

2018 Care Provider Manual

**2018 Physician, Health Care Professional, Facility and
Ancillary Care Provider Manual**

Washington Apple Health



Welcome

Welcome to the UnitedHealthcare Community Plan provider manual. This up-to-date reference PDF (manual/guide) 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 tools on our website at UHCprovider.com.

CLICK THE FOLLOWING LINKS TO ACCESS DIFFERENT MANUALS:

- [UnitedHealthcare Administrative Guide](#) for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual: go to UHCprovider.com. Click Menu on top left, select Administrative Guides and Manuals, then Community Plan Care Provider Manuals, select state..

EASILY FIND INFORMATION IN THIS MANUAL USING THE FOLLOWING STEPS:

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

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



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

Important Information about the Use of This Manual

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

This manual will be amended as policies change.

PARTICIPATION AGREEMENT

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

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

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

- Children, from birth through eighteen (18) years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act.
- Pregnant Women, eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act.
- Children eligible for the Children’s Health Insurance Program (CHIP).
- Categorically Needy – Blind and Disabled Children and Adults who are not eligible for Medicare.
- Medicaid Expansion 19–64 years old who are not eligible for another type of Medicaid and who has an income of less than 138% of the federal poverty level.
- Medicaid eligible families.
- BHO – Behavioral Health Only
- Adults – Affordable Care Act Health Care Reform

The Department of Health (DOH) will determine enrollment eligibility.



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

Integrated Managed Care (IMC)

As of Jan. 1, 2019, UnitedHealthcare Community Plan will have Apple Health IMC membership and Behavioral Health-only membership in King and Pierce counties. Apple Health non-IMC plans will remain for members in Clallam, Cowlitz, Island, Jefferson, Kitsap, Mason, Thurston, Grays Harbor, Pacific, Lewis, San Juan, Snohomish, Skagit, Wahkiakum and Whatcom Counties.

UnitedHealthcare Community Plan will not have Apple Health plans in counties other than those listed as of Jan. 1, 2019. A map and table identifying which managed care plans will be available in each region can be viewed at hca.wa.gov.

Our Approach to Health Care

WHOLE PERSON CARE MODEL

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

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

- Market-specific care management encompassing medical, behavioral and social care.
- Extended care team including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist.
- Field-based interventions engage members, connecting them to needed resources, care and services.
- Individualized and multidisciplinary care plan.

- Assistance with appointments with PCP and coordinating appointments. The CHA refers members to an RN, BHA or other specialists as required for complex needs.
- Education and support with complex conditions.
- Tools for helping members engage with providers, such as appointment reminders and help with transportation.
- Foundation to build trust and relationships with hard-to-engage members.

The goals of the WPC program are to:

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

Care Provider Resources

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

Referring Your Patient

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

SECURE CARE PROVIDER WEBSITE

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



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

The secure care provider website lets you:

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

forward slash in our web links, you can copy the direct URL into your web page address bar to quickly access that page.

PROVIDER SERVICES

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



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

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

NETWORK MANAGEMENT DEPARTMENT

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



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

CULTURAL COMPETENCY RESOURCES

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

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

HCA Interpreter Services: Effective July 1, 2018, Universal Language Service (ULS) provides interpreter services for Medicaid and Department of Social and Health Services appointments (DSHS) appointments. To request interpreters, register with ULS by contacting accounts@ULSONline.net.



Visit the HCA Interpreter Services website at hca.wa.gov for more information.

CARE PROVIDER PRIVILEGES

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

DIRECT CONNECT

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

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

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



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

COMPLIANCE

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

EVIDENCE-BASED CLINICAL REVIEW CRITERIA AND GUIDELINES

UnitedHealthcare Community Plan uses MCG Care Guidelines (formally Milliman Care Guidelines) for care determinations.

How to Contact Us

Topic	Contact	Information
Behavioral Health and Substance Use Disorder (SUD)	Optum Behavioral Health 855-802-7089 Provider Services 877-542-9231 Behavioral Provider Manual and Resources: providerexpress.com > Clinical Resource > Guidelines/Policies & Manuals > State Specific Manuals and Addendums > WA Medicaid Addendum.	Members have statewide access for behavioral health services. We limit out-of-state behavioral services to specific emergency services. See directory for a list of in-network behavioral health and substance use disorder care providers. PCP referral not required.
Behavioral Health Claim Disputes	WAIMC@optum.com	Ask about behavioral claim disputes.
Benefits	UHCprovider.com/benefits	Confirm a member's benefits and/or prior authorization.
Cardiology Prior Authorization	For prior authorization or a current list of CPT codes that require prior authorization, visit UHCprovider.com/cardiology .	Request prior authorization of the procedures and services outlined in this manual's prior authorization requirements.
Chiropractor Care	myoptumhealthphysicalhealth.com hca.wa.gov	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 Washington Health Care Authority (HCA) billing guide for billing requirements, limits and covered services.
Claims	Use the Link Provider Portal at 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 1355 S 4700 West, Suite 100 Salt Lake City, UT 84104	Ask about a claim status or about proper completion or submission of claims.

Topic	Contact	Information
Claim Overpayments	<p>See the Overpayment section for requirements before sending your request.</p> <p>Sign in to UHCprovider.com/claims to access Link, then select the UnitedHealthcare Online app</p> <p>Mailing address: UnitedHealthcare Community Plan ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800</p>	Ask about claim overpayments.
Crisis Services – Behavioral Health and Short-Term SUD	<p>King County BH-ASO – Crisis Connections: 866-427-4747 or 206-461-3222</p> <p>Pierce – Beacon Health Options: 800-576-7764, TTY 711</p> <p>Spokane County BH-ASO: Regional Behavioral Health: 877-266-1818</p> <p>Greater Columbia BH-ASO: 888-544-9986</p> <p>South West WA – Beacon Health Options – 800-626-8137, TTY 866-835-2755</p>	<ul style="list-style-type: none"> • 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. <p>Application of mental health and SUD involuntary commitment statutes, available 24/7/365 to conduct Involuntary Treatment Act assessments and file detention petition.</p>
Electronic Data Intake Claim Issues	<p>ac_edi_ops@uhc.com 800-210-8315</p>	Ask about claims issues or questions.
Electronic Data Intake Log-on Issues	800-842-1109	Information is also available at UHCprovider.com/edi .
Eligibility	<p>To access the app, sign in to UHCprovider.com/eligibility to access Link, then select the UnitedHealthcare Online app</p> <p>waproviderone.org</p>	Confirm member eligibility.
Enterprise Voice Portal	877-842-3210	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud and Abuse	800-455-4521 or 877-401-9430	Notify us of suspected fraud or abuse by a care provider or member.

Topic	Contact	Information
Healthy First Steps/ Obstetrics (OB) Referral	800-599-5985	Refer high-risk OB members. Fax initial prenatal visit form.
LabCorp for Providers	800-859-2553	LabCorp is the preferred lab provider.
Medical Claim Disputes	Sign in to UHCprovider.com/claims to access Link, then select the UnitedHealthcare Online app Reconsiderations mailing address: UnitedHealthcare Community Plan P.O. Box 31361 Salt Lake City, UT 84131-0361 Appeals mailing address: 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	877-542-8997	Assist members with issues or concerns. Available 8 a.m. – 5 p.m. Pacific Time, Monday through Friday.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	TTY 711	Available 8 a.m. – 5 p.m. Pacific Time, Monday through Friday, except state-designated holidays.
National Credentialing Center (VETTS line)	877-842-3210	Self-service functionality to update or check credentialing information.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 800-465-3203	Apply for a National Provider Identifier (NPI).
NurseLine	877-543-3409	Available 24 hours a day, seven days a week.

Topic	Contact	Information
Obstetrics and Baby Care	Healthy First Steps 800-599-5985 Fax: 877-353-6913 Pregnancy Notification Form Prenatal risk assessment form UHCBabyBlocks.com	Links for pregnant moms and newborn babies.
Optum Support Center	LinkSupport@optum.com 855-819-5909	Available 7 a.m. – 9 p.m. Central Time, Monday through Friday; 6 a.m. – 6 p.m. Central Time, Saturday; and 9 a.m. – 6 p.m. Central Time, Sunday.
Pharmacy Services	UHCprovider.com > Menu > Health Plans by State > Washington > Community Plan of Washington Home > Pharmacy Resources and Physician Administered Drugs 877-305-8952 (OptumRx) Pharmacy Help Desk 888-306-3243 Customer Service (Provider) 800-711-4555 Preferred Drug List 877-542-9231	OptumRx oversees and manages our network pharmacies.
Prior Authorization/ Notification for Pharmacy	UHCprovider.com/priorauth 800-310-6826 Fax: 866-940-7328	Request authorization for medications as required.
Prior Authorization/ Notification of Health Services	UHCprovider.com/priorauth 866-604-3267	Request authorization/notify of the procedures and services outline in the prior authorization/ notification requirements section of this manual. Complete and current list of prior authorizations.
Provider Services	UHCprovider.com/WAcommunityplan 877-542-9231	Use the automated system to: <ul style="list-style-type: none"> • 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.

Topic	Contact	Information
Radiology Prior Authorization	UHCprovider.com/priorauth 866-889-8054	Request prior authorization of the procedures and services outlined in this manual's prior authorization requirements. Complete and current list of prior authorizations.
Referral Submission/ Notifications	UHCprovider.com > Click Menu on top right, then select Referrals or use LINK. 866-604-3267	
Tobacco Free Quit Line	800-784-8669	Ask about services for quitting tobacco/ smoking.
Transportation	hca.wa.gov	The Washington HCA pays for transportation services to get members to and from non-emergency health care appointments.
Utilization Management	877-542-8997	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.
Vaccines for Children (VFC) program	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). Providers must enroll as VFC providers with DOH to bill for the administration of the vaccine.
Vision Services	marchvisioncare.com MARCH Vision Care 888-493-4070 TTY 877-627-2456	Apple Health covers routine eye exams. However, we do not cover eyeglasses or fittings. Prior authorization is required for all routine eye exams. Authorizations must be obtained from MARCH Vision Care. Call Monday through Friday, 8 a.m. to 5 p.m. Pacific Time. March Vision processes claims for services by March Vision. We process claims for services our care providers furnish.

