Welcome

Welcome to the Community Plan provider manual. This complete and up-to-date reference PDF (manual/guide) allows you and your staff to find important information such as processing a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Operational policy changes and other electronic tools are ready on our website at UHCprovider.com.

- **UnitedHealthcare Administrative Guide** for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- **West Capitated Administrative Guide**, or go to uhcowest.com > Provider, click Library at the top of the screen. The Provider Administrative Guides link is on the left.
- A different Community Plan manual—go to UHCCommunityPlan.com, click For Health Care Professionals at the top of the screen. Select the desired state.

You may easily find information in the manual using the following steps:

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

If available, use the binoculars icon on the top right hand side of the PDF.

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

We greatly appreciate your participation in our program and the care you offer our members.

**Important Information about the use of this manual**

In the event of a conflict between your agreement and this care provider manual, the manual controls unless the agreement dictates otherwise. In the event of 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.
Welcome to UnitedHealthcare Community Plan of Wisconsin.

Welcome to UnitedHealthcare Community Plan of Wisconsin. UnitedHealthcare, a division of UnitedHealth Group, administers parts of Wisconsin's State Government Health Care Benefits Program.

This provider manual is a source of information for you and your staff to help you conduct your transactions with us efficiently. Much of this material, as well as operational policy changes and additional electronic tools, are available on our website at UHCCommunityPlan.com.

Our goal is to help ensure our members have convenient access to high-quality care, and we are committed to working with you and your staff to achieve this goal.

If you have any questions about the information or material in this administrative guide or about any of our policies and procedures, please do not hesitate to contact Provider Services at 877-651-6677.

We greatly appreciate your participation in our program and the care you provide to our members.
# Table of Contents

**How to Contact Us** 6  
**Quick Reference Guide** 8  
**Member Rights and Responsibilities** 10  
**Member ID Cards** 11  
**Products and Benefits** 12  
**Behavioral Health Services** 15  
- Screening for Behavioral Health Problems  
- Referrals for Behavioral Health Services  
- Medicaid Members – ID Cards for Behavioral Health Services  
- Authorization for Continuation of Outpatient Behavioral Health Services  
- Behavioral Health Guidelines and Standards  
- Screening for Behavioral Health Issues  
- Screening Tool Forms  
**Medical Management** 21  
- Emergency Admissions  
- Care in the Emergency Room  
- Determination of Medical Necessity  
- Utilization Review Criteria and Guidelines  
- Care Provider’s Responsibility to Verify Prior Authorization  
- Authorization of Care for New Members  
- Prior Authorization Request Form  
- Outpatient Radiology Prior Authorization Program  
- Time Frames for Seeking Prior Authorization/Notifying UnitedHealthcare Community Plan  
- Maternity Care and Delivery Admissions  
- Sick Newborn Admissions  
- Enrollment of Newborns (Medicaid)  
- Concurrent Review  
- Inpatient Concurrent Review: Clinical Information  
- Discharge Planning and Continuing Care  
- Care Management  
**Healthy First Steps® (HFS)** 31  
- Baby Blocks  
- HFS OB Risk Assessment Form HFS  
**Care Provider Requirements** 33  
- Protect Confidentiality of Member Data  
- Care Provider’s Responsibility for Termination of Member as Patient  
- Credentialing and Re-credentialing  
- WI State Medicaid ID National Provider Identifier (NPI)  
- Exemption to Federal National Provider Identifier Provider Number Requirements  
- Panel Roster  
- Customer Notification of Physician Departure From the UnitedHealthcare Participating Provider Network  
- Continuity of Care for Primary Care Providers
Table of Contents

Continuity of Care During a Pregnancy
Continuity of Care When Provider Leaves Network
Utilization Management Appeals
Member Pre-Service Appeals Process
Sanctions Under Federal Health Programs and State Law
Selection and Retention of Participating Providers
Termination of Participating Provider Privileges
Appeal Process for Provider Participation Decision

Our Claims Process 41
UnitedHealthcare Community Plan Online for Efficient, Prompt Service
Change to Electronic Solutions
Complete Claims
Pharmacy Claims
Billing Members
Claim Appeals
Claim Overpayments
Outlier Appeal Process
Subrogation and Coordination of Benefits
Claim Editing
Vaccines for Children Program (VFC)

Compliance 49
Integrity and Compliance
Fraud and Abuse
Resolving Disputes

Physician and Provider Demographic Change Submission Form 53

Quality Improvement 56
Medical Record Documentation Standards
# How to Contact Us

<table>
<thead>
<tr>
<th>Healthy Savings</th>
<th><a href="http://uhcwihealthysavings.com">uhcwihealthysavings.com</a></th>
<th>Encourage Medicaid members to enroll in the program to help them with discounts on select healthy foods.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MyHealthLine (BadgerCare Plus and Medicaid SSI members)</td>
<td><a href="http://UHCmyHealthLine.com">UHCmyHealthLine.com</a></td>
<td>Encourage members to enroll in a no cost mobile phone service through the federal Lifeline Assistance program. Members can get health tips and reminders by text, calls with our member services at no cost and secure messaging with their care team.</td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan Website</td>
<td><a href="http://UHCCommunityPlan.com">UHCCommunityPlan.com</a></td>
<td>This website allows care providers to get updated provider information that includes: provider newsletters, provider administrative manual, clinical practice guidelines, provider bulletins, and reimbursement policies.</td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan Provider Portal</td>
<td><a href="http://UHCprovider.com/WI">UHCprovider.com/WI</a></td>
<td>This secure website allows care providers to process the following transactions: eligibility and benefits, claim submission and claim status, notification/prior authorization submission and status, radiology notification submission and status, single claim reconsideration and claim research project, single explanation of benefits (EOB) search, and reports.</td>
</tr>
<tr>
<td>Provider Service Center</td>
<td>877-651-6677</td>
<td>To inquire about a member’s eligibility or benefits, to check claim status, or make a claim appeal request.</td>
</tr>
</tbody>
</table>
| Prior Authorization | 877-651-6677  
Fax: 800-897-8317 | To notify us of the procedures and services outlined in the authorization requirements section of this guide. |
| Personal Care Prior Authorization | 855-821-4163  
Fax: 866-273-2240 | To request prior authorization for personal care services (not available online). |
| Notifications and Prior Authorization | [UHCprovider.com/priorauth](http://UHCprovider.com/priorauth) | To prepare and submit requests for prior authorization interactively through the web or through automated batch processing. |
| Behavioral Health | 877-651-6677 | To inquire about a member’s behavior health eligibility or benefits, to check claim status or make a claim appeal request. |
| Healthy First Steps | 800-599-5985  
Fax: 877-353-6913 | To refer pregnant members to Healthy First Steps. |
| Baby Blocks | [UHCBabyBlocks.com](http://UHCBabyBlocks.com) | Encourage members who are pregnant and/or have newborns to enroll at the Baby Blocks website. |
## How to Contact Us

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>855-516-2724</td>
<td>Care providers should contact MARCH Vision with questions about vision care services.</td>
</tr>
<tr>
<td>Transportation</td>
<td>866-907-1493</td>
<td>Share the state vendor number with your members who need transportation to and from their health care appointments.</td>
</tr>
<tr>
<td>NurseLine</td>
<td>866-827-0806</td>
<td>Health information and resources for members from registered nurses.</td>
</tr>
<tr>
<td>Dental</td>
<td>888-249-8833</td>
<td>Call for dental questions about your members in Milwaukee, Racine, Kenosha, Waukesha, Washington and Ozaukee counties. If outside of the listed counties, member benefits are covered by the state of Wisconsin.</td>
</tr>
</tbody>
</table>
Our Claims Process

To help ensure prompt payment for services:

1. **Review and copy** both sides of the member’s ForwardHealth ID card and UnitedHealthcare Community Plan ID card. Verify that the member’s eligibility is active and they’re enrolled with UnitedHealthcare Community Plan.

2. **Notify** UHC Prior Authorization of planned procedures and services on our Prior Authorization list.

3. **Prepare** a complete and accurate electronic or paper claim form (see ‘complete claims’ process below). Complete a CMS 1500 (formerly HCFA) or UB-04 form.

4. **Submit** claims timely and accurately. For electronic claim submission:
   - Be sure to use our electronic payer ID number (87726) to submit claims to us.
   - For more information, contact your vendor or our Electronic Data Interchange (EDI) unit at 800-210-8315.
   - If you do not have access to internet services, you can mail the completed claim to:

   **UnitedHealthcare Community Plan in Wisconsin**
   P.O. Box 5280
   Kingston, NY 12402-5280

Complete Claims

A complete claim includes the following:

- Member’s name, date of birth, address and ID number.
- Name, signature, address and phone number of care provider or care provider performing the service, as stated in your contract document.
- Wisconsin Medicaid Certified National Provider Identifier (NPI) number.
- Tax ID number.
- CPT and HCPCS procedure codes with modifiers where appropriate.
- ICD-10 diagnostic codes.
- Revenue codes (UB-04 only).
- Date of service(s), place of service(s) and number of services (units) rendered.
- Referring care provider’s name (if applicable).
- Information about other insurance coverage, including job-related, auto or accident information, if available.
- Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers.
- Attach an anesthesia report for claims submitted with QS modifier.
- Attach a description of the procedure/service provided for claims submitted with unlisted medical or surgical CPT codes or experimental or reconstructive services (if applicable).
- Include the exact NDC that appears on the product administered.
Other Important Information

Provider Appeals
UnitedHealthcare Community Plan Provider Appeal
P.O. Box 31364
Salt Lake City, UT 84131-0364
877-651-6677

Member Appeals Mailing Address
UnitedHealthcare Community Plan in Wisconsin
P.O. Box 31364
Salt Lake City, UT 84131-0364

Fraud and Abuse Division
UnitedHealthcare Community Plan in Wisconsin
Special Investigations Unit
866-242-7727

Review Criteria and Guidelines
UnitedHealthcare Community Plan uses state criteria and guidelines, MCG Care Guidelines, and UnitedHealthcare Community Plan medical policy for determinations of appropriateness of care.

Compliance

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

Notify UnitedHealthcare Prior Authorization Within the Following Time Frames:

Emergency Admission
Within one business day of an emergency or urgent admission.

Admission After Ambulatory Surgery
Within one business day of an inpatient admission after ambulatory surgery.

Non-Emergency Care (except maternity)
At least 14 calendar days prior to non-emergent, non-urgent hospital admissions and/or outpatient services.
Member Rights and Responsibilities

The following information is intended for UnitedHealthcare Community Plan members.

Rights

• You have the right to ask for an interpreter and have one provided to you during any BadgerCare Plus covered service.

• You have the right to receive the information provided in this member handbook in another language or another format.

• You have the right to receive health care services as provided for in federal and state law. All covered services must be available and accessible to you. When medically appropriate, services must be available 24 hours a day, seven days a week.

• You have the right to receive information about treatment options, including the right to request a second opinion.

• You have the right to make decisions about your health care.

• You have the right to be treated with dignity and respect and a right to privacy.

• You have the right to be free from any form of restraint or seclusion used as a means of force, control, ease or reprisal.

• You have the right to voice complaints or appeals about the HMO or the care you receive and to appeal to the State Division of Hearings and Appeals for a fair hearing if you believe your benefits are wrongly denied, limited, reduced, delayed or stopped by UnitedHealthcare.

• You have the right to request and receive copies of your medical records and may correct wrong information in your medical records if your doctor agrees to the correction.

• You have the right to expect that health care professionals are not prohibited or otherwise restricted from advising you about your health status, medical care or treatment regardless of benefit coverage.

• You have the right to receive information about this HMO, our services and care providers and about your rights and responsibilities.

• You have the right to make suggestions for this member rights and responsibilities policy.

Responsibilities

• You have the right to exercise your rights, and the exercise of those rights does not adversely affect the way the HMO and its network care providers treat the member.

• You have the right to receive information about your health so that you understand your health problems and help make goals for your treatment as much as possible.

• You have the right to request and receive copies of your medical records and may correct wrong information in your medical records if your doctor agrees to the correction.

• You have the right to expect that health care professionals are not prohibited or otherwise restricted from advising you about your health status, medical care or treatment regardless of benefit coverage.

• You have the right to receive information about this HMO, our services and care providers and about your rights and responsibilities.

• You have the right to make suggestions for this member rights and responsibilities policy.
Member ID Cards

ForwardHealth Card
The ForwardHealth card is the standard card issued to recipients who are eligible for BadgerCare Plus and Medicaid SSI. Possession of a ForwardHealth card does not guarantee eligibility. Periodically, recipients may become ineligible for Wisconsin Medicaid only to regain eligibility at a later date. It is possible that a recipient will present a card when they are not eligible; therefore, it is essential that providers confirm eligibility before providing services. Wisconsin Medicaid encourages recipients to keep their cards even though they may have periods of ineligibility.

