home services

A group of 6 intensive services that coordinate care across several domains, as defined under Section 2703 of the Affordable Care Act

Healthcare Effectiveness Data and Information Set

HEDIS – a set of standardized performance measures designed to ensure that health care purchasers and consumers have the information they need to reliably compare the performance of managed health care plans.

HEDIS also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS is sponsored, supported and maintained by NCQA.

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)

A range of services provided in an enrollee's home for treatment of an illness or injury. Examples include wound care, education, IV or nutrition therapy, injections and monitoring health status.

Independent review organization

IRO – a review process by a state-contracted independent third party

Integrated Provider Network Database

IPND – a database developed to provide verified and integrated care provider network information for all health plans serving Apple Health through the internet and an internal user interface

In-network provider

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

Medicaid

A federal health insurance program for low-income families and children, eligible pregnant individuals, 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 records

A confidential document containing written documentation related to the provision of physical, social and behavioral health services to a member

Medically necessary

A requested service reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the enrollee that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee requesting the service. For the purpose of this contract, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (WAC 182-500-0070).

Member

An eligible client enrolled in managed care through an MCO having a contract with HCA (42 C.F.R. § 438.2). "Member" is interchangeable with the term "enrollee." Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber.

National Committee for Quality Assurance

NCQA – an organization responsible for the accreditation of MCOs and other health care-related entities and for developing and managing health care measures that assess the quality of care and services that managed care clients receive. HCA requires contracted MCOs to achieve and maintain NCQA accreditation.

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 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

Physician incentive plan

Any compensation arrangement between a health plan and a care provider or provider group that may directly or indirectly have the effect of reducing or limiting services to enrollees under the terms of the 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 participating care provider who supervises, coordinates and provides primary health care to enrollees; initiates referrals for specialist care; and maintains the continuity of enrollee care. PCPs include, but are not limited to, pediatricians, family practitioners, general practitioners, internists, naturopathic physicians, medical residents (under the supervision of a teaching physician), physician assistants (under the supervision of a physician), or advanced registered nurse practitioners (ARNP), as designated by UnitedHealthcare Community Plan. The definition of PCP is inclusive of primary care physician as it is used in 42 C.F.R. § 438.2.

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

ProviderOne ID card

Card used to identify Medicaid-eligible patients. These cards are also known as HCA Medical ID cards or medical coupons.

Provider group

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

Quality management

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

Readmission

A hospital admission that occurs within 14 days of discharge from a prior (index) admission and is clinically related to the index admission

Referral

The practice of sending a patient to another care provider for services or consultation that the referring care provider is not prepared or qualified to provide

Remittance advice

RA – written explanation of processed claims

Rural health clinic

RHC – A clinic, located in a rural area, designated by the DOH 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 Washington Apple Health

Specialist

A care provider licensed in the state of Washington who 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 is highly skilled in a specific and restrictive field.

Subcontract

Any separate agreement or contract between the UnitedHealthcare Community Plan and an individual or entity ("subcontractor") to perform all or a portion of the duties and obligations we are obligated to perform pursuant to this contract

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.

Washington Administration Code

WAC – the rules adopted by agencies to implement legislation

Women's health care services

As defined in WAC 284-170-350, women's health care services is defined to include, but need not be limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. General examinations, preventive care and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care or other health services that are particular to women, such as breast examinations. Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health and preventive services include contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breastfeeding and complications of pregnancy.