Topic	Contact	Information
Website for UnitedHealthcare Community Plan of Washington	UHCprovider.com/WAcommunityplan	Access your state-specific Community Plan information on this website.
Whole Person Care Person-Centered Care Model (Care Management/ Disease Management)	877-542-8997	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.

Chapter 2: Care Provider Standards & Policies

General Care Provider Responsibilities

NON-DISCRIMINATION

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

1. Educate members, and/or their representative(s) about their health needs.
2. Share findings of history and physical exams.
3. Discuss options (without regard to plan coverage), treatment side effects and symptoms management.

This includes any self-administered alternative or information that may help them make care decisions.

4. Recognize members (and/or their representatives) have the right to choose the final course of action among treatment options.
5. Collaborate with the plan care manager in developing a specific care plan for members enrolled in High Risk Care Management.

PROVIDE OFFICIAL NOTICE

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

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

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

TRANSITION MEMBER CARE FOLLOWING TERMINATION OF YOUR PARTICIPATION

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

ARRANGE SUBSTITUTE COVERAGE

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



For the most current listing of network care providers and health care professionals, review our care provider and health care professional directory at [UHCprovider.com](https://www.uhcprovider.com) > Find Dr.

ADMINISTRATIVE TERMINATIONS FOR INACTIVITY

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

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

CHANGING AN EXISTING TIN OR ADDING A HEALTH CARE PROVIDER

Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the address listed on the bottom of the form. The W-9 form and the Care Provider Demographic Information Update Form are available at [UHCprovider.com](https://www.uhcprovider.com) > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form.

Otherwise, complete detailed information about the change, the effective date of the change and a W-9 on your office letterhead. Email this information to the number on the bottom of the demographic change request form.

UPDATING YOUR PRACTICE OR FACILITY INFORMATION

You can update your practice information through the Provider Data Management application on [UHCprovider.com](https://www.uhcprovider.com). Go to [UHCprovider.com](https://www.uhcprovider.com) > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form. Or submit your change by:

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

AFTER-HOURS CARE

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

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

PARTICIPATE IN QUALITY INITIATIVES

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

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

PROVIDE ACCESS TO YOUR RECORDS

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

PERFORMANCE DATA

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

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 the Washington State HCA to help providers 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.

You are required to, when contracted provider organizations with certified EHRs see an Apple Health managed care member, send a care summary (CCDA) from your EHR to the CDR. To learn more about the CDR, visit [HealthIT.wa.gov](https://www.healthit.wa.gov). To learn more about the HIE or to get connected to the CDR, email HIE@onehealthport.com.

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](https://www.UHCprovider.com).

OFFICE HOURS

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

PROTECT CONFIDENTIALITY OF MEMBER DATA

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

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

FOLLOW MEDICAL RECORD STANDARDS

Please reference Chapter 9 for Medical Record Standards.

INFORM MEMBERS OF ADVANCE DIRECTIVES

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

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.

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 [UHCCommunityPlan.com](https://www.UHCCommunityPlan.com).

Also reference Chapter 12 of this manual for information on Provider Claim Reconsiderations, Appeals and Grievances.

Appointment Standards (Washington Access and Availability Standards)

Comply with the following appointment availability standards:

PRIMARY CARE

PCPs should arrange appointments for:

- After-hours care phone number: 24 hours, 7 days a week

- Emergency care: Immediately or referred to an emergency facility
- Urgent care appointment: within 24 hours
- Non-urgent, symptomatic (i.e., routine care) appointment: within 20 calendar days.
- Transitional PCP appointment: 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.
- Routine care appointment: within 30 calendar days
- Physical exam: within 180 calendar days
- EPSDT appointments: within 6 weeks
- New member appointment: within 30 calendar days
- In-office waiting for appointments: not to exceed one hour of the scheduled appointment time

SPECIALTY CARE

Specialists should arrange appointments for:

- Urgent care: within 24 hours
- Non-urgent sick visit: within 48–72 hours
- Non-urgent care: within 4–6 weeks

BEHAVIORAL HEALTH AND SUBSTANCE USE

Behavioral health care providers should arrange appointments for:

- Emergency care (non-dangerous to self or others): immediately upon presentation
- Urgent problems: within 48 hours of request
- Non-urgent problems: within 10 days of request
- Following an emergency room visit or hospitalization: within 7 days or as medically necessary

Care providers must evaluate members to determine if Access to Care Standards are met. If criteria is met, refer the member to the Behavioral Health Organization (BHO) for services. Access to Care Standards can be found at dshs.wa.gov.

PRENATAL CARE

Prenatal care providers should arrange OB/GYN appointments for:

- First trimester: within three weeks of request
- Second trimester: within two weeks of request
- Third trimester: within one week of request

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

Care Provider Directory

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

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

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

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

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

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

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

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

PROVIDER ATTESTATION

You must confirm your provider data every quarter. You may do this through LINK or by calling Provider Services. If you have received the upgraded My Practice Profile and

have editing rights, access Link's My Practice Profile App to make many of the updates required in this section.

Prior Authorization Request

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

Identify and bill other insurance carriers when appropriate.

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

Exception to Rule and Limitation Extension

An Exception to Rule (ETR) is a request for a non-covered service. To request an ETR, submit documentation showing the member's condition requires the service. A Limitation Extension (LE) is a request to extend covered services beyond the Apple Health benefit. Examples include other limited benefit requests or coverage for a member outside the usual age limit. Submit ETR requests within 90 days of receiving the denial for the service.

Timeliness Standards for Notifying Members of Test Results

After receiving results, notify members within:

- Urgent: 24 hours
- Non-urgent: 10 business days

Requirements for PCP and Specialists Serving in PCP Role

SPECIALISTS INCLUDE: INTERNAL MEDICINE, PEDIATRICS, OR OBSTETRICIAN/GYNECOLOGY

PCPs are an important partner in the delivery of care, and Washington 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 four critical areas: access, coordination, continuity and prevention. As such, the PCP manages initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide 24 hours a day, seven days a week coverage and backup coverage when they are not available.

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

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

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



Members may change their assigned PCP by contacting [Member Services](#) at any time during the month. Customer Service is available 8 a.m. – 6 p.m., Monday through 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.

Females have direct access (without a referral or authorization) to any network OB/GYNs, midwives, physician assistants, or nurse practitioners 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 availability of 24 hours a day, seven days a week. During non-office hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services. **Recorded messages are not acceptable.**

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

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.
- Provide all well baby/well-child services.
- Coordinate each UnitedHealthcare Community Plan member's overall course of care.

- Accept UnitedHealthcare Community Plan members at your primary office location at least 16 hours a week for a one MD practice.
- Be available to members by telephone 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 enrollees 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 Washington State Hospital Association.
- Help ensure services delivered to individuals with special health care needs are appropriate to their needs.
- Refer all pregnant members to the DSHS First Steps Maternity Support Services/Infant Case Management and the Healthy First Steps programs.

Responsibilities of PCPs and Specialists Serving in PCP Role

SPECIALISTS INCLUDE INTERNAL MEDICINE, PEDIATRICS, AND/OR OBSTETRICIAN/GYNECOLOGY

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide.
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment.
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Screen members for behavioral health problems using the Behavioral Health Toolkit for the Health Care Professional found on UHCprovider.com. File the completed screening tool in the patient's medical record.
- Refer services requiring prior authorization to the Prior Authorization Department, UnitedHealthcare Community Plan Clinical, or Pharmacy Department as appropriate.
- Inform our Case Management Department at 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 or not a member has an advance directive form.
 - Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.

- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
- Complying with the 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 Center or Primary Care Clinic as PCP

Members may choose a Rural Health Clinic (RHC), a Federally Qualified Health Center (FQHC) or a Primary Care Clinic (PCC) as their PCP.

- **Rural Health Clinic:** The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be located in rural, underserved areas.
- **Federally Qualified Health Center:** An FQHC is a center or clinic that provides primary care and other services. These services include:
 - Preventative (wellness) health services from a care provider, physician assistant, nurse practitioner and/or social worker.
 - Behavioral health services.
 - Immunizations (shots).
 - Home nurse visits.
- **Primary Care Clinic:** A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a primary care clinic that may be dangerous, the PCC may refer the member to

a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

Primary Care Provider Checklist

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

- Verify eligibility using Link at UHCprovider.com/eligibility, visiting waproviderone.org or by calling Provider Services.
- Verify member identity with photo identification, if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/priorauth to locate and view the current prior authorization information and notification requirements.
- Refer to UnitedHealthcare Community Plan participating specialists unless we authorize otherwise.
- Identify and bill other insurance carriers when appropriate.
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form. See Chapter 11 for more information on submitting forms.

Specialist Care Providers Responsibilities

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

- Contact the PCP to coordinate the care/services.
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer.
- Verify the eligibility of the member before providing covered specialty care services.
- Provide only those covered specialty care services, unless otherwise authorized.
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care.

- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at one UnitedHealthcare Community Plan participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the 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, seven days a week. Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.
- 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 enrollees 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 Washington State Hospital Association.
- Refer all pregnant members to the DSHS First Steps Maternity Support Services/Infant Case Management and the Health First Steps programs.

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

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

Prenatal Care Responsibilities

Pregnant UnitedHealthcare Community Plan members should only receive care from UnitedHealthcare Community Plan participating providers.



Notify UnitedHealthcare Community Plan as soon as a member confirms pregnancy. This helps ensure appropriate follow-up and coordination by the [UnitedHealthcare Healthy First Steps](#) coordinator.

If you have questions, call [Healthy First Steps](#). To begin patient outreach, fax the prenatal assessment form.