If the card is lost, stolen, or damaged, Wisconsin Medicaid will replace the card at no cost to the recipient. If a family has more than one eligible recipient, each eligible family member receives a ForwardHealth card.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth member identification card. Always verify a member’s enrollment before providing nonemergency services to determine if there are any limitations to covered services and to obtain the correct spelling of the member’s name.

UnitedHealthcare ID Cards
UnitedHealthcare Community Plan issued member identification cards for all Wisconsin Medicaid health plans. The UnitedHealthcare Community Plan ID cards are there for reference only. Members still need to present a valid Wisconsin Department of Health Services ForwardHealth ID card to care providers when receiving care.

The UnitedHealthcare Community Plan ID cards have the Group and Member ID numbers that members use to:
- Access the secure member portal at myuhc.com/CommunityPlan.
- Use the Health4Me mobile app to access their health plan information.
## BadgerCare Plus Standard Plan
### Covered Services Overview

The covered services information in the following chart is provided as general information. Refer to your service-specific publications and the ForwardHealth Online Handbook for detailed information on covered and non-covered services and prior authorization (PA) information.

<table>
<thead>
<tr>
<th>Services</th>
<th>Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Surgery Centers</td>
<td>Coverage of certain surgical procedures and related lab services. No copayment.</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Full coverage. $0.50 to $3.00 copayment per service.</td>
</tr>
<tr>
<td>Dental</td>
<td>Full coverage in Milwaukee, Racine, Kenosha, Waukesha, Washington and Ozaukee. If the member lives outside of the above counties the benefits are covered by the state and may have a $0.50 to $3.00 copayment per service.</td>
</tr>
<tr>
<td>Disposable Medical Supplies</td>
<td>Full coverage. No copayment.</td>
</tr>
</tbody>
</table>
| Drugs                     | Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over the-counter (OTC) drugs. Members are limited to five prescriptions per month for opioid drugs. Copayments are as follows:  
  - $0.50 for OTC drugs.  
  - $1.00 for generic drugs.  
  - $3.00 for brand name drugs. Copayments are limited to $12.00 per member, per provider, per month. Over-the-counter drugs are excluded from this $12.00 maximum. |
| Durable Medical Equipment | Full coverage. No copayment.                                                                                                       |
| End-Stage Renal Disease   | Full coverage. No copayment.                                                                                                       |
## Health Screenings for Children
Full coverage of HealthCheck screenings and other services for individuals under the age of 21.
No copayment.

## Hearing Services
Full coverage.
No copayment.

## Home Care Services (Home Health, Private Duty Nursing [PDN], and Personal Care)
Full coverage of PDN, home health, and personal care services.
No copayment.

## Hospice
Full coverage.
No copayment.

## Inpatient Hospital
Full coverage.
No copayment.

## Mental Health and Substance Abuse Treatment
Full coverage (not including room and board).
No copayment.

## Nursing Home Services
Full coverage.
No copayment.

## Outpatient Hospital — Emergency Room
Full coverage.
No copayment.

## Outpatient Hospital
Full coverage.
No copayment.

## Physical Therapy, Occupational Therapy, and Speech and Language Pathology
Full coverage.
No copayment.

## Physician
Full coverage, including laboratory and radiology.
No copayment.
# Products and Benefits

## Podiatry
- Full coverage.
- No copayment.

## Prenatal/Maternity Care
- Full coverage, including prenatal care coordination, and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems.
- No copayment.

## Reproductive Health Service
- Full coverage, excluding infertility treatments, surrogate parenting and related services, including, but not limited to, artificial insemination and subsequent obstetrical care as a noncovered service, and the reversal of voluntary sterilization.
- No copayment for family planning services.

## Routine Vision
- Full coverage including coverage of eyeglasses.

## Transportation — Ambulance, Specialized Medical Vehicle (SMV), Common Carrier
- Full coverage of emergency and non-emergency medical transportation to and from a certified care provider for a covered service.
- Copayments are as follows:
  - $2.00 copayment for non-emergency ambulance trips.
  - $1.00 copayment per trip for transportation by SMV.
  - No copayment for transportation by common carrier or emergency ambulance.

**Note:** For additional information on copayments, care providers may refer to the Copayment chapter of the Reimbursement section of their specific-service area of the Online Handbook at [forwardhealth.wi.gov](http://forwardhealth.wi.gov).

### UnitedHealthcare Dual Complete (HMO SNP)

Behavioral Health Services

United Behavioral Health is an important resource to all providers when members experience mental health or chemical dependence problems. Care providers can call 877-651-6677.

United Behavioral Health:

- Operates 24 hours a day, seven days a week, 365 days per year.
- Is responsible for member emergencies and requests for inpatient behavioral health admissions 24 hours, seven days a week.
- Fully supports primary care providers with assessment and referrals to mental health and chemical dependence services.
- Provides behavioral health care management.
- Reviews, monitors, and authorizes behavioral health care.
- Is responsible for provider relations for behavioral health care providers.
- Is staffed by professionals with extensive experience in mental health disorder and chemical dependence service.

Screening for Behavioral Health Problems

PCPs should screen UnitedHealthcare Community Plan members for behavioral health problems, using the Screening Tool for Substance Abuse (a.k.a. Chemical Dependence) and Mental Health. Forms are located at the end of the Behavioral Health Section. The screening tool has been translated into the most common languages of UnitedHealthcare members. PCPs should file the completed screening tool in the member’s medical record.

Referrals for Behavioral Health Services

Primary care providers and behavioral health providers should communicate with United Behavioral Health by calling 877-651-6677 and request to speak with the intake staff.

Members can also self-refer to a participating behavioral health care provider by calling 877-651-6677. United Behavioral Health generally approves an open authorization, good for 12 months, for in-network care providers. If specialty care is needed, the care provider (or member) can discuss the need with the United Behavioral Health staff.

The initial treatment assessment must include a full psychosocial history and a mental status examination. The assessment and development of a comprehensive treatment plan must be developed within the first 30 days of treatment.

Medicaid Members – ID Cards for Behavioral Health Services

UnitedHealthcare Community Plan members use their ForwardHealth ID card and UnitedHealthcare Community Plan ID card to gain access to all mental health and substance abuse services.

Authorization for Continuation of Outpatient Behavioral Health Services

Behavioral health care providers should call to request continued treatment to the Behavioral Health Unit at 877-651-6677.
Behavioral Health Guidelines and Standards

United Behavioral Health uses specific guidelines for appropriateness of care and discharge reviews. These guidelines are located at providerexpress.com. Behavioral health care providers may not refer members to another care provider without notifying United Behavioral Health.

Screening for Behavioral Health Issues

Screening for behavioral health issues is an essential part of any preventive health care program.

As a reminder:

- Use the tools to screen all UnitedHealthcare Community Plan members for Substance Abuse and Mental Health.
- If there are any ‘yes’ answers on either form, it means that further assessment and consideration for treatment are necessary. Call United Behavioral Health at 877-651-6677 for assistance with a referral for a comprehensive evaluation and/or treatment.
- Keep the screening tool in the patient’s medical record. Our Medical Record Review Team will be checking for these tools in our members’ charts when auditing for credentialing and/or continuous quality improvement.

Your participation in UnitedHealthcare Community Plan’s initiatives is required as part of your Provider Agreement with UnitedHealthcare Community Plan. Beyond meeting the requirements, UnitedHealthcare Community Plan appreciates your efforts on behalf of our members. Please call United Behavioral Health at 877-651-6677, if you have any questions or would like copies of the screening tool in Spanish or Hmong.
# GAD-7 Anxiety

**Over the last 2 weeks, how often have you been bothered by the following problems?**

*Use ‘✓’ to indicate your answer*

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Column Totals:**  

\[ \text{Total Score} \]

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission.
### PHQ-9 Depression

Over the **last 2 weeks**, how often have you been bothered by the following problems?

*(Use ‘√’ to indicate your answer)*

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Column totals  _____ + _____ + _____ + _____

= Total Score _______________
Scoring notes.

- **PHQ-9 Depression Severity**

  Scores represent: 0-5 =mild  6-10 =moderate  11-15 =moderately severe  
  16-20 = severe depression

- **GAD-7 Anxiety Severity.**

  This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. GAD-7 total score for the seven items ranges from 0 to 21.

  Scores represent: 0-5 mild  6-10 moderate  11-15 moderately severe anxiety  
  15-21 severe anxiety.

- **Core-10**

  Key points in the scoring of the CORE-10 are as follows:

  1. Each item within the CORE-10 is scored on a 5-point scale ranging from 0 (‘not at all’) to 4 (‘most or all the time’).

  2. The clinical score is calculated by adding the response values of all 10 items.

  3. Where there are missing data the clinical score is derived by calculating the total mean score (dividing the total score by the number of completed items) and multiplying by 10.

  4. We do not recommend re-scaling the clinical score if more than one item is missing.

  5. The minimum score that can be achieved is 0 and the maximum is 40.

  6. The measure is problem scored, that is, the higher the score the more problems the individual is reporting and/or the more distressed they are.

  A score of 10 or below denotes a score within the non-clinical range, and of 11 or above within the clinical range. Within the non-clinical range we have identified two bands called ‘healthy’ and ‘low’ level distress. People may score on a number of items at any particular time but still remain ‘healthy’. Similarly, people may score in the ‘low’ range which might be a result of raised pressures or particular circumstances but which is still within a non-clinical range. Within the clinical range we have identified the score of 11 as the lower boundary of the ‘mild’ level, 15 for the ‘moderate’ level, and 20 for the ‘moderate-to-severe’ level. A score of 25 or over marks the ‘severe’ level.
The CAGE Questionnaire Adapted to Include Drugs (CAGE-AID)

1. Have you felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Score: ____ /4

2/4 or greater = positive CAGE, further evaluation is indicated

Emergency Admissions

Prior authorization is not required for emergency services. Emergency care should be rendered at once, with notification of any admission to the Prior Authorization Department at 877-651-6677 or fax to 800-897-8317 by 5 p.m. next business day. UnitedHealthcare Community Plan reviews emergency admissions within one working day of notification. UnitedHealthcare Community Plan uses MCG Care Guidelines for determinations of appropriateness of care.

Care in the Emergency Room

UnitedHealthcare Community Plan members who present at an emergency room should be screened to determine whether a medical emergency exists. Prior authorization is not required for the medical screening. We provide coverage for these services without regard to the emergency care physician's contractual relationship with UnitedHealthcare Community Plan. Emergency services, i.e. care provider and outpatient services furnished by a qualified care provider necessary to treat an emergency condition, are covered both within and outside UnitedHealthcare Community Plan’s service area.

An emergency is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect that the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child), or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy.
- Serious impairment to such person's bodily functions.
- Serious dysfunction of any bodily organ or part of such person.
- Serious disfigurement of such person.

Medical Management

Determination of Medical Necessity

UnitedHealthcare Community Plan uses MCG Care Guidelines as well as other industry standard guidelines and/or state criteria for determinations of appropriateness of care.

Medical policies and coverage determination guidelines can be found at UHCCommunityPlan.com > For Health Care Professionals > Select Your State > Provider Information > UnitedHealthcare Community Plan Medical Policies and Coverage Determination Guidelines.

Medically necessary services or supplies are those that meet the following standards:

1. Is consistent with the member’s symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability.
2. Is consistent with standards of acceptable quality of care applicable to the type of service, the type of care provider and the setting in which the service is provided.
3. Is appropriate with regard to generally accepted standards of medical practice.
4. Is not medically contraindicated with regard to the recipient's diagnoses, the member’s symptoms or other medically necessary services being provided to the member.
5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature.
6. Is not duplicative with respect to other services being provided to the member.
7. Is not solely for the convenience of the member, the recipient’s family, or a care provider.
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the member.
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the member.
Utilization Review Criteria and Guidelines

UnitedHealthcare Community Plan uses MCG Care Guidelines as well as other industry standard guidelines and/or state criteria for determinations of appropriateness of care. UnitedHealthcare Community Plan has written policies and procedures specifying responsibilities and qualifications of staff that authorize admissions, services, procedures, or extensions of stay.

You can request a copy of the guidelines or criteria, free of charge, by calling Provider Services at 877-651-6677. Members can request a copy by calling 800-504-9660.