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

Ancillary Care Provider Responsibilities

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

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

Ancillary Care Provider Checklist

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

- Verify the member's enrollment before rendering services. Go to Link at [UHCprovider.com](#) or contact [Provider Services](#). Failure to verify member enrollment and assignment may result in claim denial.

- Check the member's ID card each time the member has services. Verify against photo ID if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit [UHCprovider.com/priorauth](#).
- Identify and bill other insurance carriers, when appropriate.

Medicaid Enrollment, Non-Billing Care Providers

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

You can access the application by:

- a. Using the HCA Apple Health (Medicaid) Provider Enrollment web link reviews instructions and required documents to register as a care provider with **ProviderOne**.
- b. Completing the enrollment application.
- c. Calling the HCA at 800-562-3022, ext. 16137 if you have questions.

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

Chapter 3: Care Provider Office Procedures and Member Benefits

Apple Health members may seek services from any participating care provider. This means the Apple Health program does not require members to have assigned PCPs. Members are still encouraged 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 to optimize their care.

Choosing a Primary Care Provider

Each enrolled UnitedHealthcare Community Plan chooses a PCP.

Depending on the member's age, medical condition and location, the choice of PCP may cover a variety of practice areas, such as family practice, general practice, internal medicine, pediatrics and obstetrics.

PCP Panel Roster

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

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

Sign in to UHCprovider.com > select Link > select the UnitedHealthcare Online application on Link > select

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

Deductibles/Copayments

The UnitedHealthcare Community Plan does 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 it may be appropriate to bill a member, please contact us.

Medically Necessary Service

UnitedHealthcare Community Plan only pays for medically necessary services.

MEDICALLY NECESSARY DEFINITION

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

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

Member Assignment

ASSIGNMENT TO UNITEDHEALTHCARE COMMUNITY PLAN

The 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. The HCA makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at

month's end, but at times may occur mid-month.

At enrollment time, each member receives a welcome packet that includes a copy of the UnitedHealthcare Community Plan Member Handbook. The handbook explains the member's health care rights and responsibilities through UnitedHealthcare Community Plan.



Obtain copies of the Member Handbook online by contacting [UnitedHealthcare Community Plan Provider Services](#).

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, 2018, the member's enrollment effective date will be April 1, 2018.

ENROLLMENT AND RECERTIFICATION

Members with Apple Health Family or Apple Health for Adult members should go to [wahealthplanfinder.org](#) or call 855-WAFinder (855-923-4633). Members with Apple Health Blind & Disabled should go to [washingtonconnection.org](#), in person at their local Community Services Office (CSO). See [dshs.wa.gov/onlinecso/findservices.shtml](#) or call 877-501-2233. Washington Health Benefits Exchange list of in-person assisters, [wahbexchange.org/info-you/person-assisters/](#) can help members enroll and recertify so they don't lose coverage.

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

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

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 enrollee no longer meets rehabilitation or skilled level of care criteria.

If the member admitted to a nursing facility is the responsibility of DSHS, we are responsible for all other services, except for the room and board for the nursing facility, that are medically necessary and required to meet the client'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 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 Fee for Service (FFS) to Medicaid Managed Care during hospitalization. To avoid delays in claims processing and payment, have the payer assignment of newborns checked daily.



Get eligibility information by calling the [Medicaid Inquiry line](#).

UNBORN ENROLLMENT CHANGES:

Encourage your members to notify the Washington HCA when they know they are expecting. The HCA notifies Managed Care Organizations (MCOs) daily of unborn children when Apple Health learns a woman associated with the MCO is expecting. The MCO or you may use the online change report through the Washington website to report the baby's birth. With that information, the HCA verifies the birth through the mother. The MCO and/or the care provider's information is taken as a lead. To help speed up the process, the mother should notify the HCA when the baby is born.

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

If the newborn does not receive a separate client identifier from the HCA, the newborn enrollment will be only available through the end of the month in which the first 21 days of life occur.

- Retrospectively for the months in which the first 21 days of life occur, effective when the newborn is reported to the HCA.
- If the mother's enrollment ends before the newborn receives a separate client identifier from the 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 whose mother, who is receiving services fee-for-service when the baby is born, will be enrolled in AHMC and assigned to an MCO according to system rules (Early Enrollment).
- When a newborn is placed in foster care, the newborn remains enrolled with UnitedHealthcare Community Plan for the month of birth. The newborn is enrolled with the Apple Health Foster Care (AHFC) program effective the first of the month following placement of the newborn. Newborns placed in foster care before discharge from their initial birth hospitalization shall have their Apple Health Managed Care enrollment terminated and be enrolled in AHFC effective the first of the month after placement in foster care. UnitedHealthcare Community Plan is responsible for hospital costs until the newborn is discharged from the birth hospitalization.

Members need to report a newborn's birth by logging into their Washington Healthplanfinder account, enrolling online at wahealthplanfinder.org, and selecting the "Report a Change in Income or Household" 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.

PCP SELECTION

Although unborn children cannot be enrolled with an MCO until birth, ask your members to select and contact

a PCP for their baby prior to delivery. This will help avoid the delays and confusion that can occur with deferred PCP selections.



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

ENROLLMENT TERMINATION

Members may submit to the HCA a written request to terminate enrollment or call the HCA. Healthy Options Blind and Disabled members (HOBD) requesting disenrollment should call DSHS at 877-501-2233 or visit washingtonconnection.org.

Other members should call Apple Health Customer Service at 855-623-9357 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.

When a member changes Apple Health MCOs, and the change becomes effective during an inpatient admission, the MCO the enrollee 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 or is discharged from a facility to home or a community residential setting.

Member Eligibility

UnitedHealthcare Community Plan serves members enrolled with the Washington Apple Health program. An individual who becomes eligible for the Washington HCA program either chooses or is assigned to one of the HCA-contracted health plans. This means the HCA determines eligibility for the Washington Apple Health Program, not the plan. To determine eligibility, use the State ProviderOne website waproviderone.org.

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, notify UnitedHealthcare Community Plan in writing, as discussed in Chapter 12 of this manual. Or you may call the [Fraud, Waste, and Abuse Hotline](#).

The member’s ID card 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 nine-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. The Washington Medicaid Number is also on the ProviderOne services card.

PCP-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 event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider’s name

Mailing address:

UnitedHealthcare Community Plan
 Attn: Health Plan Operations
 1111 Third Ave., Suite 1100
 Seattle, WA 98101

2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have five business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

Sample Health Member ID Card



Verifying Member Enrollment

Verify member eligibility prior to providing services.

Determine eligibility in the following ways:

- Provider Portal: access the Link portal through UHCprovider.com/eligibility
- [UnitedHealthcare Provider Service](#) is available from 7 a.m. - 5 p.m. Central Time, Monday through Friday.
- waproviderone.org

Benefit Information

View member benefit coverage information online at

UHCprovider.com > Menu > Health Plans by State > Washington > Community Plan of Washington Homepage.

UnitedHealthcare Dual Complete (HMO SNP)

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

Chapter 4: Medical Management

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

Ambulance Services

AIR AMBULANCE AND EMERGENCY AMBULANCE TRANSPORTATION

Effective Jan. 1, 2018 all emergent and non-emergent air and land ambulance services are handled by the HCA.

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.

Applied Behavioral Analysis

Applied Behavioral Health (ABA) helps children age 20 years and younger and their families improve core symptoms associated with autism spectrum disorders or other developmental disabilities. ABA benefits support learning and assist with the development of social, behavior, adaptive, motor, vocational, and cognitive skills.

Services are limited to medically necessary diagnosis codes for members age 20 and younger only.

These services include:

- Assessments/treatment planning when provided by a board-certified behavior analyst (BCBA), limited to three per year per care provider.
- ABA therapy services when provided by a recognized Center of Excellence (COE).

Please contact Optum Behavior Health for prior authorization criteria.

Two types of care providers may apply to provide ABA therapy services: Lead behavior analysis therapists (LBATs) and therapy assistants (TAs). These care providers must have a signed Core Provider Agreement with the HCA.

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.

Collaborative Care

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

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 assure children's well-being. These services help reduce the risk of abuse, find safe alternatives to out-of-home placement, and assure 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.

Emergency/Urgent Care Services

Emergency services do not require prior authorization.

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

Covered services include:

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

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

EMERGENCY ROOM CARE

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

Before they are treated, UnitedHealthcare Community Plan members who visit an emergency room are screened to determine whether they have a medical emergency. Prior authorization is not required for the medical screening. UnitedHealthcare Community Plan covers these services regardless of the emergency care provider's relationship with UnitedHealthcare Community Plan.

After the member has received emergency care, the hospital must seek approval within one hour for pre-approval for more care to make sure the member remains stable. If UnitedHealthcare Community Plan does not respond within one hour or cannot be reached, or if the health plan and attending care provider do not agree on the member's care, UnitedHealthcare Community Plan lets the treating care provider talk with the health plan's medical director. The treating care provider may continue with care until the health plan's medical care provider is reached, or when one of these guidelines is met:

1. A plan care provider with privileges at the treating hospital takes over the member's care.
2. A plan care provider takes over the member's care by sending them to another place of service.
3. An MCO representative and the treating care provider reach an agreement about the member's care.
4. The member is released.

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

URGENT CARE (NON-EMERGENT)

Urgent care services are covered.



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

Emergency Care Resulting in Admissions

Prior authorization is not required for emergency services.

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



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

UnitedHealthcare Community Plan 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 the [Prior Authorization Department](#).

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.
 - Morning-after pill. Contact the HCA to verify state coverage.

PARENTING/CHILD BIRTH EDUCATION PROGRAMS

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

VOLUNTARY STERILIZATION

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

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.

Health Home Program

Our Health Home program is managed in partnership with the Washington state 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, quality, and increase individual participation in their own care. The program reduces Medicaid inpatient hospital admissions, avoidable emergency room visits, inpatient psychiatric admissions, and the need for nursing home admissions. We partner 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 **888-702-2053**.

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 one 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 co-morbidities and need complex care management.



Find out more on UHCprovider.com.

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.

The following devices and supplies are covered for members age 20 and younger: bilateral cochlear implants, including implants, parts, accessories, batteries, charges and repairs; bone anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries.

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 five days per month. This includes the day of admission but not the day of discharge.

INPATIENT HOSPICE

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

Members receiving inpatient hospice services through a residential facility are not covered under Managed Medicaid. 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, X-rays, Imaging Procedures

ADVANCED OUTPATIENT IMAGING PROCEDURES

Advanced outpatient imaging procedures must be prior authorized by UnitedHealthcare Community Plan Clinical.



To get prior authorization, go to UHCprovider.com/priorauth.

Reference the Medical Management chapter for more information on the Radiology Prior Authorization Program.

LAB SERVICES



LabCorp is the preferred lab provider. Contact [LabCorp](#) directly.

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

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

See the Billing and Submission chapter for more information.

Maternity/Pregnancy/Well-Child Care

PREGNANCY/MATERNITY

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



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

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

1. the woman was in her second or third trimester of pregnancy when she became a UnitedHealthcare Community Plan member, and
2. if she has an established relationship with a non-participating obstetrician.

UnitedHealthcare Community Plan must approve all out-of-plan maternity care. Care providers should call **866-604-3267** to obtain prior approval for continuity of care.

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

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

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

MATERNITY ADMISSIONS

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



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

To notify UnitedHealthcare Community Plan of deliveries, call **866-604-3267** or fax to **855-554-2152**. Provide the following information within one business day of the admission:

- Date of admission.
- Member's name and Medicaid ID number.
- Obstetrician's name, phone number, care provider ID.

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

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

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

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

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

Furnish obstetrical maternity services on an outpatient basis. This can be done under a physician's supervision through a nurse practitioner, physician's assistant 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.

POST MATERNITY CARE

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

NEWBORN ENROLLMENT

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

BRIGHT FUTURES ASSESSMENT

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics and supported by the [US Department of Health and Human Services, Health Resources and Services Administration \(HRSA\)](http://www.hrsa.gov), Maternal and Child Health Bureau (MCHB).

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

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

HOME CARE AND ALL PRIOR AUTHORIZATION SERVICES

The discharge planner ordering home care should call the [Prior Authorization Department](http://www.wahealthplanfinder.org) 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 she was told before the surgery that the procedure will result in permanent sterility.



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

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 Fee for Service program.

STERILIZATION PROCEDURES

Reimbursement for sterilization procedures are based on the member's documented request. This policy helps ensure UnitedHealthcare Community Plan members thinking about sterilization are fully aware of the details and alternatives. It also gives them time to consider their decision. In addition, 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 would 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 form.**
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 [hhs.gov](https://www.hhs.gov).

Have three copies of the consent form:

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

Neonatal Resource Services (NICU Case Management)

Our Neonatal Resource Services program manages inpatient and post-discharge NICU cases to improve outcomes and lower costs. Our dedicated team of NICU nurse case managers, social workers and medical directors offer both clinical care and psychological services.

NEONATAL RESOURCE SERVICES

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

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

The NRS nurse case manager will:

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

The NRS nurse case manager's role includes:

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

- Educating parents and families about available local resources and support services.
- Coordination with the Whole Person Care Team for additional case management needs and services.

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

Patient Review and Coordination Program

Patient Review and Coordination (PRC) is for all Apple Health Programs. The Washington HCA program helps control over-utilization 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 two years.

PCP 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 or not.



To refer a member to the PRC program, please call **877-542-8997**.

Radiology Prior Authorization Program

We use a Radiology Prior Authorization Program to improve compliance with evidence-based and professional society guidance for radiology procedures.

You must obtain a prior authorization before ordering CT scans, MRIs, MRAs, PET scans, nuclear medicine and nuclear cardiology studies in an office or outpatient setting.

The following images do not require prior authorization:

- Ordered through ER visit.
- While in an observation unit.
- When performed at an urgent care facility.
- During an inpatient stay.

Not getting this prior authorization approval results in an administrative denial. Claims denied for this reason may not be balance-billed.

To get or verify prior authorization:

- Online: UHCprovider.com/priorauth > Radiology > Online Portal link.
- Phone: **866-889-8054** from 8 a.m. - 5 p.m. Central Time, Monday through Friday. Make sure the medical record is available. An authorization number is required for each CPT code. Each authorization number is CPT-code specific.



For a list of Advanced Outpatient Imaging Procedures that require prior authorization, a prior authorization crosswalk, and/or the evidence-based clinical guidelines, use Link through UHCprovider.com or use the search option at UHCprovider.com.

Readmission Rules

A readmission is a hospital admission which occurs within 14 days of discharge from a prior admission and is clinically related to the prior admission. A readmission is preventable if there was a reasonable expectation that it could have been prevented by one or more of the following:

- Providing quality care in the prior admission. A specific quality concern, identified and documented during the first admission which then resulted in the readmission, must be identified
- Adequate discharge planning
- Adequate post-discharge follow-up
- Coordinating between inpatient and outpatient health care teams to provide required care post discharge of the prior admission.

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 and medically necessary admissions.

Critical access hospitals are excluded from denial of payment under this policy.

UnitedHealthcare Community Plan cannot deny payment prospectively based on this policy. Determination of care provider preventability must be done as a post-payment review. Payment can then be recouped, if indicated. Any disputes will be handled through UnitedHealthcare Community Plan's reconsideration and appeals process.

Screening, brief interventions, and referral to treatment (SBIRT) services

SBIRT Services are covered when:

- Provided by, or under the supervision of, a certified care provider or other certified licensed healthcare professional within the scope of their practice.
- Determining risk factors related to alcohol and other drug use disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed.

- SBIRT screening will occur during an Evaluation and Management (E/M) exam and is not billable with a separate code. You may provide a brief intervention on the same day as a full screen in addition to the E/M exam. You may also perform a brief intervention on subsequent days. Brief interventions are limited to four sessions per patient, per provider per calendar year.

WHAT IS INCLUDED IN SBIRT?

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

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

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

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

- The billing provider and servicing provider have submitted their SBIRT certification to the agency.
- The billing provider has an appropriate taxonomy to bill for SBIRT
- The diagnosis code is Z71.41 or Z71.51.
- The treatment or brief intervention does not exceed the limit of four (4) encounters per client, per provider, per year

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

- Office
- Urgent care facility
- Outpatient hospital
- Emergency room – hospital

- Federally qualified health center (FQHC)
- Community Mental Health Agencies
- Indian health service – free standing facility
- Tribal 638 free standing facility
- Homeless shelter



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

Specialty Pharmacy Medications

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

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

Specialty pharmacy medications are available through our specialty pharmacy network.

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

Transgender Health Services

We provide health services for members with gender dysphoria. Please show sensitivity in addressing members with their preferred gender identification. We cover hormone therapy and behavioral health services for all transgender members. We also cover puberty-blocking treatment for transgender adolescents. The HCA provides coverage for surgery, electrolysis and post-operative

complications from surgery through the fee-for-service program.

You and members can view the HCA’s transgender health services website at hca.wa.gov. Contact the HCA for care coordination needs for the HCA-covered benefits. Send an email to transhealth@hca.wa.gov.

Transitional Services

We shall work with appropriate staff at any hospital, including a CPE facility, to implement a safe, comprehensive discharge plan that assures continued access to medically necessary covered services which 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, and with BHOs, to help ensure member care transitions.

Tuberculosis (TB) Screening and Treatment; Direct Observation Therapy (DOT)

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

RESPONSIBILITIES

Identification – The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all members at increased risk unless they have documentation of prior positive test results or currently have active TB under treatment. You will coordinate and collaborate with 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 Local Health Department (LHD). The PCP must report known or suspected cases of TB to the LHD TB Control Program within one day of identification.

Waiver Programs

HUMAN IMMUNODEFICIENCY VIRUS (HIV)/ ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) HCBS WAIVER PROGRAM

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



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



Locate the Prior Authorization Fax Request Form at UHCprovider.com/priorauth. If you have questions, please call [Prior Authorization Intake](#).

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/member notification of denial
Non-urgent Pre-service	Within five calendar days of receipt of medical record information required but no longer than 14 calendar days of receipt	Within 24 hours of the decision	Within three business days of the decision
Urgent/Expedited Pre-service	Within two calendar days of request receipt	Within 72 hours of the request	Within 72 hours of the request
Concurrent Review	Within one business day	Notified within one business day of determination	Notified within one business day of determination
Retrospective Review	Within 30 calendar days of receiving all pertinent clinical information	Within 24 hours of determination	Within three business days of determination

Case Management

We provide case management services to members with complex medical conditions or serious psychosocial issues. The Medical Case Management 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 calling Care Management at **877-856-6351**. Additionally, UnitedHealthcare Community Plan provides the **Healthy First Steps** program, which manages women with high-risk pregnancies.

PHARMACY

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

Otherwise, we provide pharmacy management through OptumRx. OptumRx 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.

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

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

CONCURRENT REVIEW DETAILS

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

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

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

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

Determination of Medical Necessity

Examples of medically necessary services 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.
- Not experimental treatments

Determination Process

Benefit coverage for health services is determined by the member specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, or Summary Plan Description, and applicable laws.

Evidence-Based Clinical Guidelines

UnitedHealthcare Community Plan uses evidence-based clinical guidelines to guide our quality and health management programs. For more information on our guidelines, go to [UHCprovider.com](https://uhcprovider.com).

Medical and Drug Policies and Coverage Determination Guidelines

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

Referral Guidelines

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 LINK on [UHCprovider.com](https://uhcprovider.com), contacting UnitedHealthcare Community Plan's Provider Services Department, or the [Washington Medicaid Eligibility System](#).
- Submit documentation needed to support the medical necessity of the requested procedure.
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized.
- Determine if the member has other insurance that should be billed first.