UnitedHealthcare Community Plan does not prohibit or discourage a health professional from advocating on behalf of a member for appropriate medical treatment options. We do not prohibit a health professional from discussing healthcare treatments and services, regardless of coverage limitations, and quality assurance programs with a member. We do not prohibit a health professional from discussing financial arrangements between the care provider and UnitedHealthcare Community Plan with a member. We make determinations on a timely basis, as required by the exigencies of the situation. The care manager can authorize, but not deny, an admission, service, procedure, or extension of stay. If the care manager is unable to determine by chart documentation, documentation from the facility utilization review department, or discussion with the PCP or attending physician, the need for admission, surgical or diagnostic procedure, or continued stay, the case is referred to a chief medical officer or a physician reviewer. If, after reviewing all clinical information, a chief medical officer/physician reviewer determines the admission, service, procedure, or extension of stay is reasonable, the physician reviewer notifies the concurrent review nurse or care manager, who in turn notifies the facility utilization review department. We will not retroactively deny reimbursement for a covered service provided to a member by a physician who relied upon the written or oral authorization of UnitedHealthcare Community Plan prior to providing the service to the member, except in cases where there was material misrepresentation or fraud. Utilization review will be conducted by a clinical peer reviewer where the review involves an adverse determination.

Notice of an adverse determination (denials) are made verbally and in writing and include: (a) the reasons for the determination including the clinical rationale, if any; (b) instructions on how to initiate an appeal; and (c) notice of the availability, upon request of the member or the member’s designee, of the clinical review criteria relied upon to make such determination. Such notice specifies what, if any, additional necessary information must be provided to, or obtained by, us to render a decision on an appeal.

If UnitedHealthcare Community Plan renders an adverse determination without attempting to discuss such matter with the member’s health care physician who specifically recommended the health care service, procedure or treatment under review, such health care physician will have the opportunity to request a peer-to-peer discussion of the adverse determination. Except in cases of retrospective reviews, the peer-to-peer discussion occurs in a timely manner depending on availability upon the receipt of the request, and is conducted by the member’s health care physician and the clinical peer reviewer making the initial determination or designated clinical peer reviewer, if the original clinical peer reviewer is not available.

If the adverse determination is upheld, UnitedHealthcare Community Plan provides notice, and nothing precludes the member or their physician from initiating an appeal from an adverse determination.

Should UnitedHealthcare Community Plan fail to make a determination within the time period allowed, the decision is deemed to be an adverse determination subject to appeal.

Prior authorization for an inpatient stay does not mean authorization for continued inpatient stays. After giving prior authorization for an admission,
service, or procedure, UnitedHealthcare Community Plan conducts concurrent review to determine whether the stay continues to meet MCG Care Guidelines for determinations of appropriateness of care. If you want a copy of the guideline being used to determine care, please contact provider services at 877-651-6677. UnitedHealthcare Community Plan approves or denies continuation of the stay in accordance with the criteria and guidelines described in this section.

In the case of a denial of continued stay, UnitedHealthcare Community Plan notifies the facility verbally and in writing within one working day, followed by a formal written notice. The PCP, attending care providers, or the facility may appeal any adverse decision, in accordance with the procedures outlined in the denial letter.

Care Provider’s Responsibility to Verify Prior Authorization

All care providers, facilities, and agencies providing services that require prior authorization should call the Prior Authorization Department at 877-651-6677 or request prior authorization through UHCCommunityPlan.com in advance of performing the procedure or providing service(s) to verify UnitedHealthcare Community Plan has issued an authorization.

Please note: This serves only as a reference number until medical necessity of requested services has been determined.

Authorization of Care for New Members

Service Continuation for New Members:

If a new member has an existing relationship with a health care provider who is not a member of the care provider network, the member is permitted to continue an ongoing course of treatment by the non-participating physician during a transitional period as determined by the member’s condition. Each case is determined based on unique needs being taken into consideration: (1) the member has a life-threatening disease or condition, or a degenerative and disabling disease or condition, or (2) the member has entered the second trimester of pregnancy at the effective date of enrollment, in which case the transitional period will include the provision of postpartum care directly related to the delivery up until 60 days postpartum. If the new member elects to continue to receive care from the non-participating care provider, care will be authorized for the transitional period only if the physician agrees to: (a) accept reimbursement at rates established by the plan as payment in full at no more than the level of reimbursement applicable to similar care providers within our network for such services; (b) adhere to our quality assurance requirements and agree to provide us with the necessary medical information related to the care; and (c) otherwise adhere to our policies and procedures including, but not limited to, procedures regarding referrals and obtaining prior authorization in a treatment plan approved by us. In no event will this requirement be construed to require us to provide coverage for benefits not otherwise covered.

Continuing Care When a Member’s Health Care Provider Leaves the Network:

The member is permitted to continue an ongoing course of treatment with their current health care provider during a transitional period, when their care provider has left our network of care providers for reasons other than imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board that impairs the health professional’s ability to practice. The transitional period will continue if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of postpartum care directly related to the delivery, through 60 days postpartum. If the member elects to continue to receive care from a non-participating care provider, care will be authorized for the transitional period only if the care provider agrees to: (a) accept reimbursement at rates established by the plan as payment in full at no more than the level of reimbursement applicable to similar care providers within our network for such services; (b) adhere to our quality assurance requirements and agree to provide us with the necessary medical information related to the care; and (c) otherwise adhere to our policies and
procedures including, but not limited to, procedures regarding referrals and obtaining pre-authorization in a treatment plan approved by us. In no event will this requirement be construed to require us to provide coverage for benefits not otherwise covered.

**Submit Prior Authorizations Electronically**

Online prior authorization is a system that allows care providers, hospitals and facilities to notify UnitedHealthcare Community Plan of inpatient hospital admissions and procedures through [UHCProvider.com](http://UHCProvider.com).

Hospitals and facilities experience:

- 24 hours a day, seven days a week service.
- No call hold time.
- No lost faxes or incorrectly entered data from fax sheets.
- Immediate confirmation of receipt and notification tracking number.
- Real-time notification status communication.

This notification does not negate the requirement of provision of medical information to determine the medical necessity of the admission. A prior authorization of services is required.

Admission and concurrent medical reviews are conducted for all inpatient hospital stays/admissions.

The care provider, hospital or facility also receives a notification tracking number and a response that the request is:

- Automatically entered in the system.
- The request is routed to the appropriate area where they are reviewed, and turnaround time is usually one business day.
- The care provider or facility can go back into the prior notification at any time to view the request to see if there is a status change.
UHCCommunityPlan.com > For Health Care Professionals > Wisconsin

1. Click on Prior Authorization.
2. For Medicaid, click on UnitedHealthcare Community Plan Prior Authorization WI.

For Medicare, click on UnitedHealthcare Medicare Solutions and UnitedHealthcare Community Plan Notification/Prior Authorization Requirements.

Referrals to an out of network care provider requires prior authorizations by the in-network care provider.

For questions related to specific codes or services please call Prior Authorization at 866-604-3267.
Prior Authorization Fax Request Form 800-897-8317

This FAX form has been developed to streamline the Prior Auth request process, and to give you a response as quickly as possible. Please complete all fields on the form, and refer to the listing of services that require authorization; you only need to request authorization for services on that list. The list can be found at www.uhccommunityplan.com. Please select the appropriate health plan and refer to provider materials.

Date: ______________________  Contact Person _____________________________

Telephone #: ______________________  Fax #: _____________________________

Requesting Provider: ___________________________ Telephone #: _____________________________

☐ Initial request  Urgent  Routine
☐ Request for an extension  Urgent  Routine

Urgent is defined as “significant impact to health of the member if not completed within 72 hours”

Member Information:

Member Name: ___________________________ Member ID/JD# __________ Date of Birth: __________

Patient Name: ___________________________ Member ID/JD# __________ Date of Birth: __________

Is request related to MVA or work-related injury?  Does member have other insurance?
☐ Yes  ☐ No  ☐ Yes  ☐ No  Medicare  ☐ Part A  ☐ Part B

Other insurance name and policy #: _____________________________

Servicing Provider Information:

Date of Service: ___________________________ Provider ID: ___________________________

Physician or Servicing Provider: ___________________________ Phone #: ___________________________

Address: ___________________________ Fax #: ___________________________

Facility: ___________________________ PAR or Non-PAR (please circle one)

If Non-par will provider accept Medicaid/Medicare default rate -  ☐ Yes  ☐ No

Type of Service:

☐ DME – Purchase  ☐ Cosmetic or Reconstructive  ☐ Home Health/Hospice Services
☐ DME – Rental  Surgery  ☐ Skilled Nursing Facility
☐ Prosthetic / Orthotics  ☐ PT / OT / ST  ☐ Hysterectomy
☐ Inpatient Elective Surgery  ☐ MRI, MRA or PET Scan  ☐ Out Of Network (please explain)
☐ Transplantation Evaluation  ☐ Gastric Bypass Eval/Surgery  ☐ Other

Clinical Information:

Diagnoses: ___________________________ ICD-10 Codes: ___________________________

CPT/HCPCS Codes: ___________________________

Procedures: ___________________________

Number of visits: __________  Duration: __________  Frequency: __________

Number of previous visits: __________  Service name/code for previous visits: __________

NOTE: To process your request completed and timely, please submit any pertinent clinical data (i.e. progress notes, treatment rendered, tests, labs results, radiology reports) to support request for services. Any request for OON services must include documentation on the reason for the request along with the name of the OON provider. FAILURE TO PROVIDE SUFFICIENT CLINICAL INFORMATION WILL RESULT IN A DELAY IN YOUR REQUEST.
Outpatient Radiology Prior Authorization Program

UnitedHealthcare Community Plan developed Outpatient Radiology Prior Authorization based on current scientific clinical evidence and to support advanced outpatient imaging procedures. As a result, you must request prior authorization for a planned service that is subject to these program requirements. Once a prior authorization request for the planned service is received, we conduct a clinical coverage review to determine whether the service is medically necessary.

Find services requiring prior authorization at:
UHCCommunityPlan.com > For Health Care Professionals > Radiology > CPT Code List.

Outpatient Injectable Chemotherapy Prior Authorization Program

Effective Oct. 1, 2016, UnitedHealthcare Community Plan members in Wisconsin require prior authorization for injectable outpatient chemotherapy drugs given for a cancer diagnosis.

Prior authorization is required for:
- Chemotherapy injectable drugs (J9000-J9999), Leucovorin (J0640) and Levoleucovorin (J0641)
- Chemotherapy injectable drugs that have a Q code
- Chemotherapy injectable drugs that have not yet received an assigned code and are billed under a miscellaneous Healthcare Common Procedure Coding System (HCPCS) code
- All outpatient injectable chemotherapy drugs started after the chemotherapy prior authorization effective date
- Adding a new injectable chemotherapy drug to a regimen

Time Frames for Seeking Prior Authorization/Notifying UnitedHealthcare Community Plan

Emergency Facility Admission
Notify UnitedHealthcare Community Plan within 24 hours or one business day after an emergency or urgent admission.

Inpatient Admissions after Ambulatory Surgery
Notify UnitedHealthcare Community Plan within 24 hours after an inpatient admission that immediately followed ambulatory surgery.

Non-Emergency Admissions and/or Selected Out-Patient services
Seek prior authorization at least 14 calendar days prior to non-emergent, non-urgent facility admissions and/or outpatient services; for cases in which the admission is scheduled less than five business days in advance, notify us at the time the admission is scheduled. Urgent request for prior authorization should be submitted within 72 hours of planned date of service.

Maternity Care and Delivery Admissions

Maternity Care
Pregnant UnitedHealthcare Community Plan members should receive care from UnitedHealthcare Community Plan participating 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.
Medical Management

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.

Members or care providers can call Healthy First Steps at 800-599-5985 to speak with a Care Manager. Antepartum admissions follow the prior authorization guidelines for admissions.

**Delivery Admissions**

To notify UnitedHealthcare Community Plan of deliveries, call 866-604-3267 or fax to 800-897-8317.

The following information must be provided to UnitedHealthcare Community Plan 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.

**Sick Newborn Admissions**

The hospital must notify UnitedHealthcare Community Plan by calling 866-604-3267 or faxing 800-897-8317 prior to or upon the mother’s discharge, if the baby stays in the hospital after the mother is discharged.

The newborn extended stay receives a concurrent review. The hospital should make available the following information:

- Date of birth.
- Birth weight.
- Gender.
- Diagnosis.
- Name of attending neonatologist.

**Enrollment of Newborns (Medicaid)**

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

There may be circumstances where the mother delivers out-of-state. This baby may not be identified to the city/state and thus not come onto UnitedHealthcare Community Plan in a timely manner. In this case, the Enrollment Department would have to contact the city/state once the birth notification is received and request the baby be added to the health plan.

The hospital provides significant support to the enrollment process by providing required birth data at the time of admission.

**Concurrent Review**

UnitedHealthcare Community Plan performs concurrent review on all hospitalizations for the duration of the stay based on contractual arrangements with the hospital. UnitedHealthcare Community Plan performs the reviews by fax, telephone, or on-site at the facility.

**Inpatient Concurrent Review: Clinical Information**

Your cooperation is required with all UnitedHealthcare Community Plan requests for information, documents or
Medical Management

discussions related to concurrent review and discharge planning including: primary and secondary diagnosis, clinical information, treatment 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 the 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 Care Guidelines for determinations of appropriateness of care. If you want a copy of the guideline being used to determine care, please contact provider services at 877-651-6677.

The care manager may certify extension of the length of stay based on MCG Care Guidelines. Only a chief medical officer or care provider advisor may deny an extension of the length of stay.

UnitedHealthcare Community Plan notifies the facility when the care manager refers a hospital stay for review by a chief medical officer or care provider advisor. If a chief medical officer or care provider advisor determines that the extended stay is not justified, UnitedHealthcare notifies the facility by phone and fax within one working day.

The PCP, attending care provider, or the facility may appeal any adverse decision, according to the procedures in the Utilization Management Appeals section.

Discharge Planning and Continuing Care

UnitedHealthcare Community Plan care managers facilitate coordination of care across multiple sites of care. The care managers work with the member, family members, care providers, hospital discharge planners, rehabilitation facilities, and home care agencies.

They evaluate the appropriate use of benefits, oversee the transition of members between levels of care, and refer to community-based services, as needed.

Care Management

UnitedHealthcare Community Plan brings an extraordinary wealth of care management experience with programs targeting a broad set of conditions that have been implemented within extremely diverse populations. We have implemented our Personal Care Model in nearly 20 programs across the country — each one designed to improve health care delivery, utilization, and outcomes through care management and chronic care management processes.

As an organization that is fully focused on the Medicaid population, we have identified conditions that often result in significant health care utilization. These conditions, in some ways related to the socioeconomic or cultural background of our members, require assertive care management programs to help ensure the members can self-manage effectively and maintain a positive health status.

These include conditions and/or treatment such as:

- Asthma.
- Chronic obstructive pulmonary disease (COPD).
- Coronary artery disease (CAD).
- Congestive heart failure (CHF).
- Diabetes.
- End stage renal disease (ESRD).
- High risk pregnancy and neonatal intensive care unit (NICU).
Medical Management

- Human immunodeficiency virus (HIV).
- Hypertension.
- Sickle cell disease.
- Special needs (Supplemental security income – SSI).

We have implemented care management programs through our Personal Care Model across the country, both within Medicaid health plans and as stand-alone programs. In each case, the program is tailored to fit the needs of the population and the goals of the program, focusing on specific conditions and service delivery that will drive the most positive outcomes.

Care providers may refer candidates for case management by contacting Care Management at 877-651-6677.

Additionally, UnitedHealthcare Community Plan provides the Healthy First Steps program which proactively manages women with high-risk pregnancies. They can be reached at 800-599-5985.
UnitedHealthcare Community Plan has developed a maternal/prenatal program available to all pregnant members called Healthy First Steps (HFS). We have a multi-disciplinary team approach including case management, social work, medical director oversight and maternity specific utilization review.

Care providers referring pregnant women to HFS are asked to complete the HFS OB Risk Assessment Form (OBRAF) and fax the completed form to 877-353-6913. See page 36 for the form. Care providers are eligible to receive an incentive payment for each valid form submitted. A pregnant member may also self-refer to the program by calling 800-504-9660.

When a member is referred to HFS, we contact the member initially by phone. If a member cannot be reached by phone, a letter is sent to the member’s home. The letter describes the program and asks the member to participate. When the member agrees to participate, an educational packet is sent to the member about prenatal care. During initial contact the member is assessed for potential risk factors. If the member meets potential high-risk criteria, they are referred to a nurse care manager who conducts a clinical assessment. If the member meets high-risk criteria, they are enrolled in care management.

In addition, under Care Management, the care manager is responsible for coordinating a member’s care from the onset of pregnancy, through delivery, and their postpartum checkup. This integrated system is efficient and comprehensive for both members and care providers.

From the onset of pregnancy, care providers contact one individual within the team who can assist with all their needs. This approach enables the team to capture high-risk pregnancies early on and immediately refer the member to a care manager. Further, members who are hospitalized during their pregnancy work with their care manager, therefore ensuring a continuity of care after discharge. The care manager is now involved with concurrent review as well as care management activities. The structure of the obstetrical program also allows for effective and efficient referrals into prenatal care, our Healthy First Steps program, and reporting of new births.

**Baby Blocks**

Baby Blocks™ is a web-based, mobile tool to remind and reward pregnant women and new mothers to receive prenatal, postpartum and well-child care. Baby Blocks™ is available to UnitedHealthcare Community Plan members who are either pregnant or newborn.

Baby Blocks™ engages patients with a personalized, interactive tool that provides appointment reminders by text or email message. Members who enroll early in their pregnancy can earn up to eight rewards by adhering to prenatal and postpartum recommendations of the American Congress of Obstetricians and Gynecologists, and well-baby recommendations by the American Academy of Pediatrics.

**How it works.**

1. UnitedHealthcare Community Plan members are invited by care provider, mail, and phone call to enroll in Baby Blocks™.
2. Members enter information about their pregnancy and upcoming appointment at UHCBabyBlocks.com.
3. Members are reminded of upcoming appointments and are prompted to 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 discuss the benefits of the program.
3. Encourage the member to enroll at UHCBabyBlocks.com.
### Member Information
- Last Name: ________________  First Name: ________________  DOB: _______  ID#: ____________  
- Address: ___________________  City: ________________  Zip: _______  Phone #: ____________
- Date of Initial Prenatal Visit: ________________  Completion date of Pregnancy Form: ________________

### Current Pregnancy
- In PNCC __________________________
- Gravida ________  Para ________  LMP ________  EDC ________  Blood Type ____________
- □ Multiple Gestation this pregnancy  □ Maternal age ≤ 16 years  □ Maternal age ≥ 35 years of age

### Previous Pregnancies
- □ Multiple Gestations previous pregnancy  □ Previous C-Section  □ Hx of Placenta Previa
- □ Hx of SAB/TAB/Fetal Demise  □ Preterm Labor/Delivery  □ Hx of Post Partum Depression
  - Week of demise ________  Week of delivery ________

### Medical History (Check all that apply)
- □ Cardiac Disease (Current/Past)  □ Clotting Disorders (Current/Past)  □ Diabetes/Gestational Diabetes (Current/Past)
- □ HIV Testing (Current/Past)  □ Hypertension or PIH (Current/Past)  □ Incompetent cervix (Current/Past)
- □ Mental Illness (Current/Past)  □ Neurologic Disorders (Current/Past)  □ Respiratory Conditions (Current/Past)
- □ Sickle Cell Anemia (Current/Past)  □ STD (Current/Past)

### Psycho/Social Issues (Check all that apply)
- □ Drug Abuse (Current/Past)  □ Alcohol Abuse (Current/Past)  □ Smoker (Current/Past)  □ Domestic Abuse (Current/Past)
- □ Housing Issues  □ Lack of Support System

### Prenatal Care and Nutrition (Check all that apply)
- □ Missed several medical appointments  □ Currently Enrolled in WIC

### Description of above or other unlisted conditions:
_________________________________________________________
_________________________________________________________

### List of Medications:
__________________________________________________________________
__________________________________________________________________

### Provider Information
- Provider Signature: __________________________  Provider Printed Name: __________________________
- Provider Address: __________________________  Provider Phone #: __________________________
- Delivery Hospital: __________________________  Provider Fax #: __________________________

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Doc#: UHC1716g_20120419
Care Provider Requirements

Protect Confidentiality of Member Data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates who need that information to fulfill our obligations and to facilitate improvements to our members' health care experience. We require our associates and business associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we refer the member to you as the holder of the medical records. You must comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of member medical information. You agree specifically to comply in all relevant respects with the applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and associated regulations, in addition to the American Reinvestment and Recovery Act (ARRA) applicable state laws and regulations. UnitedHealthcare uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to prevent unintentional disclosure of protected health information (PHI). This includes policies and procedures governing administrative and technical safeguards of protected health information. Training is provided to all personnel on an annual basis and to all new employees within the first 30 days of employment.

Care Provider’s Responsibility for Termination of Member as Patient

UnitedHealthcare Community Plan is responsible for helping to ensure members have access to medical care, and that they understand their rights and responsibilities as a patient. If there is a need to stop seeing a UnitedHealthcare Community Plan member, you must notify the member in writing 30 days prior to the effective date of the termination. This action requires notice to the UnitedHealthcare Community Plan Quality Management department as well.

Credentialing and Re-credentialing

UnitedHealthcare Community Plan is dedicated to providing our members with access to effective health care and, as such, we periodically review the credentials of participating care providers and other health care professionals to maintain and improve the quality of care and services delivered to our members. Our credentialing standards are fully compliant with the National Committee on Quality Assurance (NCQA) requirements.

UnitedHealthcare Community Plan is a member of the Council for Affordable Quality Healthcare (CAQH), and we utilize the CAQH Universal Provider DataSource (UPD) for gathering credentialing data for care providers and other health care professionals. The CAQH process is available to you at no charge. The CAQH process results in cost efficiencies by eliminating the time required to complete redundant credentialing applications for multiple health plans, reduces the need for costly credentialing software, and minimizes paperwork by allowing care providers and other health care professionals to make updates online.

UnitedHealthcare Community Plan has implemented the CAQH process as our single source credentialing application nationally, unless otherwise required in designated states. All care providers and other health care professionals applying to begin participating in our network and those scheduled for re-credentialing are instructed on the proper method for accessing the CAQH UPD.

Notification may be sent to:

UnitedHealthcare Community Plan Quality Management
10701 Research Drive
Milwaukee, WI 53226
Rights Related to the Credentialing Process

Care providers and other health care professionals applying for the UnitedHealthcare Community Plan network have the following rights regarding the credentialing process:

- To review the information submitted to support your credentialing application.
- To correct erroneous information.
- To be informed of the status of your credentialing or re-credentialing application, upon request. You can check on the status of your application by calling Provider Services at 877-651-6677.

Confidentiality

All credentialing documents or other written information developed or collected during the approval processes are maintained in strict confidence. Except with authorization or as required by law, information contained in these records will not be disclosed to any person not directly involved in the credentialing process.

WI State Medicaid ID National Provider Identifier (NPI)

What is NPI?

- A 10 character number with no imbedded intelligence.
- Mandated for use in ALL standard electronic transactions across the industry (claims, enrollment, remittance, claim status request and response, authorization request and response, NCPDP, etc.).
- CMS contracted with Fox Systems to develop the National Plan and Provider Enumeration System (NPPES) on authority delegated by the Secretary of Health and Human Services (HHS).
- NPPES assists providers with their application, processes the application and returns the NPI to the provider.

There are two entity types for the purposes of enumeration. A Type 1 entity is an individual health care provider and a Type 2 entity is an organizational provider, such as a hospital system, clinic, or durable medical equipment (DME) providers with multiple locations. Type 2 care providers may enumerate based on location, taxonomy or department.

Only care providers who are direct care providers of health care services are eligible to apply for an NPI. This creates a subset of care providers who provide non-medical services who will not have an NPI.

NPI Compliance

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

NPI is required for care provider identification and claims payments.

How to get an NPI:

Health care providers should apply for NPIs in one of three ways:

1. For the most efficient application processing and the fastest receipt of NPIs, use the web-based application process. Simply log onto the National Plan & Provider Enumeration System - Home Page and apply online.
2. Health care providers can agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so.
3. Health care providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. The form is available only upon request through the NPI Enumerator. Health care providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of these ways:
Care Provider Requirements

- Phone: 800-465-3203 or TTY: 800-692-2326
- E-mail: customerservice@npienumerator.com
- Mail: NPI Enumerator
  P.O. Box 6059
  Fargo, ND 58108-6059

It is imperative that you communicate your NPI number to UnitedHealthcare Community Plan and the state Medicaid agency.

Exemptions to Federal National Provider Identifier Provider Number Requirements

Personal care only providers, SMV providers, and blood banks are exempt from federal NPI requirements.

Panel Roster

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

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

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

Females have direct access (without a referral or authorization) to any 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 participants understand, support, and benefit from the primary care case management system. The coverage will include availability of 24 hours, 7 days per 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) which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems. Recorded messages are not acceptable.

Assignment to PCP Panel Roster

Once a member has been assigned to a PCP, panel rosters can be viewed electronically on the UnitedHealthcare provider portal at UHCprovider.com. The portal requires a unique user name and password combination to gain access.