UnitedHealthcare Community Plan will not reimburse:

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

Second Opinion Benefit

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

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward his or her report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.

- If an in-network provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact UnitedHealthcare Community Plan at **877-542-9231**.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations.
- If follow-up care is recommended, the member meets with the PCP before receiving treatment.
- If the PCP has recommended care, and the member does not agree, the member can see a different network care provider without referral.

Services Not Covered by UnitedHealthcare Community Plan

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

- Any health care not given by a doctor from our list (except emergency treatment)
- Any care covered by Medicaid but not through managed care:
 - Long-term care services in a nursing home.
 - Non-skilled nursing facility services.
 - Intermediate care facilities for members with mental handicap.
 - Home- and community-based waiver services.
 - Dental services, except for those performed in an outpatient setting. UnitedHealthcare Community Plan covers the facility and anesthesia services when deemed medical necessary. Prior authorization is required.
- Phones and TVs used when in the hospital.
- Personal comfort items used in the hospital such as a barber.
- Contact lenses, unless used to treat eye disease.
- Sunglasses and photo-gray lenses.
- Ambulances.
- Infertility services.
- Substance use treatment services. These are covered through the DSHS Behavioral Health and Service Integration Administration (BHSIA).

Services Requiring Prior Authorization



For a list of services that require prior authorization, go to UHCprovider.com/priorauth.

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

Utilization Management Guidelines



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

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

UTILIZATION MANAGEMENT (UM) APPEALS

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

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

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

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

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

Government Childhood and Adolescent Immunizations Guide: [cdc.gov/vaccines/parents/resources/childhood.html](https://www.cdc.gov/vaccines/parents/resources/childhood.html)

Government Quick Reference Guide: [cdc.gov/vaccines/schedules/index.html](https://www.cdc.gov/vaccines/schedules/index.html)

HCA EPSDT Billing Guide for Additional Recommended Frequencies: [hca.wa.gov](https://www.hca.wa.gov)

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 assure 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 contacting the regional center or local education agency, a service coordinator will be assigned to help the child’s parents through the process to determine eligibility.

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

 | Call **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 HCY Lead Risk Assessment form.)
- Personal-social and language skills
- Fine motor/gross motor skills

- Hearing
- Vision
- Dental (screen and fluoride, under age 3 only)

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

Interperiodic Screens

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

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

Lead Screening/Treatment

Call Provider Services if you find a child has a lead blood level over 10ug/dL. Children with elevated blood lead levels will be offered enrollment in a care coordination program.

Medically Intensive Children’s Program (MICP)

This 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 four 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 MICH services to MICP@dshs.wa.gov.

Safe/Care Examinations

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

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 five 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 tuberculosis, HIV/AIDS, etc., or who have been exposed to communicable diseases, until the risk of exposure has passed

Referral – Members who are eligible for TCM services are referred to a Regional Center or local governmental health program as appropriate for the provision of 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 (VFC)

The Vaccines for Children 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](#) with questions.
Phone: 800-219-3224
Fax: 573-526-5220

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 a federally qualified health center or rural health clinic; they cannot receive vaccinations from a private health care provider using a VFC-supplied vaccine).

Chapter 6: Value-Added Services

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call Provider Services at **877-542-9231** unless otherwise noted.

Baby Blocks™ Program

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

BABY BLOCKS™ BENEFIT

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

How it Works

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

How You Can Help

1. Identify UnitedHealthcare Community Plan members during prenatal visits.
2. Share a Baby Blocks brochure with the member and talk about the program.

3. Encourage the member to enroll at UHCBabyBlocks.com.



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

Dental Services

Except as otherwise identified as follows, dental services are the responsibility of the state of Washington or its agent. For members younger than age 3, we will reimburse dental screens and fluoride treatments. Services must be billed by medical care provider using CPT coding.

UnitedHealthcare Community Plan is responsible for:

- Hospital emergency department services related to dental emergencies,
- Operating room services or same-day surgery suites (excluding the dental procedures), and
- Dental/oral health screening per EPSDT guidelines for members age 20 and younger
- Oral surgery services performed by an oral and maxillofacial surgeon. (Services must be billed by medical care provider using CPT coding.)

UnitedHealthcare Community Plan does not cover routine dental services for anyone 21 years and older. Standard ADA coding guidelines apply to all claims.

For more details, go to UHCprovider.com.

On My Way

On My Way is an engaging, interactive program that informs Washington youth and helps prepare them for many real-world situations that lie ahead. Read more at uhcOMW.com.

Fresh EBT

A smartphone app that helps educate members who receive Supplemental Nutrition Assistance Program (SNAP) Benefits by helping them to make healthy choices on a budget. The Fresh EBT app lets members check their balance quickly and easily, track spending habits, find places that accept EBT, locate grocery deals, keep a shopping list and get healthy low-cost recipes.

Healthy First Steps

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

As a result, Healthy First Steps program helps mothers:

- Overcome common social and psychological barriers to prenatal care;
- Understand the importance of early prenatal care;
- The mother build a support system;
- Ensure appropriate postpartum and newborn care;
- Develop the care provider/member relationship before and after delivery.

In addition to reminders to get preventive care services, we use a proprietary Universal Tracking Database to identify members who have fallen behind in scheduling appointments. We also identify care providers who are not focusing on preventive care and optimal treatment.

HFS-MATERNAL CARE MODEL

The HFS-Maternal care model strives to:

- Increase early identification of expectant mothers and

facilitate case management enrollment

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



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

Mobile Apps

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

- **Health4Me** enables users to review health benefits, access claims information and locate in-network providers.
- **Text4baby** is a free mobile information service that helps members through their pregnancy and baby's first year of life. The weekly text4baby messages give tips about:
 - Keeping healthy.
 - Labor and delivery.

- Breastfeeding.
- The importance of immunizations (shots).
- Exercise and healthy eating.

To sign up for text4baby, members must text the word BABY to 511411.

NurseLine

NurseLine is available at no cost to our members 24 hours a day, seven days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the emergency room or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **877-543-3409** to reach a nurse.

Quit for Life®

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

Women, Infants and Children Supplemental Nutrition Program (WIC)

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

Eligibility –

- Pregnant women- as soon as there is a positive pregnancy test
- Women who have been pregnant within the previous six months

- Breastfeeding women
- Children younger than 5

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

A current hemoglobin or hematocrit is required:

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

Contact Information:

doh.wa.gov

Chapter 7: Behavioral Health and Substance Use

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

The National Optum Behavioral Health manual is located on providerexpress.com. The state-specific Medicaid Network Manual is located on providerexpress.com > Clinical Resources > Guidelines/Policies & Manuals > State Specific Manuals and Addendums > WA Medicaid Addendum.

Optum works with the Washington State Behavioral Health Organization (BHO) to help ensure our members receive the appropriate level of care. The BHO's use state-mandated criteria to evaluate and direct members. The criteria can be found at nppes.cms.hhs.gov.

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

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

To request an ID number, go to the Department of Social Services website at nppes.cms.hhs.gov.

Washington Recovery Help Line:

Phone: **866-789-1511**

Website: www.warecoveryhelpline.org

Credentialing

Credentialing information is available at providerexpress.com > Clinical Resources > Guidelines/Policies & Manuals > Credentialing Plans > Optum

Covered Services

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

liveandworkwell.com, accessed through a link on myuhc.com, includes behavioral health and well-being information, articles on health conditions, addictions and coping, and provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources. Enter "UHCWA" to access Washington care provider information on liveandworkwell.com.



For member resources, go to providerexpress.com. Go to the Live and Work Well (LAWW) clinician center. Locate Health Condition Centers at the Clinical Resources tab. The Provider Express Recovery and Resiliency page includes tools to help members addressing behavioral health and substance use issues.

Benefits include but are not limited to:

- Crisis stabilization services (includes treatment crisis intervention).
- Outpatient assessment and treatment:
 - Partial hospitalization
 - Social detoxification
 - Day treatment
 - Intensive outpatient
 - Medication management
 - Lower-level behavioral health services

- Outpatient therapy (individual, family, or group), including injectable psychotropic medications
- Psychological evaluation and testing
- Hospital observation room services (up to 23 hours and 59 minutes in duration)
- Child-parent psychotherapy
- Multi-systemic therapy
- Functional family therapy
- Electroconvulsive therapy
- Virtual Visits
- Psychiatric services
- Neuropsychological testing
- Annual depression screenings for members and caregivers younger than 6 months of age as well as members aged 12-20

Eligibility

Verify the UnitedHealthcare Community Plan 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 Link at UHCprovider.com.

Authorizations

Members may access all behavioral health outpatient services (behavioral health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care. Help ensure prior authorizations are in place before rendering non-emergent services. Get prior authorization by going to UHCprovider.com/priorauth, calling **866-604-3267**, or faxing **844-881-4772**.

Portal Access

Website: UHCprovider.com

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

View the Prior Authorization list, find forms and access the care provider manual. Or call Provider Services at 866-815-5334 to verify eligibility and benefit information (available 8 a.m. - 5 p.m. Central Time, Monday through Friday).

Website: providerexpress.com

Update provider practice information, review guidelines and policies, and view the national Optum Network Manual. Or call Provider Services at 877-542-9231.

Appeals and Grievances

Call **877-542-8997**, and a Provider Services representative will assist you with the Appeals and Grievances process. You may file an appeal with written consent from the member within 60 calendar days of the adverse benefit determination.

Send written requests to:

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

Claims

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

Monitoring Audits

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

Addressing the Opioid Epidemic

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

BRIEF SUMMARY OF FRAMEWORK

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

INCREASING EDUCATION & AWARENESS OF OPIOIDS

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

Access these resources at [UHCprovider.com](https://www.uhcprovider.com). Then click “Drug Lists and Pharmacy”. Click Resource Library to find a list of tools and education.