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

Customer Notification of Physician Departure From the UnitedHealthcare Community Plan Participating Care Provider Network

- When you leave a participating network Medical Group, your medical group is required to notify UnitedHealthcare Community Plan of your departure as described in your medical groups’ participation agreement.
- You are required to notify UnitedHealthcare Community Plan when you terminate from our network as described in your care provider contract.
- At least 30 days prior to the effective date of your termination or your groups’ termination from the network, UnitedHealthcare Community Plan sends, by regular mail, notification to our affected members/
your patients. If an applicable state statute requires earlier notification, the state statute prevails, assuming UnitedHealthcare Community Plan has been provided timely notice from you or your medical group practice.

• Your affected patients/our members include those UnitedHealthcare Community Plan members for whom a claim was filed on your behalf or on behalf of your medical group within the six months prior to the effective date of termination or departure, or the state statutory look-back period, whichever is greater.

Continuity of Care for Primary Care Providers

Should a PCP terminate the Provider Agreement, the care provider will provide services to members assigned to the care provider through the end of the month in which termination becomes effective. In the event of UnitedHealthcare Community Plan’s insolvency or other cessation of operations, the care provider will continue to provide benefits to members through the period for which the premium has been paid, including benefits to members in an inpatient facility.

Despite the above provisions, if UnitedHealthcare Community Plan terminates the Provider Agreement for cause, UnitedHealthcare Community Plan will not be responsible for health care services provided to members following the effective date of termination.

Continuity of Care During a Pregnancy

In the case of a member in the second or third trimester of pregnancy, at the time of notice of the termination, the transitional period will extend through postpartum care related to delivery. Any health service provided during the transitional period will be covered by UnitedHealthcare Community Plan under the same terms and conditions as applicable to participating care providers.

Continuity of Care When a Provider Leaves the Network

Upon termination of the Provider Agreement, UnitedHealthcare Community Plan will use its best efforts to persuade members assigned to the care provider to choose an alternative participating care provider.

However, the care provider will continue to furnish covered services to any member under the provider’s care who, at the time of termination of the Provider Agreement, is a registered bed patient at a hospital or other institution, until the member’s discharge.

Upon termination of the Provider Agreement, a member may continue an ongoing course of treatment with the care provider, at the member’s option, for a transitional period of up to 60 days from the date the member was notified by UnitedHealthcare Community Plan of the termination of the Provider Agreement. UnitedHealthcare Community Plan, in consultation with the care provider and member, may extend the transitional period if clinically appropriate. Continued care is provided under the same terms and conditions.

Utilization Management Appeals

Overview of Utilization Management Appeals

UnitedHealthcare Community Plan operates an internal appeals process to review appeals by members (or a member’s designee) who are dissatisfied with UnitedHealthcare Community Plan utilization management decisions. Members may also appeal directly to the State of Wisconsin’s Department of Health Services.

Providers May Appeal on Behalf of Members

An appeal is defined as a request for review of a denial or limited authorization of a requested service. A care provider may appeal on behalf of a member with written consent of the member. A member may appeal by contacting our Customer Service at 800-504-9660.

A member grievance or complaint is defined as any expression of dissatisfaction with anything other than a denial or limited authorization of requested service.

Grievances may be filed by the member or provider by contacting Customer Service at 800-504-9660.
Care Provider Requirements

Care provider appeals are defined as a disagreement with the HMO’s payment or nonpayment of a claim or if you disagree with a UM determination in which you have already provided services. Please see the ‘Our Claims Process’ chapter of this manual for a description of care provider appeals processes.

Concurrent Review Requests - Behavioral Health
The phone number is 877-651-6677. This line is available anytime.

Appeals are decided within 30 calendar days from receipt of request. For appeals, call 866-556-8166, which is available for oral appeals 7 a.m. – 6 p.m. CT, with voicemail after hours and return phone call the next business day.

Written appeals should be sent to:
United Behavioral Health
Attn: Appeals
P.O. Box 30512
Salt Lake City, UT 84130

Member Pre-Service Appeals Process

Definitions

Clinical Appeal
A request for review of a denial or limited authorization of a requested service.

Pre-Service
Applies to adverse determinations on elective procedure and surgeries. Members may appeal or care providers may appeal on behalf of a member. Appeals must be received within 45 calendar days of the denial letter.

Expedited Appeal
The appeal is to be expedited if the delay would significantly increase the risk of a member’s health. A decision will be made within two business days of the expedited request.

UM Administrative Appeals
Are appeals for administrative denials. An example of these appeals include late notification of an admission or other insurance primary. Appeals must be filed within 45 calendar days of the denial letter when pre-service and 60 days when post service.

Send administrative appeals to:
UnitedHealthcare Community Plan Provider Appeal
P.O. Box 31364
Salt Lake City, UT 84131-0364

Appeals of claims regarding any other denial reason or alleged inappropriate type or level of payment are addressed in the ‘Our Claims Process’ chapter.

For post-service care provider appeals, you have the right to appeal to the Wisconsin Department of Health Services if we fail to respond to your appeal within 45 days or if you are not satisfied with the appeal response. To ask the Wisconsin Department of Health Services to review our decision, you may send appeals to:
P.O. Box 6470
Madison, WI 53716-0470
Fax: 608-224-6318

UM Appeal Process
An appeal can be initiated as follows:

• A call from the member (or member’s designee) to Member Services where the call is recorded and forwarded to the UM Appeals Coordinator at 800-504-9660.

The appeal should contain the following information:

• Member name and UnitedHealthcare Community Plan member ID number.
• Care provider name and UnitedHealthcare Community Plan care provider number.
• Care provider’s address and phone number.
• Requested procedure or service.
• Date of denial (if known).
• Diagnosis and medical justification for the procedure or service.
• A copy of the original denial letter.
Mail or fax the appeal to:
UnitedHealthcare Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

If a portion of the identified necessary information is received, UnitedHealthcare Community Plan will request the missing information, in writing.

For members, before and during the appeal review period, the member or designee may see their case file. The member may present evidence to support their appeal in person or in writing. The member receives notice of this at least seven days prior to the date of the hearing, in person or in writing, which will be heard by the UnitedHealthcare appeal committee.

UnitedHealthcare will send the member the appeal committee hearing information at least seven days before the date of the hearing.

The UnitedHealthcare Community Plan chief medical officer or care provider reviewer determining the appeal is not the same physician who rendered the initial denial, as required by law. The chief medical officer or care provider reviewer rendering an appeal decision responds in writing either to reinstate some or all of the denied service or to uphold the denial.

UnitedHealthcare Community Plan sends notification to the care provider and the member, in writing, of the appeal determination within two business days of rendering such determination and no more than 30 days after the receipt of appeal request. An extension of 14 days may be allowed.

If the denial is upheld, this is called the final adverse determination. UnitedHealthcare Community Plan's notice of a final adverse determination of a utilization review appeal is in writing, dated and includes the following:

1. A clear statement describing the basis and clinical rationale for the denial as applicable to the member.
2. A clear statement that the notice constitutes the final adverse determination and further appeal rights with the state.

(3) Health plan contact information and telephone number.
(4) Member’s coverage type.
(5) Contact information including full address and telephone number of our appeals department.
(6) A description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or care provider proposed to provide the treatment, and the developer/manufacturer of the health care service.

Expedited Appeal
The appeal is to be expedited if a delay would significantly increase the risk to a member’s health as verified by a medical professional. Such circumstances may include:

- Continued or extended health care services, procedures or treatments.
- Additional services for a member undergoing a course of continued treatment.
- A denial in which the health care provider believes an immediate appeal is warranted.

UnitedHealthcare Community Plan provides reasonable access to its care provider reviewer within one business day of receiving a request for an expedited appeal.

UnitedHealthcare Community Plan renders a decision on the expedited appeal within two business days of receipt of verbal or written request for an expedited appeal.

To facilitate the expedited resolution of an appeal, UnitedHealthcare Community Plan encourages the health care provider to work collaboratively, including, but not limited to, sharing information by telephone or fax.

For expedited appeals, UnitedHealthcare Community Plan immediately notifies the member and their health care provider by telephone or fax to identify and request the necessary information, followed by written notification.

Expedited appeals that do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process to the State of Wisconsin’s Department of Health Services.
**Care Provider Requirements**

**Fair Hearing Rights**
A fair hearing can be requested by the member at any point during a grievance or appeal process.

To initiate a fair hearing with the State of Wisconsin Division of Hearing and Appeals, the member can send a written fair hearing request to:

Department of Administration
Division of Hearing and Appeals
P.O. Box 7875
Madison, WI 53707-7875

**Sanctions Under Federal Health Programs and State Law**
It is the policy of UnitedHealthcare Community Plan to provide due process to care providers who are terminated by UnitedHealthcare Community Plan.

Participating care providers must help ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other federal health care programs are employed or subcontracted by the participating provider.

Participating care providers must disclose to UnitedHealthcare Community Plan whether the participating care provider or any staff member or subcontractor has any prior violation, fine, suspension, termination, or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of Wisconsin, the federal government, or any public insurer. Participating care providers must notify UnitedHealthcare Community Plan immediately if any such sanction is imposed on the participating care provider, staff member or subcontractor.

**Selection and Retention of Participating Care Providers**
UnitedHealthcare Community Plan is responsible for arranging covered services that are provided to thousands of members through a comprehensive care provider network of independent practitioners and facilities that contract with UnitedHealthcare Community Plan. The network includes health care professionals, such as primary care providers, specialist care providers, medical facilities, allied health professionals, and ancillary services providers.

UnitedHealthcare Community Plan’s network has been carefully developed to include those contracted health care professionals who meet certain criteria, such as availability, geographic service area, specialty, hospital privileges, quality of care, and acceptance of UnitedHealthcare Community Plan managed care principles and financial considerations.

UnitedHealthcare Community Plan continuously reviews and evaluates participating care provider information and re-credentials participating care providers every three years. The credentialing guidelines are subject to change based on regulatory requirements and UnitedHealthcare Community Plan standards.

All care providers and practitioners are required to participate in and cooperate with the UnitedHealthcare Community Plan Quality Management program. The UnitedHealthcare Community Plan Quality Management program is allowed to use practitioner and performance data to conduct quality activities.

**Termination of Participating Care Provider Privileges**

**Termination Without Cause**
UnitedHealthcare Community Plan and a participating care provider must provide at least 60 days written notice, or according to contract language, to each other before terminating a contract without cause.
Care Provider Requirements

Appeal Process for Care Provider Participation Decision

**Care Providers**
If UnitedHealthcare Community Plan decides to suspend, terminate or non-renew a care provider’s participation status, UnitedHealthcare Community Plan must:

- Give the affected care provider written notice of the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the care provider, and the numbers and mix of care providers needed by UnitedHealthcare Community Plan.
- Allow the care provider to appeal the action to a hearing panel, and give the care provider written notice of his/her right to a hearing and the process and timing for requesting a hearing.
- Help ensure the majority of the hearing panel members are peers of the affected care provider.

If a suspension or termination is the result of quality of care deficiencies, UnitedHealthcare Community Plan must give written notice of that action to the National Practitioner Data Bank, the Medical Examining Board, and any other applicable licensing or disciplinary body to the extent required by law.

Subcontracted care provider groups must provide that these procedures apply equally to care providers within those subcontracted groups.

**Other Care Providers**
UnitedHealthcare Community Plan decisions subject to appeal include decisions regarding reduction, suspension, or termination of a participating care provider’s participation resulting from quality deficiencies. UnitedHealthcare Community Plan will notify the National Practitioner Data Bank, the Medical Examining Board, and any other applicable licensing or disciplinary body to the extent required by law. Written communication to the participating care provider will detail the limitations and inform him or her of their rights to appeal.

Notification of Members of Care Provider Termination
When a contract termination involves a primary care provider, UnitedHealthcare Community Plan notifies all members, who are patients of that primary care provider, of the termination. UnitedHealthcare Community Plan makes a good faith effort to provide written notice of termination of a participating care provider to all members who are patients seen on a regular basis by that care provider, at least 30 calendar days before the termination effective date, regardless of the reason for the termination.

Confidentiality of Member Information
Participating care providers must comply with all state and federal laws concerning confidentiality of personal health information (PHI) and other information about members. Participating care providers must have policies and procedures regarding use and disclosure of health information that comply with applicable laws.
UnitedHealthcare Community Plan
Online for Efficient, Prompt Service

Register at UHCprovider.com/EDI, for our free online service for network care providers, health care professionals and facilities. Here you can:

- Have faster claims payments.
- Submit claims electronically.
- Verify member eligibility including secondary coverage.
- Review benefits and coverage limits.
- Check claim status.
- View your panel roster.
- Access remittance advice and review recoveries.
- Review your HEDIS Physician Profile Report.
- Submit demographic profile changes.

UnitedHealthcare Community Plan Online is also a source for important updates, and to obtain information about UnitedHealthcare Community Plan’s policies, products and processes.

Once you’ve registered, review the member’s eligibility at UHCprovider.com.

Alternately, to check member eligibility by phone, call the state’s voice response system at 800-947-3544, or the Provider Service Center at 877-651-6677. You can also visit the ForwardHealth Portal at forwardhealth.wi.gov/WIPortal/ to check for member eligibility (you will need a log-in.)

To prepare a complete and accurate claim form, submit the claim online at UHCprovider.com or use another electronic option.

If you currently use a vendor to submit claims electronically, be sure to use our electronic payer ID (87726) to submit claims to us. For more information, contact your vendor or our electronic data interchange (EDI) unit at 800-842-1109, and the e-mail address is ac_edi_ops@uhc.com. Please check the EDI Support Services page on UHCprovider.com for more information regarding electronic claims and remits.

Change to Electronic Solutions

UnitedHealthcare Community Plan has Electronic Fund Transfer (EFT) and Electronic Payments & Statements (EPS) available for claims payments.

With EFT, you can expect payment within 24 – 48 hours after your claims have been processed and approved for payment, rather than waiting up to a week for a check to arrive in the mail.

To sign up for this free service, go to UHCprovider.com/EPS and log into the Secure Online Services section.

Once you have logged into your account, download the Electronic Payment Authorization/ Maintenance Form. This form includes instructions for completion and an address and fax number to send it once completed.

With EPS, receive payment and EOB five to seven days faster than with paper. EPS is a free electronic funds transfer (EFT) and electronic remittance advice (ERA) service. To learn more about EPS, visit UHCprovider.com/EPS.

If you have questions about EPS, call us at 866-842-3278 and select option 5, to speak with an EPS representative.

Claim payment is subject to our payment policies (reimbursement policies), which are available to you online or upon request. You must not bill our member for amounts unpaid due to application of a payment policy.
Our Claims Process

UnitedHealthcare Community Plan will adjudicate claims submitted per the Wisconsin State Department of Insurance Prompt Pay Law.

Copayment
Federal law permits states to charge members a copayment for certain covered services. You are required to request copayments from members. You may not deny services to a Wisconsin Medicaid SSI or BadgerCare Plus Standard Plan.

Beginning Jan. 1, 2016, UnitedHealthcare Community Plan will no longer charge BadgerCare Plus members copayments for many covered services. As a result, you no longer need to collect payment from UnitedHealthcare BadgerCare Plus members before providing treatment for the following services:

- All covered medical services
- All covered dental services in Milwaukee, Kenosha, Ozaukee, Racine, Washington and Waukesha counties

Complete Claims

Whether you use an electronic or paper form, complete a CMS 1500 (formerly HCFA 1500) or UB-04 form (formally UB 92). A complete claim includes the following information. We may require additional information for particular types of services or based on particular circumstances or state requirements.

A clean claim has no defect or impropriety and meets the following criteria:

- The claim is an eligible claim for a health service provided by an eligible health care provider to a UnitedHealthcare Community Plan member under the agreement.
- The claim does not lack any of the required substantiating documentation.
- The claims contains correct coding of diagnosis, procedure, or other required information.
- There is no dispute regarding the amount claimed.

- UnitedHealthcare Community Plan has no reason to believe the claim has been submitted fraudulently.
- The claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the agreement.

The following data elements are required for correct claims payment. The bolded information is critical for correct claim payment:

- CMS 1500
  - Member ID number.
  - Member’s name, sex, and date of birth.
- Information about other insurance coverage, including job-related, auto or accident information.
- Referring care provider’s name (if applicable).
- Current ICD-10 diagnostic codes by specific service code to the highest level of specificity.
- Date of service(s), place of service(s) and number of services (units) rendered, current CPT-4 and HCPCS procedure codes with modifiers where appropriate.
- Care provider’s NPI and federal tax ID number.
- Charges per service, and total charges.
- Name and signature.
- Name, address and phone number of care provider performing the service, as in your contract document.

You are responsible for the accuracy, truthfulness, and completeness of all claims submitted whether prepared or submitted by your office or by an outside billing service or clearinghouse.

All care providers are required to supply their assigned care provider ID on all claims in the PIN field.

- Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers as well as CPT 99360 (physician standby).
- Attach a detailed documentation of the procedure or service provided for claims submitted with unlisted medical or surgical Current Procedural Terminology.
Our Claims Process

(CPT) as well as experimental or reconstructive services.

- Attach nursing notes and treatment plan for claims submitted for home health care, nursing care, or skilled nursing services.

If your contract rate is tied to the Medicaid fee schedule (i.e., 100% of Medicaid fees), you must bill your services on the claim form which is required by the State of Wisconsin Medicaid program. The use of any other form will result in denials or recoveries.

- UB-04
  - Date and hour of admission and discharge as well as member status-at-discharge code.
  - Type of bill code, type of admission (e.g., emergency, urgent, elective, newborn).
  - Birth weight of a newborn.
  - Current revenue code and description.
  - Current principal diagnosis code at highest level of specificity. Current other diagnosis codes, if applicable, at highest level of specificity.
  - Attending care provider ID.
  - Bill all outpatient surgeries with the appropriate revenue and CPT/HCPCS code.
  - Provide specific CPT and appropriate revenue code (e.g., laboratory, radiology, diagnostic or therapeutic) for services reimbursed based on a contractual fee maximum.
  - Attach an itemized statement if submitting a claim that will reach the contracted stop loss.
  - Submit claims according to any special billing instructions that may be indicated in your agreement or letter of agreement.
  - Care provider tax identification number (TIN).

You are responsible for the accuracy, truthfulness, and completeness of all claims submitted whether prepared or submitted by your office or by an outside billing service or clearinghouse.

Submission of CMS 1500 Claims with Unlisted Codes and Experimental or Reconstructive Services

Submission of Medical or Surgical Codes
Attach a detailed documentation of the procedure or service provided for claims submitted with unlisted medical or surgical CPT or ‘other’ revenue codes as well as experimental or reconstructive services.

Submission of CMS 1500 Unlisted Drug Codes
Second submissions, tracers, and claim status requests should be submitted electronically no sooner than 45 days after original submission.

Pharmacy Claims
Covered care provider administered drugs should be billed to UnitedHealthcare Community Plan.

Billing Members

UnitedHealthcare Community Plan contracted care providers are generally prohibited by the terms of their contract and by Wisconsin State Law from billing members for any costs related to services they provide, other than any applicable copayment amount. For covered services, payment by UnitedHealthcare Community Plan is considered payment in full.

Please be aware that you must not balance-bill members for any of the following reasons:

- If there is a difference between the charge amount and the UnitedHealthcare Community Plan fee schedule.
- If a claim has been denied for late submission, unauthorized service, or as not medically necessary.
- When claims are pending review by UnitedHealthcare Community Plan.

The use of care provider TIN is mandatory, as the adjudication system will verify the care provider TIN prior to loading the claim for payment. If the care provider TIN is not found or is incorrect, the claim will be rejected for processing and must be resubmitted with the correct care provider TIN.
If applicable, please remember to obtain the member copay at the time of service. If you wish to bill the member for non-covered services, you must discuss this with the member prior to rendering the services and obtain signed waiver of liability from that member that specifies the service and specific amount in question.

If you have questions about submitting claims to us, please contact Provider Services at 877-651-6677 or visit UHCCommunityPlan.com and click on the EDI Support Services link.

**New Claim Submission**
Submit claims 90 days after the service date or as listed on your contract.

**COB Submissions**
Submit COB claims 90 days after receiving the primary insurance carriers EOB or as listed on the care provider’s contract.

**Corrected Claim Submissions**
Submit corrected claims 90 days after the remit date or as listed on your contract.

**Claim Appeals**
If you disagree with a claim payment, you can appeal our decision by submitting a claim reconsideration request (for administrative denials only) and/or a formal appeal. All claim consideration requests and formal appeals must be received by UnitedHealthcare Community Plan within 60 days of the date of the provider remittance. You may submit a claim reconsideration request first and if you do not receive a decision on your claim reconsideration request, or don’t agree with the outcome of that claim reconsideration request, you may file a formal appeal as long as the formal appeal with the required documentation is received by UnitedHealthcare Community Plan within 60 days of the date of the provider remittance. A claim reconsideration request is not considered a formal appeal. You must submit a formal appeal to reserve your right to appeal our decision to the Wisconsin Department of Health Services.

You must submit a formal appeal to reserve your right to appeal our decision to the Wisconsin Department of Health Services.

You may file an electronic or paper claim reconsideration.

Paper claim reconsiderations go to:
UnitedHealthcare Community Plan
P.O. Box 5280
Kingston, NY 12402-5280
Fax: 801-994-1224

For detailed instructions on filing a claim reconsideration, click here or go to UHCprovider.com/claims > Submit a Claim Reconsideration/Begin Appeal Process or select Submit Reconsideration Requests for Multiple Claims.

Claim reconsideration requests include, but are not limited to, disputes concerning the following reasons:
- Failure to obtain required prior authorization.
- Untimely submission.
- Reimbursement disputes.

UnitedHealthcare Community Plan policy requires all formal appeals (including those for administrative denials, inpatient administrative denials and medical necessity determinations) must be received by UnitedHealthcare Community Plan with required documentation within 60 days of notice of denial. You may formally appeal any type of claim issue, including those that are:
- Denied in entirety.
- Denied in part.
- Paid at a rate inconsistent with contracted rates.

Formal appeals should be sent to the following address:
UnitedHealthcare Community Plan Appeals
P.O. Box 31364
Salt Lake City, UT 84131

The cover letter should state you are filing a formal appeal. Several claims with the same reasons for appeal may be combined in a single appeal letter, with an attached list of claims.

State the specific denial reason denial on the remittance. UnitedHealthcare Community Plan does not accept appeals that fail to address the reason for the denial stated on the remittance.
For payment appeal rates, state the basis for the dispute and enclose all relevant documentation, including but not limited to contract rate sheets and fee schedules.

You have the right to appeal to the Department of Health Services if we fail to respond to your formal appeal within 45 days or if you are not satisfied with the formal appeal response. You may not appeal a claim reconsideration decision to the state unless you’ve submitted a formal appeal for the same issue to UnitedHealthcare Community Plan within 60 days of the date of the initial claim determination. To ask the state to review our decision, you may send appeals to:

BadgerCare Plus and Medicaid SSI
Managed Care Unit – Provider Appeals
P.O. Box 6470
Madison, WI 53716-0470
Fax: 608-224-6318

A decision to uphold the HMO’s original payment denial or to overturn the denial will be made based on the documentation submitted for review. Failure to submit the required documentation or submitting incomplete/insufficient documentation may lead to an upholding of the original denial. The decision to overturn an HMO’s denial must be clearly supported by the documentation.

Care providers may use the department’s form when submitting an appeal for state review. All elements of the form must be completed or listed in the letter if the form is not used. The form with instructions is available at the following website: dhs.wisconsin.gov.

Care providers are required to submit legible copies of all of the following documentation, regardless if the Managed Care Program Provider Appeal form or their own appeal letter is used. Incomplete appeals will not receive departmental review, will be returned and the denial upheld. The appeal packet must contain:

- A copy of the original claim submitted to the HMO. If applicable, include a copy of all corrected claims submitted to the HMO.
- A copy of all of the HMO’s payment denial remittance(s) showing the date(s) of denial and reason code with a description of the exact reason(s) for the claim denial.

- A copy of the care provider’s written appeal to the HMO.
- A copy of the HMO response to the appeal.
- A copy of the medical record for appeals regarding coding issues, medical necessity, or emergency determination. Care providers should only send relevant medical documentation that supports the appeal. Large records submitted with no indication will not be reviewed. Large documents should be submitted on a CD.
- A copy of contract language that supports your appeal. If contract language is submitted, indicate the exact language that supports overturning the payment denial. Contract language submitted with no indication will not be reviewed.
- Any other documentation that supports the appeal (e.g., commercial insurance explanation of benefits/explanation of payment to support Wisconsin Medicaid as the payer of last resort).

Care providers should notify ForwardHealth if the HMO overturns their original denial and reprocesses and pays the claim for which they have submitted an appeal. Notification should be faxed to ForwardHealth at 608-224-6318. This documentation will be added to the original appeal documentation to complete the record.

Claim Overpayments

If you identify a claim where you were overpaid or if we identify an overpaid claim that you do not dispute, you must send us the overpayment within 30 calendar days from the date of your identification of the overpayment or our request. 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.

All overpayments received from us or credit balances existing on your records should be sent to:
Our Claims Process

UnitedHealthcare Community Plan
P.O. Box 740804
Atlanta, GA 30374-0800

Please include appropriate documentation that outlines the overpayment including member ID and number, date of service and amount paid.