PRESCRIBING OPIOIDS

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

Medication Assisted Treatment (MAT)

Evidence-based MAT treatment is central to OUD treatment. MAT takes a chronic condition approach and incorporates medication use in addition to other services, such as counseling, cognitive behavioral therapies, and recovery support, to provide a comprehensive approach to OUD.

These services are a medical benefit and only to care providers with a CLIA Waiver. 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](https://www.hca.wa.gov). You can also call Provider Services at 877-542-9231.

To find a MAT provider in Washington:

1. Go to [UHCprovider.com](https://www.uhcprovider.com)
2. Select “Find a Care Provider” from the menu on the home page
3. Select under “Specialty Directory and Tools” the option of Optum Behavioral Health, EAP, Worklife & Mental Health Services
4. Click on “Search for a Behavioral Health Provider”
5. Enter “(city)” and “(state)” for options
6. Refine the search by selecting “Medication Assisted Treatment”

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

Chapter 8: Member Rights and Responsibilities

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

Privacy Regulations

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

ACCESS TO PROTECTED HEALTH INFORMATION

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

AMENDMENT OF PHI

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

ACCOUNTING OF DISCLOSURES

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

- For treatment, payment and health care operations purposes

- To members or pursuant to member's authorization
- To correctional institutions or law enforcement officials
- For which federal law does not need us to give an accounting

RIGHT TO REQUEST RESTRICTIONS

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

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

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

Member Rights and Responsibilities

The following information is in the Member Handbook at the following link under the Member Information tab: [UHCCommunityPlan.com](https://www.uhc.com/CommunityPlan).

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 may:

- Request information on advance directives.
- Give and be treated with respect, dignity and privacy.
- Receive courtesy and prompt treatment.
- Receive cultural assistance, including having an interpreter during appointments and procedures.
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered.
- Know the qualifications of their health care provider.
- Give their consent for treatment unless unable to do so because life or health is in immediate danger.
- Discuss any and all treatment options with you.
- Refuse treatment directly or through an advance directive.
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do.
- Receive medically necessary services covered by their benefit plan.
- Receive information about in-network care providers and practitioners, and choose a care provider from our network.
- Change care providers at any time for any reason.
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response.
- Tell us their opinions and concerns about services and care received.
- Register grievances or complaints concerning the health plan or the care provided.
- Appeal any payment or benefit decision we make.
- Review the medical records you keep and request changes and/or additions to any area they feel is needed.
- 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 health care professionals are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage.

- Make suggestions about our member rights and responsibilities policies.
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply.

MEMBER RESPONSIBILITIES

Members should:

- Understand their benefits so they can get the most value from them.
- Show you their Medicaid member ID 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 emergency room 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 three primary member responsibilities as required by the National Committee of Quality Assurance (NCQA) are to:

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

Chapter 9: Medical Records

Medical Record Charting Standards

You are required to keep complete and orderly medical records, which fosters efficient and quality member care. You are subject to our periodic quality medical record review. The review determines compliance to the following requirements:

Topic	Contact
Confidentiality of Record	Office policies and procedures exist for: <ul style="list-style-type: none"> • 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.
Record Organization	<ul style="list-style-type: none"> • Have a policy that provides medical records upon request. Urgent situations require copies be provided within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. The records should be: <ul style="list-style-type: none"> - In order. - Fastened, if loose. - Separate for each member. - Filed in a manner for easy retrieval. - Readily available to the treating care provider where the member generally receives care. - Promptly sent to specialists upon request. • Medical records are: <ul style="list-style-type: none"> - Stored in a manner that helps ensure privacy. - Released only to entities as designated consistent with federal requirements. - Kept in a secure area accessible only to authorized personnel.

Topic	Contact
Procedural Elements	<p>Medical records are readable*</p> <ul style="list-style-type: none"> • 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	<p>An initial history (for members seen three or more times) and physical is performed. It should include:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - 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

Topic	Contact
<p>Problem Evaluation and Management</p>	<p>Documentation for each visit includes:</p> <ul style="list-style-type: none"> • Appropriate vital signs (Measurement of height, weight, and BMI annually) <ul style="list-style-type: none"> - 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 Early, Periodic, Screening, Diagnosis and Treatment (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: <ul style="list-style-type: none"> - Timeframe for follow-up visit as appropriate - Appropriate use of referrals/consults, studies, 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, practitioner are documented.

*Critical element

SCREENING AND DOCUMENTATION TOOLS

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

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 two visits, with ongoing physical assessments occurring on following visits. It should also include:

- Problem list with:
 - Biographical data with family history.
 - Past and present medical and surgical intervention.
 - Significant medical conditions with date of onset and resolution.
 - Documentation of education/counseling regarding HIV pre- and post-test, including results.
- Entries dated and the author identified.
- Legible entries.
- Medication allergies and adverse reactions (or note if none are known).
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen three or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record.
- Tobacco habits, alcohol use and substance abuse (12 years and older).
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one.
- History of physical examination (including subjective and objective findings).

- Unresolved problems from previous visit(s) addressed in subsequent visits; Diagnosis and treatment plans consistent with finding.
- Lab and other studies as appropriate.
- Member education, counseling and/or coordination of care with other care providers.
- Notes regarding the date of return visit or other follow-up.
- Consultations, lab, imaging and special studies initialed by primary care provider to indicate review.
- Consultation and abnormal studies including follow-up plans.

Member hospitalization records should include, as appropriate:

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

Medical Record Documentation Standards Audit Tool Sample

Provider Name		
Provider ID#:	Provider Specialty:	
Reviewer Name:	Review Date:	Score:
Member Name/Initials:	Member ID#:	

Confidentiality & Record Organization & Office Procedures	Confidentiality & Record Organization & Office Procedures			Confidentiality & Record Organization & Office Procedures			Confidentiality & Record Organization & Office Procedures		
	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. The office has a policy regarding medical record confidentiality that addresses office staff training on confidentiality; release of information; record retention; and availability of medical records housed in a different office location (as applicable).									
2. Staff is trained in medical record confidentiality.									
3. The office uses a Release of Information form that requires member signature.									
4. There is a policy for timely transfer of medical records to other locations/ care providers.									
5. There is an identified order to the chart assembly.									
6. Pages are fastened in the medical record.									
7. Each member has a separate medical record.									
8. Medical records are stored in an organized fashion for easy retrieval.									
9. Medical records are available to the treating practitioner where the member generally receives care.									
10. Medical records are released to entities as designated consistent with federal regulations.									
11. Records are stored in a secure location only accessible by authorized personnel.									
12. There is a mechanism to monitor and handle missed appointments.									

History	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. Medical and surgical history is present.									
2. The family history includes pertinent history of parents and/or siblings.									
3. The social history minimally includes pertinent information such as occupation, living situation, etc.									

Preventative Services	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. Evidence of current age appropriate immunizations.									
2. Annual comprehensive physical (or more often for newborns).									
3. Documentation of mental & physical development for children and/or cognitive functioning for adults.									
4. Evidence of depression screening.									
5. Evidence of screening for high-risk behaviors such as drug, alcohol and tobacco use, sexual activity, exercise and nutrition counseling									
6. Evidence that Medicare members are screened for functional status and pain.									
7. Evidence of tracking and referral of age and gender appropriate preventive health services.									
8. Use of flow sheets or tools to promote adherence to clinical practice guidelines/preventative screenings.									

Problem Evaluation and Management	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
Documentation for each visit includes:									
1. Appropriate vital signs (i.e., weight, height, BMI measurement annually).									
2. Chief complaint.									
3. Physical assessment.									

Problem Evaluation and Management	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
4. Diagnosis.									
5. Treatment plan.									
6. Treatment plans are consistent with evidence-based care and with findings/diagnosis.									
7. Appropriate use of referrals/consults, studies, tests.									
8. X-rays, labs, consultation reports are included in the medical record with evidence of practitioner review.									
9. Timeframe for follow-up visit as appropriate.									
10. Follow-up of all abnormal diagnostic tests, procedures, X-rays, consultation reports.									
11. Unresolved issues from the first visit are followed-up on the subsequent visit.									
12. There is evidence of coordination of care with behavioral health.									
13. Education, including counseling, is documented.									
14. Member input and/or understanding of treatment plan and options is documented.									
15. Copies of hospital discharge summaries, home health care reports, emergency room care, physical or other therapies as ordered by the practitioner are documented.									

$$\begin{array}{ccccccc}
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 & & & & \text{of Questions)} & & \text{of Questions)} & &
 \end{array}$$

If a care provider scores less than 85%, review five more charts. Only review those elements the care provider received a “NO” on in the initial phase of the review. Upon secondary review, if a data element scores at 85% or above, that data element is recalculated as a “YES” in the initial scoring. If upon secondary review, a data element scores below 85%, the original calculation remains.

***Items are MUST PASS**

Chapter 10: Quality Management (QM) Program and Compliance Information

What is the Quality Improvement Program?

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

The program consists of:

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

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

COOPERATION WITH QUALITY-IMPROVEMENT ACTIVITIES

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

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

Quality Improvement Program

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

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

Credentialing Standards

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

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

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

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 RE-CREDENTIALING

UnitedHealthcare Community Plan evaluates the following practitioners:

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

Excluded from this process are practitioners who:

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

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

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



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

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

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

ADVANCE DIRECTIVES

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

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

Peer Review

CREDENTIALING PROCESS

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

RE-CREDENTIALING PROCESS

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

PERFORMANCE REVIEW

As part of the re-credentialing 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 may review the information in support of credentialing/ re-credentialing applications as well as your application status. This review is at your request and is facilitated by the credentialing staff. The staff notifies you of any information found during the credentialing or re-credentialing process that varies from what you gave UnitedHealthcare Community Plan. You may correct errors if the credentialing staff asks for clarification.

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.

FAILURE TO MEET RE-CREDENTIALING REQUIREMENTS

If you don't meet our re-credentialing requirements, we will end your participation with our network. We will give you a written termination notice. The termination notice will include the reasoning, the effective date and an explanation of your appeal rights, if applicable.