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

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal the determination (see Claim Appeals).

If you are appealing a claim that was denied because filing was not timely, for:

- **Electronic claims** – Include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim.
- **Paper claims** – Include a copy of a screen print from your accounting software to show the date you submitted the claim. The accounting software information must also include proof the claim is for the correct member and the correct visit.

If you disagree with an overpayment refund request, send a letter of appeal to the address noted on the refund request letter. Your appeal must be received within 30 days of the refund request letter to allow sufficient time for processing the appeal, and avoid possible offset of the overpayment against future claim payments to you. When submitting the appeal, please attach a copy of the refund request letter and a detailed explanation of why you believe the refund request is in error.

If you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed.

Outlier Appeal Process

You must submit a formal appeal for an outlier payment. The outlier appeal request must be submitted within the appeals time frame. The outlier appeal request must be submitted to:

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

You are notified of the need to review the cost outlier, request medical records and a line itemized bill. Upon receipt of all documentation, the claim is reviewed for an outlier payment.

If you agree with the review determination, the claim is processed for payment.

You have the right to appeal to the Department of Health Services if we, or UnitedHealthcare Community Plan, fail to respond to your appeal within 45 days or if you are not satisfied with our appeal response. To ask the state to review our decision, you may appeal to:

BadgerCare Plus and Medicaid SSI
Managed Care Unit – Provider Appeals
P.O. Box 6470
Madison, WI 53716-0470
Fax: 608-224-6318

Subrogation and Coordination of Benefits

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

**Subrogation** – We reserve the legal right to recover benefits paid for a member’s health care services when a third party causes the member’s injury or illness.

**COB** – Coordination of benefits is administered according to the member’s benefit contract and in accordance with applicable statutes and regulations.
Please update your member’s insurance information at each visit to avoid confusion and inaccurate COB.

**Appeal Requests for Primary Payment when we are the Secondary Insurer**

You may request primary payment from us when UnitedHealthcare Community Plan is the secondary insurer if you received a denial from the member’s primary insurance due to no member response.

To request an appeal for primary payment, send us the following information:

- Denied claim from UnitedHealthcare Community Plan
- Denied remit from the primary insurer telling you they need additional information from the member
- Two letters sent to our member at least 15 days apart showing you attempted to reach them to update the primary insurance information

Please mail to:

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

**Claim Editing**

**Care Provider Claim Editing – iCES Clearinghouse From Optum:**

UnitedHealthcare Community Plan uses iCES (INGENIX Claim Edit System clearinghouse), which is owned and maintained by Optum. iCES is a clinical edit system application that analyzes physician health care claims based on business rules designed to automate UnitedHealthcare Community Plan reimbursement policy and industry standard coding practices.

iCES is interfaced with the claims application, and claims are analyzed prior to payment to validate billings to minimize inaccurate claim payments.

The UnitedHealthcare Community plan care provider portal, [UHCCommunityPlan.com](http://UHCCommunityPlan.com), outlines the reimbursement policies which are applied in iCES as clinical edits. In addition iCES applies the following edits:

1. Basic field validity screens for member demographic and clinical data elements on each claim.
2. Effective-dated ICD-10-CM, CPT-4 and HCPCS Level II code validation, based on service dates and member clinical data.

**Facility Claim Editing – Facility Editor From Optum:**

UnitedHealthcare Community Plan uses the Optum Facility Editor for claims for outpatient services provided to Medicaid beneficiaries. The Facility Editor is a rules-based software application that evaluates outpatient claims data for validity and reasonableness. These reasonableness tests incorporate the Outpatient Code Edits (OCE) developed by the Centers for Medicare and Medicaid Services (CMS) for hospital outpatient claims. The Facility Editor is used to examine outpatient facility-based claims prior to payment to validate billings to minimize inaccurate claim payments.

The UnitedHealthcare care provider portal outlines the reimbursement policies which are applied in Facility Editor as clinical edits. The CMS OCE edits that will be applied by the Facility Editor include:

1. Basic field validity screens for member demographic and clinical data elements on each claim.
2. Effective-dated ICD-10-CM, CPT-4 and HCPCS Level II code validation, based on service dates and member clinical data.
3. Facility-specific National Correct Coding Initiative edits. The NCCI edits identify pairs of codes that are not separately payable, except under certain circumstances. NCCI edits were developed for use by all health care providers; the Facility Editor incorporates those NCCI edits that are applicable to facility claims. The NCCI edits in the Facility Editor are applied to services billed by the same hospital for the same beneficiary on the same date of service. There are two categories of NCCI edits: (a) Comprehensive code edits, which identify individual codes, known as component codes, which are considered part of another code, and which are designed to prevent unbundling; and (b) Mutually exclusive code edits, which identify procedures or services that could not reasonably be performed at
the same session by the same care provider on the same beneficiary.

4. Other OCE edits for inappropriate coding, including incorrect coding of bilateral services, evaluation and management services, incorrect use of certain modifiers, and inadequate coding of services in specific revenue centers are also included in the Facility Editor.

**Other Claim Edits – Claim Processing System From Perot Systems**

**Generic Claim Edits:**

- Member active in system on date of service.
- Care provider active in system on date of service, for contract to be paid upon.
- Timely filing checks by type of care provider or line of business.
- Check for authorization, if required for service on claim.
- Diagnosis, procedure, HCPCS, revenue code or modifier valid in system.
- Paperwork missing when required for claim processing (e.g. EOB for coordination of benefits).
- Duplicate payment.
- Dates of services validity.
- Facility-specific claim edits.
- Incomplete or invalid member status, admission date, admission type, or discharge information.
- Date of service precedes date of death.

**Vaccines For Children (VFC) Program**

Immunizations offered in the state VFC Program must be ordered by your office. We do not reimburse you for the vaccine ordered by the VFC Program, but we reimburse for administering the vaccine. You must submit the vaccine procedure code for all VFC vaccines to receive the administration fee.

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

- Eligible for Wisconsin 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).
Integrity and Compliance

Introduction
UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with members, care providers, suppliers, and governmental officials and agencies. The need to make sound, ethical decisions as we interact with physicians, other health care providers, regulators, and others has never been greater. It’s not only the right thing to do, it is necessary for our continued success and that of our business associates.

Compliance Program
As a business segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity Program. The UnitedHealthcare Corporate Compliance Program is a comprehensive program designed to educate all employees regarding the ethical standards that guide our operations, provide methods for reporting inappropriate practices or behavior, and procedures for investigation of, and corrective action for any unlawful or inappropriate activity. The UnitedHealth Group Ethics and Integrity 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 education of employees.
- Assessing compliance by monitoring and auditing.
- Responding to allegations or information regarding violations.
- Enforcement of policies and discipline for confirmed misconduct or serious neglect of duty.
- Reporting mechanisms for employees, managers and others 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 located in each health plan or business unit. In addition, each health plan has an active Compliance Committee, consisting of senior managers from key organizational functions. The Compliance Committee provides direction and oversight of the program with the health plan.

Reporting and Auditing
Any unethical, unlawful or otherwise inappropriate activity by a UnitedHealthcare Community Plan employee which comes to the attention of a care provider should be reported to a UnitedHealthcare Community Plan senior manager in the health plan or directly to the Ethics and Compliance Help Center at 800-455-4521.

UnitedHealthcare Community Plan’s Special Investigations Unit (SIU) is an important component of the Corporate Compliance Program. The SIU focuses on proactive prevention, detection, and investigation of potentially fraudulent and abusive acts committed by care providers and plan members. This department is responsible for the conduct and/or coordination of anti-fraud activities in all UnitedHealthcare business units. A toll-free Fraud and Abuse Hotline, 866-242-7727, has been set up to facilitate the reporting process of any questionable incidents involving plan members or care providers. Please refer to the Fraud and Abuse section of this administrative guide for additional details about the UnitedHealthcare Fraud and Abuse Program.

An important aspect of the Corporate Compliance Program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews and audits to help ensure compliance with law, regulations, and contracts. When informed of potentially irregular, inappropriate or potentially fraudulent practices within the plan or by our care providers, UnitedHealthcare Community Plan conducts an appropriate investigation. Care providers are expected to cooperate with the company and government authorities in any such inquiry, both by providing access to pertinent records (as required by the Participating Care Provider Agreement) and access to provider office staff. If activity in violation of law or
Compliance

regulation is established, appropriate governmental authorities will be advised.

If you become the subject of a governmental inquiry or investigation, or a government agency requests or subpoenas documents relating to your operation (other than a routine request for documentation from a regulatory agency), you must advise UnitedHealthcare Community Plan of the details of this and of the factual situation which gave rise to the inquiry.

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are estimated to reduce program spending by $11 billion over five years. These provisions are aimed at reducing Medicaid fraud.

Under Section 6032 of The DRA, every entity that receives at least $5 million in Medicaid payments annually must establish written policies for all employees of the entity, and for all employees of any health plan or agent of the entity, providing detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a contracted care provider with UnitedHealthcare, you and your staff are subject to this provision. The UnitedHealth Group policy, titled 'Integrity of Claims, Reports and Representations to Government Entities' can be found at UHCCommunityPlan.com. This policy details our commitment to compliance with the federal and state false claims acts, provides a detailed description of these acts and of the mechanisms in place within our organization to detect and prevent fraud, waste and abuse, as well as the rights of employees to be protected as whistleblowers.

Definitions of Fraud and Abuse

Fraud: An intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Abuse: Care provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Examples of fraud and abuse include:

Misrepresenting Services Provided
- Billing for services or supplies not rendered.
- Misrepresentation of services/supplies.
- Billing for higher level of service than performed.

Falsifying Claims/Encounters
- Alteration of a claim.
- Incorrect coding.
- Double billing.
- False data submitted.

Administrative or Financial
- Kickbacks.
- Falsifying credentials.
- Fraudulent enrollment practices.
- Fraudulent third party liability reporting.

Member Fraud or Abuse Issues
- Fraudulent/Altered prescriptions.
- Card loaning/selling.
- Eligibility fraud.
- Failure to report third party liability/other insurance.

Fraud and Abuse

Fraud and abuse by care providers, members, health plans, employees, etc. hurts everyone. Your assistance in notifying UnitedHealthcare Community Plan about any potential fraud and abuse that comes to your attention and cooperating with any review of such a situation is vital and appreciated. We consider this an integral part of our mutual ongoing efforts to provide the most effective health outcomes possible for all our members.
**Compliance**

**Reporting Fraud and Abuse**

If you suspect another care provider or a member has committed fraud or abuse, you have a responsibility and a right to report it. Reports of suspected fraud or abuse can be made in several ways.

- Go to [UHCCommunityPlan.com](http://UHCCommunityPlan.com) and select ‘Contact Us’ to report information relating to suspected fraud or abuse.
- Call the UnitedHealthcare Special Investigations Unit Fraud Hotline at **866-242-7727**.

For care provider related matters (e.g. doctor, dentist, hospital, etc.) please furnish the following:

- Name, address and phone number of care provider.
- Medicaid number of the care provider.
- Type of care provider (physician, physical therapist, pharmacist, etc.).
- Names and phone numbers of others who can aid in the investigation.
- Dates of events.
- Specific details about the suspected fraud or abuse.

For member-related matters (beneficiary/recipient) please furnish the following:

- The person’s name, date of birth, social security number, ID number.
- The person’s address.
- Specific details about the suspected fraud or abuse.

**Resolving Disputes**

**Agreement Concern or Complaint**

If you have a concern or complaint about your relationship with UnitedHealthcare Community Plan, send a letter containing the details to the address in your agreement with us. A representative will look into your complaint and try to resolve it through informal discussions. If you disagree with the outcome of this discussion, an arbitration proceeding may be filed as described below and in your agreement with us.

If your concern or complaint relates to a matter which is generally administered by certain UnitedHealthcare Community Plan procedures, such as the credentialing or Care Coordination process, you and UnitedHealthcare Community Plan will follow the dispute procedures set forth in those plans to resolve the concern or complaint. After following those procedures, if one of us remains dissatisfied, an arbitration proceeding may be filed as described below and in our agreement.

If we have a concern or complaint about your agreement with us, we’ll send you a letter containing the details. If we can’t resolve the complaint through informal discussions with you, an arbitration proceeding may be filed as described in our agreement.

Arbitration proceedings are held at the location described in your agreement with us.

If a member has authorized you to appeal a clinical or coverage determination on their behalf, that appeal follows the process governing member appeals outlined in the member’s benefit contract or handbook.

**Arbitration**

Any arbitration proceeding under your agreement will be conducted in Wisconsin under the auspices of the American Arbitration Association, as further described in our agreement.

For more information on the American Arbitration Association guidelines, visit their website at [adr.org](http://adr.org).

If a member has authorized you to appeal a clinical or coverage determination on their behalf, that appeal follows the process governing member appeals outlined in the member’s benefit contract or handbook.
Physician and care provider demographic change submission form

The "Physician and provider demographic change submission form" (#M44539-A or M44539-B) on the CD version of the Welcome Kit includes an outdated fax number.

The corrected form is available at UHCprovider.com > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form.
## Physician and provider demographic change submission form

**Please use this form for demographic changes or to update your NPI information.**

Please help ensure that ALL pertinent information is completed as we will be unable to process incomplete forms. Complete all information pertaining to your practice. Fields with an asterisk* are required.

**Please reference the grid in section three. UnitedHealthcare and its affiliates/alliances are listed by fax number/state. Please fax your completed form to the appropriate fax number.**

### Section I  Group demographics

<table>
<thead>
<tr>
<th>Practice/Organization Name</th>
<th>Current Tax ID (TIN)</th>
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<tbody>
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<tr>
<th>National Provider Identifier</th>
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<th>Medicaid ID number</th>
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*Please refer to Section III (page 2) of this fax form for taxonomy code definitions*

*Please list your NUCC Taxonomy Code(s) 1) 2) 3) 4) 5)*

Basis for NPI (applies to organizations only, select only 1 per NPI):

- Provider Name
- Tax ID only (entity whose name is in the W-9 form)
- License Number
- NUCC Taxonomy Code
- Place of Service Address
- Department
- Other (please explain)

☐ Please check here if you have multiple NPIs representing your Practice or Organization. Refer to Section III (page 2) of this fax form.

---

### Section II  Practice/Organization information changes

☐ The new tax ID number is: *Effective* (please attach a copy of the W-9)

☐ We have moved. Our new address is effective

- This new address is a:  ☐ Practice Address  ☐ Billing Address  ☐ Both Practice & Billing Address  ☐ Correspondence Address

☐ Should this new address print in the directory?  ☐ Yes  ☐ No

<table>
<thead>
<tr>
<th>New</th>
<th>Old</th>
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☐ We have changed our practice name to: *Effective*

☐ These physicians/health care providers have left our practice (please provide the effective date and reason for leaving):

☐ These physicians/health care providers have joined our practice effective ________________, (please attach a copy of the W-9)
Section II  continued

☐ Change pertains to all physicians/health care providers under the Tax ID (TIN):
☐ Specify physicians/health care providers affected by the change:

☐ We are closing our practice to new patients effective
☐ We are reopening our practice to new patients effective
☐ Check this box if you do not have a private office and only see patients at the hospital

Signature of Participating Physician/Health Care Provider: Date

Section III  National Provider Identification - Requested information

We would like to capture the “basis” or reason for each NPI, if the organization has more than one NPI or has sub-parts who have NPIs. Please use the grid below as a reference when filling in the “Basis for NPI” and Level Information columns in the NPI Collection Grid below (page 3).

<table>
<thead>
<tr>
<th>If the Basis for your NPI is:</th>
<th>Then supply this information in the Level Information column</th>
<th>Instructional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>C = Entity whose name is on the W-9</td>
<td>Tax ID and Name Filed on W-9</td>
<td>If the organization or sub-part was enumerated strictly on the basis of the name associated with the Tax ID on the W-9 form, then use a “C” in the “Basis for NPI” column. (You will need to indicate whether the Tax ID is a Social Security number or if it is an employer identification number.) Place the Tax ID in the “Level Information” column.</td>
</tr>
<tr>
<td>D = Department</td>
<td>Department Name</td>
<td>If the organization or sub-part was enumerated on the basis of a particular department, provide the Department Name that the NPI was based on, and designate this with a “D” in the “Basis for NPI” column. Insert the Department Name in the “Level Information” column.</td>
</tr>
<tr>
<td>L = License</td>
<td>License Number and State or (state code)</td>
<td>If the organization or sub-part was enumerated by License, provide the state or (state code) and License Number that the NPI was based on, and designate this with an “L” in the “Basis for NPI” column. Insert the License Number and state or state code in the “Level Information” column.</td>
</tr>
<tr>
<td>P = Place of Service Address</td>
<td>Place of Service Address (Street, City, State, ZIP +4)</td>
<td>If the organization was enumerated by place of service address, provide the street address that the NPI was based on and designate this with a “P” in the “Basis for NPI” column. Insert the Place of Service address in the “Level Information” column.</td>
</tr>
<tr>
<td>T= Tax ID Number and Provider Name</td>
<td>Tax ID and Provider Name, where provider is not the name on the W-9, but bills using this TIN</td>
<td>If the organization or sub-part was enumerated by Tax ID and Provider Name, where the provider is not the name listed on the W-9, but uses this TIN, then designate this with a “T” in the “Basis for NPI” column. Place the Tax ID in the “Level Information” column and indicate whether the Tax ID is a Social Security number or if it is an employer identification number.</td>
</tr>
<tr>
<td>X = Taxonomy</td>
<td>NUCC Taxonomy Code</td>
<td>If the organization or sub-part was enumerated by a NUCC Taxonomy code, please provide the Taxonomy Code that the NPI was based on and designate this with an “X” in the “Basis for NPI” column. Place the NUCC Taxonomy Code in the “Level Information” column.</td>
</tr>
<tr>
<td>O = Other</td>
<td>Specify details for selecting “Other”</td>
<td>Provide any other basis for NPI in the “Basis for NPI” column and designate as “O”, with a description of the basis for that NPI in the “Level Information” column.</td>
</tr>
<tr>
<td>M = Name</td>
<td>Provider Name</td>
<td>This is intended for use by physicians and allied health professionals (people providers). Insert the name in the “Level Information” column.</td>
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</tbody>
</table>
**NPI collection grid**

In the grid below please insert your Organization or Sub-Part NPI Number, Name, and Taxonomy Code(s) associated with that NPI. Please indicate the basis for that particular NPI with the appropriate letter from the grid above in the “Basis for NPI” column. Indicate the appropriate ‘Level Information’. If the number of NPIs exceeds this sheet, please use the formatted spreadsheet (NPI Tracking Template) available on UHCprovider.com > Most Visited > National Provider Identifier (NPI) > Multiple NPI Submission Fax Form to list your NPIs.

<table>
<thead>
<tr>
<th>NPI Number</th>
<th>Organization / Sub-Part Name</th>
<th>Taxonomy Code (Codes associated with each individual NPI)</th>
<th>Basis For NPI</th>
<th>Level Information</th>
<th>NPI Issue Date MM/DD/YYYY</th>
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Name of individual completing this form

Telephone (   ) Email

**Please fax your completed form to the appropriate fax number below.**

**UnitedHealthcare and its affiliates/alliances**

<table>
<thead>
<tr>
<th>Fax number</th>
<th>States (if applicable)</th>
</tr>
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<tbody>
<tr>
<td>1-855-265-8686</td>
<td>MD, VA, WV, DC, DE,</td>
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<tr>
<td>1-855-264-7582</td>
<td></td>
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<tr>
<td>1-855-263-9590</td>
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<tr>
<td>1-855-314-6844</td>
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<tr>
<td>1-855-312-1651</td>
<td>NY, NJ, CT (excludes Upstate NY and Empire Health Plan)</td>
</tr>
<tr>
<td>1-855-773-3156</td>
<td>AL, AK, AR, AZ, CO, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MA (New England), MI, MO, MS, MT, NC, NE, NH, NV, NM, OH, OK, OR, PA, PR, RI, SC, SD, TN, TX, UNY (Upstate NY), Empire (Mkts 99318, 99309, 99310), UT, VI, VT, WA, WI, WY</td>
</tr>
</tbody>
</table>

Wisconsin 04/17
UHCCommunityPlan.com

Confidential and Proprietary
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Quality Improvement

Accessibility of Service
UnitedHealthcare Community Plan establishes standards for appointment access and after-hours care to help ensure timely access to care for members. Your hours of operation must not discriminate against Medicaid/ BadgerCare or SSI members.

In addition, performance standards are established for facility and office wait times. Performance against these established standards is measured and evaluated on an annual basis.

### Type of Service | Standard
---|---
Preventive Care Appointment With PCP | Within 30 days
Regular/Routine Care Appointment With PCP | Within 30 days
Urgent Care Appointment | Same Day
Emergency Care | Immediate
After Hours Care – PCP | 24 hours/7 days a week
Facility and Office Wait Times | 20 minutes

Office Hours
Care providers must offer office hours of operation to Medicaid members that are not less than those offered to commercial members.

Care Provider Office Site Quality
UnitedHealthcare Community Plan and affiliates monitor complaints concerning participating care providers and facilities. Complaints about a care provider’s office site and facilities are recorded, investigated, and appropriate follow-up is conducted to assure that members receive care in a safe, clean, accessible and appropriate environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all primary care provider office sites to help ensure the quality of the facility in which the care is provided.

UnitedHealthcare Community Plan requires that all clinic facilities meet the following minimum site standards:

- Overall appearance is clean and orderly
- Handicapped parking is available
- Facility is handicapped accessible
- Adequate waiting room space
- Exam room(s) are adequate for providing patient care
- Exam room(s) allow for privacy
- Exits are clearly marked
- Fire extinguishers are accessible
- Record of fire inspection in the last year

Medical Record Documentation Standards
All participating primary care UnitedHealthcare Community Plan providers are required to maintain medical records according to UnitedHealthcare Community Plan Medical Records Documentation Standards contained in this manual, and in a complete and orderly fashion which promotes efficient and quality patient care and maintains patient confidentiality. Participating care providers are subject to UnitedHealthcare Community Plan’s periodic quality review of medical records to determine compliance to the following medical record keeping requirements.
Quality Improvement

Confidentiality of Records

Office policies and procedures exist for the following:

- Confidentiality of the patient medical record
- Initial and periodic training of office staff concerning medical record confidentiality
- Release of information
- Record retention
- Availability of medical record when housed in a different office location (as applicable)

Record Organization

An office policy exists that addresses a process to respond to and provide medical records upon request of patients to include a provision to provide copies within 48 hours in urgent situations.

Medical records are maintained in a current, detailed, organized and comprehensive manner. Organization should include evidence of:

- Identifiable order to the chart assembly
- Papers are fastened in the chart
- Each member has a separate medical record

Medical records are:

- Filed in a manner for easy retrieval
- Readily available to the treating care provider where the member generally receives care
- Promptly sent to specialty care providers upon member request and within 48 hours in urgent situations

Medical records are:

- Stored in a manner that helps ensure protection of confidentiality
- Released only to entities as designated consistent with federal requirements.
- Kept in a secure area accessible only to authorized personnel
### Procedural Elements

**Medical records are legible.***

All entries are signed and dated.

Member name/identification number is located on each page of the record.

Linguistic or cultural needs are documented as appropriate.

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.

Mechanism for monitoring and handling missed appointments is evident.

An executed 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 regarding advance directives.

**A problem list includes a list of all significant illnesses and active medical conditions.***

**A medication list includes prescribed and over the counter medications and is reviewed annually.***

**Documentation of the presence or absence of allergies or adverse reactions is clearly documented.***

### History

An initial history (for members seen three or more times) and physical is present to include:

- **Medical and surgical history***
  - A family history that minimally includes pertinent medical history of parents and/or siblings
  - A social history that minimally includes pertinent information such as occupation, living situations, education, smoking, ETOH, and/or substance abuse use/history
  - Current and history of immunizations of children, adolescents and adults

Screenings of/for:

- Recommended preventive health screenings/tests
- Depression
- High risk behaviors such as drug, alcohol and tobacco use; and if present, document tobacco counseling, engage in appropriate drug, alcohol, tobacco treatment programs
- Medicare members for functional status assessment and pain
- Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate
## Problem Evaluation and Management

Documentation for each visit includes:

- Appropriate vital signs (Measurement of height, weight, and BMI annually)
- Chief complaint*
- Physical assessment*
- Diagnosis*
- Treatment plan*

Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines.

Documentation of all elements of age appropriate federal 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

- 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 practitioner review.

There is evidence of practitioner 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 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, physical or other therapies, as ordered by the care provider are documented.
Advance Directives

Wisconsin law allows persons 18 and older to execute an advanced directive. An advanced directive is a legal document instituted in advance of any incapacitating illness or injury. A Power of Attorney for Healthcare and a Living Will are advanced directives.

UnitedHealthcare Community Plan respects and encourages all members to have a written Advanced Directive and does not discriminate in providing care for individuals who execute an Advanced Directive nor against providers who have policies or beliefs which prohibit them from honoring certain types of requests made in Advanced Directives.

UnitedHealthcare Community Plan also requires contracted providers to document in the medical records whether or not their members have executed an advance directive.