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

HIPAA Compliance – Your Responsibilities

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

TRANSACTIONS AND CODE SETS

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

UNIQUE IDENTIFIER

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

NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

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

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

SECURITY

Covered entities must meet basic security measures:

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

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



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

Ethics & Integrity

INTRODUCTION

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

COMPLIANCE PROGRAM

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

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

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

REPORTING AND AUDITING

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

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



To facilitate the reporting process of questionable incidents involving members or care providers, call our [Fraud and Abuse line](#).

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

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

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

EXTRAPOLATION AUDITS OF CORPORATE-WIDE BILLING

UnitedHealthcare Community Plan will work with the State of 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 the 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 (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

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

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

You must cooperate with the state or any of its authorized representatives, the Washington HCA, the Centers for Medicare & Medicaid Services, 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 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 services (QOS) concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all 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.

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

Chapter 11: Billing and Submission

Our Claims Process

UnitedHealthcare Community Plan follows the same claims process as UnitedHealthcare.



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

National Provider Identifier

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



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

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

General Billing Guidelines

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

Fee Schedule

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

Modifier Codes

Use the appropriate [modifier codes](#) on your claim form. The modifier must be used based on the date of service.

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 and occurrence span codes. A separate authorization for the administrative days is required in addition to the initial acute care or observation level of care authorization(s).

Administrative days claims for patients waiting to be discharged to a skilled nursing facility require the claim to include the appropriate occurrence span code. Claims for administrative days for patients waiting to be discharged to home or to a location other than a skilled nursing facility 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 1500 and UB-04 claim forms.

Use the 02/12 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services.

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

Clean Claims and Submission Requirements

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

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

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

Submit any services completed by nurse practitioners or physician assistants who are part of a collaborative agreement.

Care Provider Coding

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

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.

- OptumInsight can provide you with clearinghouse connectivity or your software vendor can connect through an entity that uses OptumInsight.
- All claims are set up as “commercial” through the clearinghouse.
- Our payer ID is 87726.
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don’t successfully transmit.
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for HCFA 1500 and UB-04 forms.

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



For more information, contact [EDI Claims](#). You can also see [enshealth.com](#) or contact [Provider Services](#).

EDI Companion Documents

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

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

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



The companion documents are located on [UHCprovider.com/edi](https://uhcprovider.com/edi) > Go to companion guides

Importance and Usage of EDI Acknowledgment/Status Reports

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



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

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

e-Business Support

UnitedHealthcare Community Plan support services are available 8 a.m. to 5 p.m., Monday through Friday (Pacific Time). They can help you with Electronic Remittance Advices (ERAs) and Electronic Funds Transfers (EFTs). To use ERAs, you must enroll through a clearinghouse or entity that uses OptumInsight.

Support is also available for [EDI Claims](https://uhcprovider.com/edi) (800-210-8315, ac_edi_ops@uhc.com) and [EDI Log-on Issues](https://uhcprovider.com/edi) (800-842-1109, [UHCprovider.com](https://uhcprovider.com))

Find more information at [UHCprovider.com/edi](https://uhcprovider.com/edi). You can also call EDI Customer Service at 800-210-8315.

IMPORTANT EDI PAYER INFORMATION

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

Completing the CMS 1500 Claim Form



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

Visit the [National Uniform Claim Committee](https://www.nacm.com) website to learn how to complete the CMS 1500 form.

Completing the UB-04 Form

Bill all hospital inpatient, outpatient and emergency room services using revenue codes and the [UB-04 claim form](https://uhcprovider.com/edi):

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

Form Reminders

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

Subrogation and Coordination of Benefit

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

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

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

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

This means:

- Affected members will have three ID cards: a ProviderOne card, a primary insurance card, and a UnitedHealthcare Community Plan card.
- You must verify eligibility.
- 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, prenatal diagnosis, prenatal procedure codes, private duty nursing procedure codes and ABA procedure codes follow our Pay & Chase policy.
- We may bill or adjust claims with OHI 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.

Medicare Crossover Claims

The HCA 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.

Hospital and Clinic Method of Billing Professional Services

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

Correct Coding Initiative

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

COMPREHENSIVE AND COMPONENT CODES

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

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

Clinical Laboratory Improvements Amendments

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

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

Billing Multiple Units

When billing multiple units:

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

Billing Guidelines for Obstetrical Services

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

- If billing for both delivery and prenatal care, use the date of delivery.
- Use one unit with the appropriate charge in the charge column.
- Gather all required referrals and evaluations to complete the pre-transplant evaluation process once the member is a possible candidate.

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.

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](https://www.cms.gov) for Place of Service codes.

Asking About a Claim

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

PROVIDER SERVICE

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

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

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

UNITEDHEALTHCARE COMMUNITY PLAN PROVIDER PORTAL

You can view your online transactions with Link by signing in to Link on [UHCprovider.com](https://uhcprovider.com) with your Optum ID. This portal offers you with online support any time. If you are not already registered, you may do so on the website.

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


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

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

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

Find Link training on [UHCprovider.com](https://uhcprovider.com).

Resolving Claim Issues

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

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 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.

FOR PAPER CLAIMS

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

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

TIMELY FILING

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

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

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

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

To be timely, you must 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.

Balance Billing

Do not balance bill members if:

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

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



If you don't know who your provider advocate is, email washington_PR_Team@uhc.com. A provider advocate will get back to you.

Chapter 12: Claim Reconsiderations, Appeals and Grievances

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

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

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
SITUATION	DEFINITION	WHO MAY SUBMIT?	SUBMISSION ADDRESS	ONLINE FORM FOR FAX OR MAIL	CONTACT PHONE NUMBER/ FAX	WEBSITE (Care Providers Only) for Online Submissions	CARE PROVIDER FILING TIMEFRAME	UnitedHealthcare Community Plan RESPONSE TIMEFRAME
Member Appeal	A request to change an adverse benefit determination that we made.	<ul style="list-style-type: none"> Member Care provider on behalf of a member with written member consent 	Address as shown in Member Handbook	UHC provider.com	877-542-8997	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	Urgent appeals – must receive within 5 business days. Standard appeals – 60 calendar days	Urgent appeals We will respond within 72 hours of request Standard appeals= 14-28 days
Member Grievance	A member's written or oral expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	<ul style="list-style-type: none"> Member Care provider on behalf of a member with written member consent 	Address as shown in Member Handbook	UHC provider.com	877-542-8997	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	30 business days	30 business days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

SITUATION	DEFINITION	WHO MAY SUBMIT?	SUBMISSION ADDRESS	ONLINE FORM FOR FAX OR MAIL	CONTACT PHONE NUMBER/ FAX	WEBSITE (Care Providers Only) for Online Submissions	CARE PROVIDER FILING TIMEFRAME	UnitedHealthcare Community Plan RESPONSE TIMEFRAME
Care Provider Claim 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	UHC provider.com	877-542-9231	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	24 months from initial process date	30 business days
Care Provider Claim Reconsideration	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care Provider	UnitedHealthcare Community Plan P.O. Box 31361 Salt Lake City, UT 84131-0361	UHC provider.com	877-542-9231	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	24 months from initial process date	45 business days
Care Provider Claim Formal Appeal	A review when you do not agree with how a claim was paid.	Care Provider	UnitedHealthcare Community Plan Attention: Formal Claim Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	UHC provider.com	877-542-9231	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	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	UHC provider.com	866-815-5334 Fax: 801-994-1082	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	120 business days	30 business days

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

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

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

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

Denial

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

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

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

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

Other top reasons for denial include:

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

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

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

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

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

Claim Correction

What is it?

A corrected claim replaces a previously denied submitted claim due to an error. A denied claim has been through claim processing and determined it can't be paid.

When to use:

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

Mailing address:

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

Additional Information:

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

Resubmitting a Claim

What is it?

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

When to use it:

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

Common Reasons for Rejected Claims:

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

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

How to use:

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

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

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

Claim Reconsideration

What is it?

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

When to use:

Submit a claim reconsideration when you think a claim has not been properly processed.

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, mail or fax:

- **Electronically:** Use the Claim Reconsideration application on Link. Include electronic attachments. You may also check your status using Link.
- **Phone:** Call Provider Services at **877-542-9231** 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.

- **Fax:** Send the Claim Reconsideration Request Form to **801-994-1224**.

Valid Proof of Timely Filing Documentation (Reconsideration)

What is it?

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

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

A submission report is not proof of timely filing for electronic claims. It must be accompanied by an

acceptance report. Timely filing denials are often upheld due to incomplete or wrong documentation submitted with a reconsideration request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use:

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

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

Additional Information:

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

Appeals

What is it?

A claim appeal is a review of how a claim was paid.

When to use:

If you do not agree with the outcome of the claim reconsideration decision, use the claim appeal process.

How to use:

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

- **Electronic claims:** Use the Claims Management or ClaimsLink application on Link. You may upload attachments.

- **Mail:** Send the appeal to:

UnitedHealthcare Community Plan

Formal Claim Appeals

P.O. Box 31364

Salt Lake City, UT 84131-0364

- **Fax:** Send the appeal to **801-994-1082**.

TIPS FOR SUCCESSFUL CLAIMS RESOLUTION

To help process claim reconsiderations:

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

Overpayment

What is it?

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

How to use:

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

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

If you prefer to mail a refund, send an Overpayment Return Check or the Return Overpayment through the Adjustment Request form.

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

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

Where to send:

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

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

Instructions and forms are on UHCprovider.com.

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

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

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

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

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

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 toll free at **877-542-9231**

- **Mail:** Send care provider name, contact information and your grievance to:

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

Member Appeals and Grievances Definitions and Procedures

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

APPEALS

What is it?

An appeal is a review UnitedHealthcare Community Plan performs of an adverse benefit determination.

You or a member may appeal when the plan:

- Makes an adverse determination or limits a requested service(s). This includes the type or level of service.

- Lowers, suspends or ends a previously authorized service.
- Fails to provide services in a timely manner, as defined by the state or CMS.
- Doesn't act within the time frame CMS or the state requires.

When to use:

You may act on the member's behalf with their written consent. You may provide medical records and supporting documentation as appropriate.

Where to send:

Call, mail or fax the information within 60 calendar days from the date the service was denied to:

UnitedHealthcare Community Plan

Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 8413-0364

Toll-free: **877-542-8997**

Fax: **801-994-1082**

How to use:

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

- Receive a copy of the rule used to make the decision.
- Ask someone (a family member, friend, lawyer, health care provider, etc.) to help. The member may present evidence, and allegations of fact or law, in person and in writing.
- The member or representative may 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. Provider certification is a written confirmation from you that the expedited request is urgent. Fax urgent appeal requests to 801-994-1261.

- Ask for continuation of services during the appeal. However, the member may have to pay for the cost of the benefits received for the first 60 calendar days after the appeal or hearing request was received if it is continued or if the member should not have received the service.
- We must resolve a standard appeal 14 calendar days from the day we receive it, unless we request an extension.
- We must resolve an expedited appeal 72 hours from when we receive it. We may extend the response up to 14 calendar days if the following conditions apply:
 1. Member requests may take longer.
 2. We request additional information and explain how the delay is in the member's interest.

MEMBER GRIEVANCE

What is it?

Grievances are complaints about anything other than an adverse benefit determination.

When to use:

You may file a grievance as the member's representative with their written consent.

Where to send:

You or the member may file a grievance by calling Member Services or writing UnitedHealthcare Community Plan:

Mailing address:

UnitedHealthcare Community Plan

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

Toll-free: **877-542-8997**

We will send an answer no longer than 45 working days from the date the complaint or grievance was filed. We will send a response to all parties involved in the grievance within 45 working days.

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:

Members have 120 days from the original denial letter date 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:

The UnitedHealthcare Community Plan member 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 **800-583-8271**.

- If the member has not been given their rights to a hearing contact the Participant Services Unit at **800-392-2161**.
- The member may have someone attend with them. This may be a family member, friend, care provider or lawyer.
- Hearings are held on the phone. Members may go to the local Family Support Division office for the hearing or can take part from home.

Request for Independent Review Organization

A member may seek review by a certified Independent Review Organization (IRO) following the Office of Administrative Hearing's (OAH) decision to uphold our decision to deny, modify, reduce, or terminate coverage of or payment for a health care service. Upon notice by a certified IRO, the 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 no later than three working days from receipt of the request for said information.

Petition for Review by the Board of Appeals

The HCA member handbook describes the process members can follow if they are dissatisfied with the outcome of the final decision by an IRO. The member may appeal the decision to the HCA Board of Appeals (BOA). The BOA reviews administrative hearing decisions issued by administrative law judges at the OAH. BOA review judges are attorneys who review hearing decisions for legal and factual errors, change the decisions as necessary. Then they issue final decisions on behalf of the Secretary of the Department of Social and Health Services. All BOA review judges are members of the Washington state Bar Association.

Processes Related to Reversal of Our Initial Decision

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

Also report the incidents to all the following entities within 5 business days of learning of the allegation:

- Call us at 866-242-7727 or visit uhc.com/fraud.
- Email Washington State Health Care Authority at HotTips@hca.wa.gov or 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 the UnitedHealth Group policy on Fraud, Waste and Abuse at uhc.com/fraud or call **866-242-7727**.

The Deficit Reduction Act (DRA) has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least \$5 million in annual Medicaid payments must have written policies for entity employees and contractors. They must provide detailed information about false

claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

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

EXCLUSION CHECKS

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

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

WHAT YOU NEED TO DO FOR EXCLUSION CHECKS

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

Chapter 13: Care Provider Communications & Outreach

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

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

Care Provider Websites

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

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

- An online version of this manual
- Clinical practice guidelines (which cover diabetes, ADHD, depression, preventive care, prenatal, and other guidelines)
- Electronic data interchange
- Quality and utilization requirements
- Educational materials such as newsletters and bulletins

- Provider service updates – new tools and initiatives (UHC on Air, PreCheck MyScript, etc.)

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

Care Provider Office Visits

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

Care Provider Newsletters and Bulletins

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

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

The newsletters also include notifications about changes in laws and regulations. UnitedHealthcare Community Plan posts electronic bulletins on [UHCprovider.com](https://www.uhcprovider.com). Click Menu, then Resource Library, News to quickly share urgent information that affects the entire network.



Find more information about the Network Bulletin, Medical Policy Update Bulletin and other communications on [UHCprovider.com/guides](https://www.uhcprovider.com/guides) > Provider Communication Chapter 17.

Care Provider Manual

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

Find the following forms online:

- Sterilization Consent Form on [hhs.gov](https://www.hhs.gov)
- Informed Consent for Hysterectomies Form on [hca.wa.gov](https://www.hca.wa.gov)
- Core Provider Agreement (HCA 09-015) on [hca.wa.gov](https://www.hca.wa.gov)
- Prior Authorization Form on [UHCprovider.com](https://www.uhcprovider.com)

Chapter 14: Glossary

AABD

Assistance to the aged, blind and disabled

Abuse (by care provider)

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

Abuse (of member)

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

Acute Inpatient Care

Care provided to members sufficiently ill or disabled requiring:

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

Administrative Hearing

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.

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

The denial or limited authorization of a requested service.

This includes:

- Type or level of service
- Requirements for medical necessity
- Appropriateness
- Setting or effectiveness of a covered benefit
- Reduction, suspension or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Determination of whether the member has good cause not to cooperate with third-party liability procedures when this will result in denial of payment
- 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
- Our failure to act within the time frames for disposition, resolution, and notification of appeals and grievances
- Denial of an enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities
- Rural area resident with only one managed care organization available
- Denial of an enrollee's request under 42 C.F.R. § 438.52(b)(2)(ii) to obtain services outside the contractor's network.
- A plan's denial of coverage by an out-of-network care provider when the network care providers do not have the needed training, experience, and specialization; or do not provide the service the member seeks, when receiving all care in-network would subject the member to unnecessary risk; or when other circumstances warrant out-of-network treatment. (42 C.F.R. § 438.400(b)).

Ambulatory Care

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

Ambulatory Surgical Facility

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

Ancillary Provider Services

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

Appeal

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. Healthy Options is now managed care coverage in Washington Apple Health to the end of the definition.

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 through Friday, 8 a.m. to 5 p.m., Pacific Time, 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 Primary Care Provider (PCP).

Centers for Medicare & Medicaid Services (CMS)

The federal agency within the U.S. DHHS that administers the Medicare program and works in partnership with state governments to administer Medicaid, the CHIP, and health insurance portability standards.

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.

CMS

Centers for Medicare and Medicaid Services, the federal agency within the U.S. Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children’s Health Insurance Program (CHIP), and health insurance portability standards.

Community Service Office (CSO)

An office under the HCA that administers social and health services and determines eligibility for benefits at the local community level.

Contracted Health Professionals

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

Contracted Services

Services to be provided by UnitedHealthcare Community Plan under the terms of our contract with HCA.

Coordination of Benefits (COB)

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

Core Provider Agreement

A basic contract that HCA holds with medical care providers serving HCA clients. The care provider agreement outlines and defines terms of participation in the Medicaid program.

Covered Services

Health care services HCA determines are covered for members.

Credentialing

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

Current Procedural Terminology (CPT) Codes

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

Delivery System

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

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 provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member. Examples are:

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

Discharge Planning

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

Disenrollment

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

Dispute

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

DSHS

Department of Social and Health Services, the Washington State agency responsible for providing a broad array of health care and social services.

Dual Coverage

When a member is enrolled with two UnitedHealthcare Community Plan plans at the same time.

Durable Medical Equipment (DME)

Equipment that:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful for a person in the absence of illness or injury; and
- Is appropriate for use in the client's place of residence.

Early Periodic Screening Diagnosis and Treatment Program (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 two or more organizations.

Electronic Funds Transfer (EFT)

The electronic exchange of funds between two or more organizations.

Electronic Medical Record (EMR)

An electronic version of a member's health record and the care they have received.

Eligibility Determination

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

Emergency Care

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

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

Enrollee

An eligible client enrolled in managed care through a Managed Care Organization (MCO) having a contract with HCA (42 C.F.R. § 438.10(a)). Enrollee is interchangeable with the term member. Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber.

Enrollment

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

Evidence-Based Care

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

Expedited Appeal

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

treatment that is the subject of the appeal.

Expedited Grievance

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

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).

Grievance

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 care provider or employee, or failure to respect the member's rights.

HCA

The 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 six 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 National Committee for Quality Assurance (NCQA).

HIPAA

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

Home Health Care (Home Health Services)

A range of services provided in a member'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 HO, SCHIP and BH 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 women, people with disabilities, and other adults. The federal government pays for part of Medicaid and sets guidelines for the program. States pay for part of Medicaid and have choices in how they design their program. Medicaid varies by state and may have a different name in your state.

Medical 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 member 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 client 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 individual who is eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement.

NCQA

National Committee for Quality Assurance, 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.

NPI

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

Out-Of-Area Care

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

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 members under the terms of the agreement.

Preventative Health Care

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

Primary Care Provider (PCP)

A participating care provider who supervises, coordinates, and provides primary health care to members; initiates referrals for specialist care; and maintains the continuity of member 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 health 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 which the referring care provider is not prepared or qualified to provide.

Remittance Advice (RA)

Written explanation of processed claims.

Rural Health Clinic

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

Service Area

The geographic area served by UnitedHealthcare Community Plan, designated and approved by Washington Apple Health.

Specialist

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

TANF

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

Third-Party Liability (TPL)

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

Timely Filing

When UnitedHealthcare Community Plan puts a time limit on submitting claims.

Title XIX

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

UnitedHealthcare Community Plan

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

Utilization Management (UM)

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

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.